Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
National Advisory Council

MEETING MINUTES: March 22-23, 2006

March 22, 2006

The National Advisory Council (NAC) for the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) convened on March 22, 2006, at 9:00 a.m. at SAMHSA's headquarters in Rockville, Maryland. CMHS Director A. Kathryn Power, M.Ed., presided. Council members present during the 2-day meeting included Jeffrey Geller, M.D., Timothy A. Kelly, Ph.D., Carlette Randall, M.S.W., and Michael Vergare, M.D. Judge Ginger Lerner-Wren and D.J. Ida, Ph.D. were unable to attend due to other professional commitments. Sally L. Satel, M.D. and Maria Kovacs, Ph.D. were absent for medical reasons. Cheryll Bowers-Stephens, M.D., M.B.A., joined the meeting on Day 2. Also in attendance were *ex officio* member William Van Stone, M.D., CMHS Deputy Director Ted Searle, M.B.A., and Council Executive Secretary Dianne McSwain, M.S.W.

WELCOME AND OPENING REMARKS
A. Kathryn Power, M.Ed., Director, CMHS and Chair, CMHS National Advisory Council

Ms. Power welcomed participants and introduced Mr. Christopher Carroll, who recently accepted a position as her Special Assistant. The Council members introduced themselves and Ms. Power provided an overview of the agenda for the 2-day meeting. She highlighted two key areas: The SAMHSA supportive response in the aftermath of Hurricanes Katrina, Rita, and Wilma; and the priority of "consumers first" in the mental health transformation message.

PROGRESS TOWARD TRANSFORMATION: 2005-2006
A. Kathryn Power, M.Ed., Director, CMHS and Chair, CMHS National Advisory Council

Incorporating Recovery in Every Aspect of Our Work

Ms. Power stated that CMHS staff were incorporating the concept of recovery into every aspect of their work and the agency was embedding an understanding of recovery into every service system. She reported that a brochure was published describing the National Consensus Statement on Mental Health Recovery after 1 ½ years of work to achieve consensus. More than 100 experts, representing mental health consumers, family members, providers, advocates, researchers, academicians, managed care organizations, and accreditation organizations contributed. Ms. Power asked Council members to review the statement and provide reactions so that discussion on the topic could continue over time. She noted that a member of NAC's Consumer Subcommittee raised the issue of adding economic empowerment to the statement. She said the brochure could be used as a tool for stimulating discussion, while providing common language for the field. Dr. Kelly suggested adding the concept of a real home, a real job, and a satisfactory life with friends and family to the recovery statement. It was also suggested that the brochure be dated to distinguish it from subsequent versions.

Ms. Power stated that CMHS was identifying 2006 as the "Year of the Consumer" to ensure that the consumer voice is incorporated into all agency work. The first activity marking the Year of the Consumer was the photo exhibit, "Fine Line: Mental Health/Mental Illness" by photographer Michael Nye.

She also reported that the National Anti-Stigma Campaign was moving to the next level. This is a 3-year program sponsored by SAMHSA in conjunction with the Ad Council to reduce the stigma and discrimination faced by people with mental health problems. The groundwork was laid by the Elimination of Barriers (EBI) Initiative, a demonstration project that involves eight States in a public education and awareness campaign. Members of CMHS' Office of Consumer Affairs were planning to meet with the Ad Council in New York to finalize the national strategic plan for anti-stigma messaging via TV, radio, and print PSAs.

Communication Efforts

Ms. Power said that multimedia and the arts are powerful tools that can be used to express the agency's belief in recovery. In 2005, SAMHSA received an Emmy from the National Television Academy for the PSA, "*15+ Make Time to Listen…Take Time to Talk About Bullying*, which provided parents and caregivers with information about bullying and methods for communicating with their children on the subject. The campaign was launched in the Washington, DC area in conjunction with a local TV station.

The photo exhibit, "Fine Line: Mental Health/Mental Illness" by photographer Michael Nye was on display at SAMHSA for 2 months, beginning on January 3rd. The 55 portraits and recorded voices feature the stories of persons impacted by mental health problems. Ms. Powers noted that these types of artistic efforts should be promoted in other arenas.

The Voice Awards, part of the National Anti-Stigma Campaign, honor writers and producers of television programs and movies who provide accurate portrayals of people with mental illnesses. Ms. Power stated that the second annual Voice Awards will take place on August 23 in Los Angeles. SAMHSA is partnering with the Writers Guild of America, the Ad Council, the American Psychiatric Foundation, the American Psychological Association, the National Association of State Mental Health Program Directors, the Mental Health Media Partnership, and the Mental Health Research Organization in this effort. Ms. Power said nominations for the Voice Awards would be accepted through Friday, April 7, 2006.

Mental Health Transformation SIG

The seven States that were awarded Mental Health Transformation State Incentive Grants (MHT SIGs) held their first meeting on January 18-20, 2006. Ms. Power said CMHS is supporting them as they move forward with transformation. Each State has been using the first months of the grant period to organize their local networks and begin the work that applies in their unique situations. Ms. Power said the Government has demonstrated a strong commitment to systems change by investing in the infrastructure needs of these grantees.

Transformation Action Initiative (TAI) – Connectors/Brokers

To assist the MHT SIG States, a CMHS Project Officer has been designated as a "Connector" for each State. They serve as resources for the States, share information on the States' progress with each other and CMHS, and foster learning across grantee locations. A "Broker" is a consultant assigned to a specific SIG State who helps negotiate technical assistance and works directly with the designated Connector.

Dr. Kelly stated that he believes there is a window of opportunity for transformation before the effort becomes stale. He asked Ms. Power if the MHT SIG grants represent the leading edge of this initiative. She replied that they are part of the leading edge and will demonstrate the effects of an investment in infrastructure. The plan is build a "contagion factor" with other States and with the Federal Partners so that the successes of the SIG States are replicated. Dr. Kelly asked if it would be possible to have a second wave of MHT SIG grants. Ms. Power said this is not funded in the FY07 budget.

Institute of Medicine Report: Improving the Quality of Health Care for Mental and Substance Use Conditions

Ms. Power asked to hear observations from the Council about the new IOM report. It states that mental health and substance use conditions are health conditions and should be addressed as such. The report also touches on the issue of stigma. Ms. Power said this report contributes to a change in semantics that will benefit the field of behavioral health and relates to the messages the field is trying to convey. Dr. Kelly mentioned the new publication, *From Study to Action: A Strategic Plan for Transformation of Mental Health Care,* published by the California Institute for Mental Health. Ms. Power acknowledged that the document is a powerful tool.

National Business Group on Health—Employer Toolkit

Ms. Power spoke about *An Employers Guide to Behavioral Health Services,* published by the National Business Group on Health (NBGH), which represents Fortune 500 companies. NBGH collaborated with CMHS in the Guide's development. The document recommends that employers draw on behavioral health services to care for their employees' overall health needs, which will improve productivity. It touches on the issue of parity, using the synonymous term, "equalizing benefits." Ms. Power said the ongoing dialogue with the business community represents a new sphere of influence for behavioral health.

Federal Partners Action Agenda Update

Ms. Power stated that the number of Federal Partners continues to grow. She said the Federal Executive Steering Committee (FESC) recently held their first meeting and noted that it is unprecedented for the Deputy Secretaries and Under-Secretaries from 21 Federal agencies to come together as they have. The Federal Partners are starting their work by focusing on five areas in 2006: suicide prevention, integration of primary and mental health care, appropriate financing of mental health care, employment and transition issues, and disaster response and recovery. Ms. Power stated that this broad partnership provides an opportunity to foster change within the cultures of these agencies that will transcend administrations.

Acute Care Workgroup Report

The New Freedom Commission asked CMHS to address several issues, one of which was acute care. The workgroup that was created for this purpose met for over a year and delivered a report to Ms. Power in January 2006. The agency was analyzing the best way to use the information provided.

Rural Mental Health Initiatives

Ms. Power stated that rural mental health initiatives are taking place under Anne Mathews-Younes, Ed.D. and Susan Keys, Ph.D. An action outline was developed with the Federal Partners and specific activities and strategy development with SAMHSA was planned.

Matrix Modernization

Ms. Power reported on changes to the SAMHSA priorities matrix. Workforce development was made a cross-cutting principle and the work of the Annapolis Coalition would be reflected in SAMHSA's workforce efforts moving forward. Suicide prevention was made a stand-alone area. Ms. Power said she would be working with CMHS' Richard McKeon, Ph.D. and others on suicide prevention efforts across SAMHSA and in the States' transformation efforts. She noted that Congress funded the Garrett Lee Smith Act in the FY07 budget.

The Spirit of Recovery: All-Hazards Behavioral Health Preparedness and Response

A conference will be held in New Orleans on May 22-26, 2006 to discuss the experiences and lessons learned during SAMHSA's response to the hurricanes. Ms. Power noted the phenomenal amount of work accomplished by SAMHSA's staff and the fact that the agency is still heavily engaged in the response.

CMHS UPDATES AND COUNCIL DISCUSSION

FY07 Budget
Ted Searle, Deputy Director, CMHS

Mr. Searle reported on current budget activities, explaining that CMHS was conducting auditing and reviews for FY05, working on budget execution for FY06, and waiting for Congressional action on the budget submitted for FY07. Budget planning and formulation were taking place for FY08. Instructions for CMHS on increases and decreases were expected from SAMHSA and the Office of Management and Budget (OMB). Mr. Searle referred to a handout depicting funding trends since 1993. He pointed out that in 2001 and 2002, there was significant growth in all programs. CMHS has grown steadily, with the exception of the last couple of years. Mr. Searle noted that the Garret Lee Smith Act would have a strong impact on funding for suicide prevention, which is receiving an increase of $2.9 million in '07 for a new American Indian/Alaska Native Youth Suicide Prevention Initiative.

Dr. Kelly asked if he was correct in stating that funding for CMHS effectively doubled under the current administration. Mr. Searle pointed out that this growth actually began in 1998, but had in fact been significant under the current administration.

Dr. Kelly asked if the NAC could provide input on the FY08 budget and request funding for a second wave of MHT SIG grants. Ms. Power encouraged Dr. Kelly to bring that request to SAMHSA Administrator Charles Curie's attention when he addressed the group.

Mr. Searle stated that under the proposed '07 budget, the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program would be maintained at $34 million. The Projects for Assistance in Transition from Homelessness (PATH) would be maintained at $54.2 million and the Children's Mental Health Services Program would be maintained at $104 million. The Programs of Regional and National Significance (PRNS) were to receive $228 million. Overall, the budget for CMHS was proposed at $849 million, a $35 million net decrease (about 2 percent) from 2006. While this represented a net decrease of $67 million from the FY 2006 Appropriation, Mr. Searle pointed out that the decrease reflected a number of grant programs that were coming to a natural end in 2006. Examples were the Safe Schools/Healthy Students and Youth Violence Prevention grants, Seclusion and Restraint, and Statewide Family Networks. He explained that the two highest SAMHSA budget priorities for '07 were the Access to Recovery program at CSAT and Mental Health Transformation activities at CMHS.

Mr. Searle said the proposed budget would reform the Community Mental Health Block Grant so that the States would be required to use amounts above the 1998 State allotment for transformation activities. This means that of the $428 million provided through the Block Grant, at least $153 million would be directed toward mental health transformation. Guidance was being prepared for the States on implementing this change and they were to be held accountable for using these funds for transformation. Mr. Searle clarified that the same formula would be used to distribute funds to each State. The budget also proposed $19.8 million to continue support for the seven MHT SIGs that were awarded in 2005**.**

Comments and Questions

In response to a question from Dr. Michael Vergare, Ms. Power explained that the CSAT Block Grant and the CMHS Block Grant are not interconnected and that CSAT funding was not included in the CMHS budget handout that meeting participants were referring to. However, funding "by Center" was shown in the DHHS 2007 Justification of Estimates book received by each member of the Council. It was noted that the Block Grant for substance abuse treatment is larger than the CMHS Block Grant. CSAT uses their Block Grant for increasing capacity. Ms. Power noted that more discussion was needed on using both Block Grants to bring about change in behavioral health.

Dr. Geller expressed concern about the overall decrease in funding for CMHS over the previous 2 years. Ms. Power stated that it was a difficult fiscal environment and that CMHS was holding its own in budget discussions and maximizing the usefulness of the dollars received.

Dr. Kelly noted a net increase in funding for CMHS of about $70 million under the current administration.

Ms. Power introduced the speakers for the next session.

Achieving Consensus on Recovery
Paolo del Vecchio, Associate Director for Consumer Affairs

Mr. del Vecchio provided additional background on the development of the National Consensus Statement on Mental Health Recovery. He said the statement originated from a recommendation by the President's New Freedom Commission Report, which led to a meeting in December of 2004 on the definition of recovery. The meeting was held by SAMHSA, the Interagency Committee on Disability Research, and six other Federal agencies. Participants commissioned a series of papers and reports on various aspects of recovery. The consensus statement was derived from expert panelist deliberations on the findings.

Mr. del Vecchio said that since the statement's release, CMHS has disseminated it to a university that uses it in training programs. A press release and letter about the statement under Kathryn Power's name were sent to numerous mental health and technical assistance organizations. Mr. del Vecchio asked for ideas on further dissemination and asked how the statement could be used to promote further dialogue with Federal agencies on the concept of recovery.

Comments and Questions

Dr. Vergare stated that a group of 50 psychiatrists in Pennsylvania met on the topic of recovery and barriers to practice and were preparing a paper on the subject, including information on creating culturally sensitive services. They planned to take the paper around the country to foster further discussion. They were also considering how to include this information in training programs for residents in clinical services using the film *Inside/Outside* as a starting point. These doctors feel it is important to incorporate the concept of recovery into the early stages of training.

Dr. Kelly said that some mental health policy makers in California were becoming jaded concerning the promotion of recovery. He felt traction was needed to move forward before more momentum was lost. He also remarked that the concept of "empowerment" is a western idea that focuses on the individual and asked if language should be added to the statement about giving back to the local community.

Dr. Geller commented that the idea of economic empowerment was already included in the consensus statement within the concept of self-direction.

Mr. del Vecchio closed by stating that the next step for Consumer Affairs was to work in the area of person and family-centered planning and he reported that a meeting was held on the topic in December 2005. Those who attended were examining the application of ideas from the disability community in mental health settings. Four training guides on person-directed planning were being developed by a contractor.

Ms. Power introduced Dr. Crystal Blyler of CMHS, who was overseeing the activities of the MHT SIG States and charged with leading the evaluation efforts for the grants.

Transformation – News from the States
Crystal Blyler, Ph.D., Community Support Programs Branch

Dr. Blyler provided an update on the status of the MHT SIG grantees, which include Connecticut, Maryland, New Mexico, Ohio, Oklahoma, Texas, and Washington. She said the States were working to meet the New Freedom Commission goals for a system that is consumer-driven and recovery-based. Using the public health approach for the full lifespan of the consumer, which includes

children, youth, and families, the States were being asked to develop individual plans of care. They were building their efforts on existing State and Federal resources across all relevant agencies and departments. Dr. Blyler said the collaboration of the partners in the Federal working group was serving as a model for interactions among the States, which are conducting a series of meetings with the National Governors Association.

The types of infrastructure activities planned under the grants include: developing financing strategies; making organizational/structural changes; developing consumer and family networks; examining regulations and statutes to inform policy development; credentialing the workforce; developing data infrastructure/MIS systems that focus on outcomes, rather than just service utilization; and creating communications/public awareness campaigns.

Formation of the TWGs

The first task of the MHT SIG States was to form a Transformation Working Group (TWG) led by senior-level executives representing all local agencies and offices that deliver, fund, or administer services and supports for people with mental illnesses and their families. Dr. Blyler explained that the grants were given to the Governor's offices, which have authority over all of these systems, not just mental health. The Governor was to appoint the members of the TWG. The grant requires that the TWG be led by a dynamic chairperson who has an operational vision of transformation, experience managing projects that require the integration of diverse perspectives or agencies, and outstanding oral and written communication skills. It is a full-time position.

There are six areas of mandatory TWG participation: the State Mental Health Commissioner, the Governor's office, youth and adult mental health consumers and family members, Medicare and Medicaid services, the child welfare system, and the criminal and juvenile justice systems. Representatives of housing and employment are also recommended. The TWG is responsible for addressing issues of diversity and cultural competence.

Dr. Blyler explained that within the first year, grantees are required to complete a needs assessment and an inventory of resources from all agencies across the State, and based on the results of these activities, to develop a Comprehensive State Mental Health Plan that reflects the six goals of the New Freedom Commission Report. Ms. Blyler said each plan must be approved before the State could move to the implementation stage. She said the States were in the process of getting the TWGs up and running. She passed out the guidance document developed by CMHS in collaboration with the States for conducting the needs assessment and inventory of resources.

Measuring Outcomes

Dr. Blyer addressed the types of measures that will be used to monitor the progress of the MHT SIG grantees. The seven GPRA infrastructure indicators are: policy changes completed, number of persons in the workforce trained in service improvements (mental health and related), financing policy changes completed, organizational changes completed, number of organizations that regularly obtain and analyze data relevant to the goals, number of consumers and family members in statewide consumer and family run networks, and number of programs implementing practices consistent with the Comprehensive Mental Health Plan. All of these indicators are tied back to the Comprehensive Mental Health Plan.

Dr. Blyler then explained the requirements related to the National Outcome Measures (NOMS). They are part of the State Mental Health Block Grant reporting requirements and will ultimately be built into all CMHS discretionary grant programs. NOMs are the SAMHSA performance measures that focus on positive outcomes, such as employment status, stability of the family, and living conditions. They will serve as a test bed for measuring what recovery means for consumers and for pinpointing where States most need transformation. SAMHSA Administrator Charles Curie has committed to implement NOMs across SAMHSA by 2007, which will allow Congress and consumers to judge programs' effectiveness. The NOMS include:

- Symptoms/functioning;
- Employment and education;
- Criminal justice involvement;
- Living conditions;
- Access to services/number served;
- Hospital readmissions;
- Social support/connectedness;
- Client perception of outcomes;
- Cost effectiveness; and
- Use of evidence-based practices.

In addition, the SIG States are responsible for process measures that will help determine why a program is effective or not effective. They must also use recovery measures. Dr. Blyler handed out examples of recovery measurement instruments that are currently used in the field. They measure recovery as an outcome, but also measure supports for recovery. Dr. Blyler closed by stating that the performance measures described would be used to continuously improve transformation efforts.

Ms. Power then introduced the MHT SIG Connectors who were present at the meeting: Wanda Finch, Pamela Fischer, and Sandra Black. She explained that the States were focused on efforts to establish the TWGs and lay a comprehensive foundation for the work of the grant.

Dr. Geller expressed interest in cultural variables and Dr. Blyler referred him to the handouts she provided, which described the Goal 3 category that focuses on eliminating disparities. She also stated that this priority cuts across all the other goals. Dr. Geller noted that treatment is different in different environments and with different populations. Ms. Power explained that the grantee States' work is not yet at that level of specificity. She stated that she had conversations with the States about addressing the needs of various cultural groups and they will be refining their approaches over time.

Disaster Response – Action and Planning
Anne Mathews-Younes, Ed.D., SAMHSA Emergency Response Center

Dr. Mathews-Younes opened the session with a slide presentation that portrayed the losses of those affected by the hurricanes in the Gulf States. She described Mr. Curie's mobilization of the SAMHSA Emergency Response Center (SERC), through which a multi-disciplinary team of Federal employees and contractors assisted in the response. The SERC's Incident Commander was Brenda Bruun, Special Assistant to the Director of the Division of Prevention, Traumatic Stress, and Special Programs within CMHS. Dr. Mathews-Younes said the SERC was operational 7 days a week and

volunteers worked 12 to 14 hour days. A total of 257 SAMHSA staff members—approximately half of the agency—participated in SERC activities. They were easily recognizable by their orange shirts and SAMHSA caps.

SAMHSA awarded Emergency Response Grant (SERG) funds to four impacted States (LA, MS, TX, AL) within 14 days of the hurricane's landfall. The total distributed was $600,000. Agency staff reviewed 29 FEMA Crisis Counseling Grants, and based on SAMHSA recommendations, FEMA awarded 29 full and 2 partial awards. Mission assignments totaled $12,300,000.

Several papers were developed, including *SAMHSA's Role in Hurricanes Katrina and Rita,* and *Mobilizing Providers and Others*. SAMHSA contributed to an HHS document on infrastructure recovery and developed detailed geo-mapping analysis to determine the location of grantees in the impacted areas. The Public Information Office added a new section to SAMHSA Website: "*SAMHSA's Hurricane Response: Empowering Recovery*," for fast access to publications, assessment tools, training guidelines, other technical assistance materials, and links to key resources and organizations. The Public Information Office also worked with HHS and the Ad Council to develop a series of public service announcements directed at parents, adults, and first responders; and the Office created 12 fact and tip sheets and booklets on disaster behavioral health needs for impacted States, shelters, and others requesting specific materials. Many of these products were translated into Spanish.

More than 800 Federal and civilian staff were deployed to meet LA, TX, and MS local requests for mental health and substance abuse services and program and administrative staff. Participating Federal agencies included NIH, HRSA, and VA. Approximately 650 clinicians were assigned through the contractor Westover. Clinical teams were placed in schools, mental health and substance abuse treatment programs, trailer and tent cities, and the cruise ships that housed the first responders.

Dr. Mathews-Younes reported that over 55,000 clinical sessions had been conducted, 91 percent of which were individual sessions. The issues faced by the clinicians included waiting lists at the clinics; significant alcohol, opiate, and prescription drug misuse; domestic violence; and co-occurring depression and anxiety. Those staying on the cruise ships dealt with the lack of transportation, employment, child care, communication, and recreation.

Dr. Mathews-Younes closed by remarking on the importance of the proactive behavioral health response in this situation and noted that the concept of stigma evaporated in the Gulf Coast, as everyone wanted to tell their story.

Seth Hassett, M.S.W., Branch Chief, Emergency Mental Health and Traumatic Stress Services Branch

Mr. Hassett stated that the FEMA crisis counseling and training program has been in place for 30 years and said the funding for it comes from the President's disaster fund. He noted that the response to Katrina was unprecedented in its scale. SAMHSA mobilized quickly and worked with State offices to create their own emergency response centers. He said a meeting would be held in New Orleans on May 22-26, 2006 to discuss the lessons learned during SAMHSA's response.

Mr. Hassett explained that the response and recovery effort took place in two phases: 1) immediate; and 2) regular services; and emphasized that regular services were still ongoing. He said 29 States

received immediate services grants and most had transitioned to the longer-term services grants. The grants were to continue until November or December of 2006.

Comments and Questions

Ms. Power remarked that SAMHSA was forever changed by this experience. She thanked Dr. Mathews-Younes, Ms. Brunn, and Mr. Hassett for mobilizing the response so quickly.

Dr. William Van Stone asked what kind of interventions were useful in the situation, given that there was no electricity, phone service, or transportation. Mr. Hassett replied that early interventions were very low tech because people were in shock. The first responders basically provided psychiatric first aid. They worked on immediate needs, such as connecting victims to necessary resources. By building rapport in these situations, the staff members were in a position to address the victims' psychological needs more intensively at a later time. Dr. Mathews-Younes added that SERC staff worked with people as they waited in lines to see FEMA representatives and went from area to area to reach evacuees.

Ms. Carlette Randall asked what happened to people who were in institutions. Ms. Power replied that there were difficulties related to evacuating people in institutions that must now be addressed so the situation is handled more effectively in the future. She also said peer support became a very important part of the response, and that had not been fully considered before. Mr. Hassett agreed, and said it was unprecedented for the entire population of a city to be displaced. He stated that some people were placed in special needs shelters. The capacity to handle the evacuation varied from one State to the next and many decisions were made on the spot. Dr. Mathews-Younes explained how the SERC staff talked with each individual who was brought by bus to see the condition of their homes.

Dr. Kelly applauded the success of SAMHSA's effort and asked how the volunteer program worked. Dr. Mathews-Younes said that the 257 SAMHSA staff members volunteered and the contractor Westover worked with her to bring in additional non-Federal personnel. These personnel were paid $200 for travel and per diem for each 14-hour day over a 14-day period. Many were clinicians that were located through professional listservs that verified licensing and other requirements. Each group had a team leader and an effort was made to hire local people once that became possible. Dr. Kelly asked about collaboration with faith-based organizations and Dr. Mathews-Younes said some of those organizations housed them and that they served as focal points in the community.

Dr. Vergare commented that the Federal response successfully broke through barriers to meet community-level needs. He said this situation could help reduce stigma and asked if there was an opportunity to look at the issue of delivering medications to those with pre-existing needs. He also asked about lessons that will apply to community initiatives. Ms. Power said that deliberating bodies were looking at these lessons and determining how things could be done differently as rebuilding begins. This analysis would lead to a larger-scale discussion about health care delivery, because the disaster made the importance of behavioral health services apparent to more people.

Ms. Randall asked if the SERC assisted the tribe affected in Louisiana, because mental health services are not accessible on the reservation. Dr. Mathews-Younes said they reached them and provided services.

In response to a question about the debriefing process, Dr. Mathews-Younes said they take this very seriously. Debriefing can take 15 minutes or 4 to 5 hours and the staff tried to conduct debriefing sessions regularly. Mr. Hassett said SAMHSA also held a "hotwash" for volunteers to address lessons learned from an operational perspective. A report on the results was in development.

School Mental Health Services
Judith L. Teich, A.C.S.W., Organization and Financing, Office of the Director

Ms. Teich described a study on school mental health (MH) services funded by CMHS and conducted by the contractor Abt Associates, Inc. The study report was released in November 2005. Ms. Teich said the need for the study became clear when it was documented that schools are major providers of mental health services, yet it was unknown what these services were. "School Mental Health Services in the United States, 2002-2003: A National Survey" was the first-ever nationally representative sample of U.S public elementary, middle, and high schools and their associated school districts. It provides a baseline for information about the role of schools in providing services and how these services are organized, staffed, funded, and coordinated.

Study components included a literature review, an expert panel with several Federal agencies, the development and testing of survey instruments and protocols, extensive data collection and input, development of an analytic plan, and data analysis. Two separate questionnaires were developed for the study:

- For schools: On types of mental health problems, services provided, and types and qualifications of staff; and
- For districts: Funding sources for MH services and issues related to administration and funding of these services.

A self-administered mail survey was sent to contact persons at each school and district, with extensive telephone follow-up and verification. Study respondents included 1,147 schools in 1,064 districts, with weighted response rates of 61% for schools and 60% for districts.

The study was intended to capture "traditional" mental health services related to an identified individual student, not school-wide or classroom-wide prevention activities. It also described services currently being delivered. It did not to assess the need for services or issues of quality, adequacy, or appropriateness of services. The study did not capture amount or intensity of services.

Major Findings

Ms. Teich described study findings related to mental health problems and services in the school setting. In the vast majority of schools (87%), all students, not just those in special education, were eligible to receive MH services. On average, schools reported that 1/5 of students received school-supported MH services in the school year prior to the study. The definition of "service" varied widely, from a brief, 10-minute consultation to five to six counseling sessions. About 3/4 of schools reported that "social, interpersonal, or family problems" were the most frequent MH problems for both males and females. For males, aggressive and disruptive behaviors were next, followed by behavioral problems associated with neurological disorders. For females, anxiety was next, followed by adjustment problems.

At the elementary school level, the most frequently encountered MH problems were:

- Males: Social, interpersonal, or family problems; aggression or disruptive behavior; behavioral problems associated with neurological disorders.
- Females: Social, interpersonal, or family problems; anxiety; adjustment issues.

At the middle school level:

- Males: Social, interpersonal, or family problems; aggression or disruptive behavior; behavioral problems associated with neurological disorders.
- Females: Social, interpersonal, or family problems; adjustment issues; depression, grief reaction.

At the high school level:

- Males: Social, interpersonal, or family problems; aggression or disruptive behavior; substance use or abuse.
- Females: Social, interpersonal, or family problems; depression, grief reaction; anxiety.

Concerning the types of services provided; 87% of schools provided assessment for MH problems, behavioral management consultation, and crisis intervention. Referrals to specialized programs were provided by 84% of schools; individual counseling by 76%; case management by 71%; and group counseling by 68% of schools.

The problems that reportedly consume the most resources are social, interpersonal, and family problems. Aggressive/disruptive behavior is the most resource-intensive problem at 20% of schools, while 10% cited behavior problems associated with neurological disorders (e.g., ADHD) as consuming the most MH resources.

The survey measured prevention and early intervention efforts at the schools, finding that 78% have school-wide strategies to promote safe and drug-free schools and 72% have school-wide strategies to prevent alcohol, tobacco, or drug use. Pre-referral interventions for mild MH problems were reported by 63% of schools and 59% have curriculum-based programs to enhance social and emotional functioning.

The second area of major study findings concerns administrative arrangements for the delivery and coordination of MH services in schools:

- 32% of school districts use school or district-based staff exclusively;
- 23% of districts contract with outside providers exclusively;
- 36% of districts use combined school and district-based staff, either exclusively or in combination with outside providers; and
- Overall, 59% of districts use contracts or other formal arrangements with community-based organizations and/or individuals.

Concerning coordination and referral practices, 53% use active referrals (completing forms with families, making calls and appointments, or assisting with transportation), while 73% use passive referrals (brochures, lists, or provider phone numbers). Forty percent of schools follow up with families and providers and 19% use passive referrals as their only routine referral practice.

The third major area of findings concerns the staff members that provide MH services. In 96% of schools, at least one staff member's responsibilities included providing MH services to students. The most common types of providers are school counselors, nurses, school psychologists, and social workers. Substance abuse counselors, clinical psychologists, psychiatrists, and other provider types are available in less than 20% of schools. Sixty-nine percent of schools reported having a school nurse who provided MH services, spending one-third of their time on this function.

The broad distribution of MH staffing is:

- 1 MH staff member at 8% of schools;
- 10 or more MH staff at 6% of schools;
- Most common: 51% of schools have between 2-5 staff who provide MH services; and
- Most common combinations are: 1) school counselor, school psychologist, and nurse; and 2) school counselor, school psychologist, nurse, and social worker.

The fourth area of major findings relates to funding, budgeting, resource allocation, and data use. The funding sources most common for MH in schools are:

- Individuals with Disabilities Education Act (IDEA): 64%;
- State special education funds: 55%;
- Local funds: 49%;
- State general funds: 41%; and
- Medicaid: 38%.

Ms. Teich noted that the use of Medicaid to support school MH services appears to be increasing.

One-third of school districts reported that funding for MH services had decreased since the previous year (2001-2002); another 40% reported that funding had stayed the same. However, over two-thirds of districts reported that the need for MH services had increased since the previous year.

Conclusions and the Need for Further Research

Ms. Teich then presented the overall conclusions of the study. The most frequent MH problems in schools were reported as social, interpersonal, and familial. Several basic MH services were widely available in schools (assessment, behavior management, counseling, crisis intervention), but intensity, provider qualifications, and unmet need are not known. The vast majority of schools had at least one staff member with a graduate degree and license in his or her field providing MH services (but not necessarily a MH specialty). Over half of the schools had arrangements with community MH providers for services. Funding comes from multiple categorical funding streams;

40% of the districts access Medicaid. The services and need are perceived as increasing, but funding for MH remains static or is decreasing.

Further research is needed on training, availability, and qualifications of the staff providing MH services; the quantity and quality of MH services; the use of Medicaid as a funding source; and the distribution of funding sources. The latter includes the equity of funding for prevention, assessment, and treatment; disparities among well-resourced and under-resourced schools; and an analysis of the types of services supported and their funding streams.

Implications for Policy

Ms. Teich stated that although more than half of all schools offer some services for social, interpersonal, and familial problems, family support services and group counseling (e.g., social skills groups) are somewhat less available than other interventions (e.g., behavior management, consultation, and individual counseling). She reported that in the majority of schools, all students, not just those in special education, were eligible to receive MH services. However, schools with high minority enrollment were somewhat more likely to restrict MH services to special education students.

In spite of a relatively extensive array of MH services available in schools, the financial constraints faced by the families were the most frequently reported barrier to receiving services. Almost half of schools cited inadequate internal and community MH resources as barriers. Responses to open-ended questions indicated concern about a lack of treatment options in the community, especially residential and inpatient beds. A common response was that MH needs are increasing dramatically. Students are presenting with serious MH needs at an earlier age.

Comments and Questions

Dr. Van Stone noted the importance of anti-bullying efforts and asked how that issue was included in the study. Ms. Teich said that although the lists provided by the study did not highlight it, the issue may have been included in some of the schools' responses. She said it also came up in the responses to the open-ended questions. Ms. Power thought the anti-bullying issue may be related to changing the social climate of the schools and determining which programs are effective for that purpose. This may represent another level of investigation.

Dr. Vergare said he would like to see a comparison of the Medicaid benefit for mental health funding versus other types of funding. He said that although it's good to see services shifting into the schools in cases where they are needed, not all communities need services in the schools. He said there is a need to look at the ability of schools to refer students elsewhere for care. Dr. Kelly added that parental backlash against school-based services should be addressed. Some parents feel that mental health services don't belong in the schools.

Ms. Randall said that she was surprised that there were so many services in some schools. In her experience with foster children, those with behavior problems were given three chances and then suspended. She said the schools would rather do that than identify the child's problem.

Ms. Power introduced Charles G. Curie, SAMHSA Administrator.

SAMHSA ADMINISTRATOR'S REPORT
Charles G. Curie, M.A., A.C.S.W.

Mr. Curie stated that Ms. Power has done a tremendous job leading CMHS, providing strong leadership for mental health transformation efforts. He thanked her for bringing together the 21 Federal partners to address mental health issues across the Federal Government. He also noted the effectiveness of the SERC's disaster response, Ms. Power's prioritization of suicide prevention, her success in developing a dialogue with business leaders, and the CMHS emphasis on evidence-based practices.

SAMHSA Matrix

Mr. Curie addressed the recent changes to the SAMHSA Matrix. He stated that disaster readiness and response became a cross-cutting principle because of changes in the country since 9/11. He noted that CMHS has a long history of working alongside the Red Cross and FEMA. He said further progress must be made in continuity of care during disasters, in areas such as substance abuse treatment, the needs of the homeless, and HIV. He said the Matrix would have an international focus because of the collaborative work taking place with other countries. In addition, workforce development was being added as a cross-cutting principle, with a focus on recruitment, retention, and a range of consumer-operated services. Suicide prevention was being added as a program priority, and Mr. Curie stated that there are effective models to address this problem. He noted that the Matrix changes were made after receiving input from a range of stakeholders, including consumers.

FY 07 Budget

Mr. Curie stated that the $3.3 million budget for SAMHSA provides the agency with many opportunities, but noted that it was the most difficult budget cycle in 10 years. Agency discretionary spending was cut overall by 2 percent. However, the Mental Health Block Grants were among the three Federal block grants maintained at the same levels. He said the SAMHSA Matrix was used to help determine budget priorities for the agency, and grant programs coming to a natural end were taken into consideration. The two key focuses of the SAMHSA budget were CSAT's Access to Recovery program and mental health system transformation activities. The proposed budget included $19.8 million to continue to support the seven Mental Health Transformation State Incentive Grants. The States would also be required to use a portion of the Block Grant allotment for transformation activities. Although there was latitude in how this money was to be used, the State systems were required to move toward consumer- and family-driven services.

Under the CMHS Programs of Regional and National Significance (PRNS) budget line, the Suicide Prevention Programs were to be funded at $34.7 million, an increase of $2.9 million over the FY 2006 Appropriation. Of the total amount, $26.7 million was for Garrett Lee Smith suicide prevention activities and $2.9 million was included for a new American Indian/Alaska Native Youth Suicide Prevention Initiative. The Co-Occurring State Incentive Grants program was to be funded at $7.6 million, supporting the continuation of 11 grants and one contract. $29.4 million was proposed for the National Child Traumatic Stress Initiative, which would fully fund grant and contract continuations. While SAMHSA would maintain funding for the School-Based Violence Prevention activities at almost $76 million, this was a $17.5 million reduction from FY 2006. The reduction was a result of Safe Schools/Healthy Students and Youth Violence Prevention grants coming to a

natural end. Other CMHS grants coming to a natural end included Seclusion and Restraint, Statewide Family Networks, and Mental Health Services to the Homeless (GBHI).

Mr. Curie stated that overall, the proposed PRNS budget of $228 million would support 330 grants and contracts, consisting of 237 continuations and 93 new/competing awards from CMHS. The proposed budget maintained funding for the Community Mental Health Services Block Grant at just over $428 million. The Protection and Advocacy for Individuals with Mental Illness (PAIMI) was maintained at $34 million, the Projects for Assistance in Transition from Homelessness (PATH) was maintained at $54.2 million, and the Children's Mental Health Services Program was maintained at $104 million.

Questions and Comments

Dr. Vergare commented that in Pennsylvania, the services available in the public sector are much better than in the private sector. However, because of recent change in the CMS arrangements, Medicare, and changeovers in co-insurances, individuals are being directed away from good care and placed in settings that run counter to the ideals of recovery and self-determination. He felt that the employer dialogue on insurance begun by CMHS was important to continue.

Dr. Geller asked to hear more about the Federal partnership. He also noted that the Bazelon Center published information on Medicare Part D, and said the IMD exclusion is a barrier to transformation. Mr. Curie said the Federal Partners provide a forum for CMHS to make its case to other agencies. He said CMS had been responsive and was committed to evidence-based practices; i.e., they would pay for practices that have been demonstrated to work. However, there is an offset issue, because paying for new services means that something else will not be paid for. Mr. Curie encouraged the advisory groups to use the Federal Partners as a conduit.

Dr. Kelly said the transformation initiative must be pushed with California policymakers while the ideas were still fresh. He noted that the proposed budget cut some transformation activities and asked if there was a way for the NAC to advocate for a second wave of MHT SIG grants in the FY 08 budget. Mr. Curie said that was an appropriate role for the NAC.

Ms. Randall was pleased with the increased emphasis on suicide prevention and asked if there were other initiatives planned to benefits tribes or any new collaborations with IHS. Mr. Curie said the new Acting Deputy Administrator, Admiral Eric Broderick, was from the Indian Health Service (IHS) and had been assigned to focus on tribal considerations. In addition, a third annual conference with IHS was scheduled to take place in South Dakota in June to strengthen the inter-agency partnership and benefit tribes.

YOUTH AND YOUNG ADULTS IN CONSUMER-CENTERED/CONSUMER-DRIVEN SERVICE MODELS

Gary Blau, Ph.D., Chief – Child, Adolescent and Family Branch, CMHS

Dr. Blau explained that he was given the task of leading mental health transformation for youth in America and said that he is placing youth at the core of these efforts. He described the effort's logic model, which shows the contexts, strategies, and desired outcomes for transformation. Committee members received a folder of related materials that included the logic model, the formal communications plan, and other fact sheets and booklets. Dr. Blau said a website was recently

created at www.systemsofcare.samhsa.gov, which is devoted to providing information about the mental health of children, youth, and families. A system of care is a coordinated network of community-based services and supports organized to meet the challenges of children and youth with serious mental health needs and their families. It is not a program at SAMHSA or a specific grantee-driven activity. Dr. Blau said "Systems of Care" is a philosophy about how children's mental health needs should be met across the country.

Demonstrating the information available on the website, Dr. Blau said his team embarked on the task of defining family-driven care, i.e., families have a primary decisionmaking role in the care of their own children, as well as the policies and procedures governing care for all children in their community, State, tribe, territory and Nation. This includes:

- Choosing supports, services, and providers;
- Setting goals;
- Designing and implementing programs;
- Monitoring outcomes;
- Partnering in funding decisions; and
- Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

A number of guiding principles and core characteristics for family-driven care have also been established and are listed on the website. Dr. Blau stated that the next effort would create train-the-trainer curricula so that people could act as ambassadors for this philosophy, instilling these ideas in children's mental health systems.

The website also focuses on 47 evidence-based practices for children's mental health. Dr. Blau pointed out that a family guide was included in the folder, available in Spanish, which helps families walk through the mental health system. It was being translated into Chinese and Vietnamese.

Dr. Blau stated that a Quality Improvement model is being created that incorporates the following priorities: family-driven, youth-guided, evidence-based, clinical excellence, and cultural and linguistic competence. Dr. Blau said the mental health system is different as it relates to youth, and some concepts, such as recovery, are not the same. He noted that a consultant wrote a booklet on resilience and recovery that was included in the folder.

Dr. Blau reported that in the previous year it was decided to incorporate the youth voice into everything the Branch does. They now have 56 active sites with grants for youth, from which they solicited nominations for 15 youth to be part of a national Board. It is helping shape concepts of care by incorporating young people's involvement in children's mental health services. Several Board members were present and addressed the NAC.

Marlene Matarese, Resource Specialist, Technical Assistance Partnership for Child and Family Mental Health, American Institutes for Research

Ms. Marlene Matarese is the national coordinator for youth involvement in systems of care through the Technical Assistance Partnership for Child and Family Mental Health. She was hired 3 years previously and said she was thankful that funding for the Board increased. She spoke about the application process that led to the selection of 12 youth to serve on the Board. These individuals had been involved in multiple public systems and were leaders for youth in their local communities. The

group was initially called the National Youth Development Board (NYDB), but the name was changed to Youth MOVE (Youth Motivating Others through Voices of Experience).

Ms. Matarese introduced T. J. Curtis and Ashley Thornton of Youth MOVE.

Ashley Thornton
YouthMOVE

Ms. Thornton stated that she had been in the juvenile mental health system and in foster homes, separated from her brothers, but was eventually placed in a permanent home. She wants to use what she learned so that others don't have to go through the same experiences she did. She works with youth in El Paso, Texas, and they also want to make changes for those who come after them. Ms. Thornton came to realize that she is an expert on her own life and can help others make changes. She stated that her participation in the Youth Board has been very meaningful and said that they were working hard to ensure results.

T. J. Curtis
YouthMOVE

Mr. Curtis said he had been in foster care, group homes, the mental health system, and had experienced trauma. He was placed in Special Education classes at an early age. He was adopted at 16 and was the only minority in his household. He went through cultural shock when he began living in a different culture. He later met people in the Latino and African American communities who helped him learn about his cultural background and he started to write poetry. He graduated as Valedictorian of his class. Mr. Cutis said that only a small percentage of the youth in his community went to college, and many ended up homeless or on drugs. Of all his siblings, he's the only one who's doing well. He's been able to reach other youth and help them with their struggles by serving as a role model. He advocates for them and helps them identify and speak up for their needs. Mr. Curtis said he was also attending college.

Ms. Power thanked the speakers for sharing their lives with the group and for their willingness to teach.

Comments and Questions

In response to a question from Dr. Vergare, Ms. Thornton explained that there is no hierarchy in the group; each person contributes what they can individually. She said the Board is geographically and ethnically diverse. They meet via conference call on a monthly basis and twice a year in person. She described some of their activities, including development of a youth guide to the system of care, presenting at conferences, and providing consulting. She noted that youth don't like the term "SED" (seriously emotionally disturbed) because they consider it insulting and they want to develop a more youth-friendly term.

Dr. Geller expressed the opinion that the Board should not be composed only of exemplary survivors, but should be more representative of youth with various types of challenges. Mr. Curtis explained that some of those youth are not yet ready to share their experiences with strangers in a public setting. They need to develop trust first. Ms. Power added that the dedicated youth on the Board are starting a movement and they're serving as ambassadors. They're sending the message that

no matter who you are, no matter what level you're at, you have the right to be treated with dignity and your voice is important. Over time, these youth will engage others. Ms. Thornton stated that the youth on the Board are still dealing with many problems and therefore do represent their constituency. She said that someone less strong might feel attacked by Dr. Geller's statement. Ms. Matarese added that many youth still have crises while serving on the Board, including being hospitalized or homeless.

Dr. Kelly asked about the difference between youth who are struggling to "make it" but fall short, and those who do make it. Ms. Thornton said they define youth success in their terms, not as the goals set by others. This makes the process more meaningful. She said it's important to give youth a voice and work with them in a collaborative way. The more successful youth support those who are coming up.

Dr. Vergare asked about the accessibility of the website to other youth. Dr. Blau said that the site www.systemsofcare.samhsa.gov was designed for providers, but another site by youth and for youth would come later.

Dr. Geller asked what the CMHS role will be in working for changes that will provide greater access to children's mental health services. Dr. Blau replied that the agency has roles at several levels, such as Ms. Power's work with other Federal agencies. As an example, he said CMS is developing a waiver program and CMHS needs to be at the table to weigh in on eligibility issues. The agency also has to work closely with the States and the health care industry. There needs to be a focus on outcomes so that the data demonstrates that programs are effective and reduce costs. Dr. Blau said this message must go out, but SAMHSA can't do it alone and must be part of the larger Federal picture. At the Center level, youth and families need to be part of CMHS and SAMHSA and they should inform service delivery, financing and resource development, and grantee activity. He said there is also work at the individual level, which is shown in the logic model.

TRANSFORMING PERFORMANCE MEASUREMENT AT CMHS

Ms. Power introduced the speakers on performance measurement.

Sue Becker, Public Health Analyst, Office of Policy, Planning and Budget, SAMHSA

Ms. Becker spoke on the National Outcome Measures (NOMs). The NOMS have a recovery domain and four resiliency or sustaining recovery domains (employment or education, decreased crime and criminal justice involvement, stability in housing, and social connectedness). She pointed out the NOMs domains and outcome measures are on the SAMHSA public website and said there are three purposes or levels in their construction. First, the domains were designed for consumers, to include the areas that constitute a life in the community. Second, the NOMs can demonstrate value to public and private payers. Third, the NOMs will support SAMHSA's ability to conduct performance management. The indicators will demonstrate whether the agency is below expectations, meeting, or exceeding expectations. The indicators will not provide information for an evaluation, but can send a red flag concerning problem areas. They will be collected regularly and the reporting will be universal. This data can be used to target where evaluation or technical assistance are needed. SAMHSA is trying to reach the point where the NOMs and evaluations are coordinated for a more in-depth understanding.

Ms. Becker said that comparing against a benchmark, i.e., GPRA, provides a limited amount of information. SAMHSA is exploring the idea of using control group data from clinical trials to set benchmark bands. Conceptually, the control group would represent the standard of care. SAMHSA would therefore have a comparison against the standard of care rather than an arbitrary plus or minus percent gain or decrease. However, Ms. Becker agreed with Dr. Geller that clinical trials are often done with a population that's not representative of the population targeted for the intervention. The comparison might not be feasible in such cases, and Ms. Becker said this issue would have to be examined.

Ms. Becker explained another benefit of the NOMs, which is that many programs have multiple funding streams from SAMHSA and must report on different measures. The NOMs will help eliminate this administrative burden. The NOMs will also allow SAMHSA to sum up data across the Centers in a deliberate way.

Dr. Kelly said he felt the domain of "Abstinence" should be changed to "Symptom Relief." Ms. Becker said she would take the message forward and stated that there were some new options concerning the NOMS structure under discussion.

Diane Abbate, Acting Director, Office of Planning and Coordination, CMHS

Ms. Abbate said that GPRA requires a fundamental shift in thinking to performance-based decisionmaking. She said there will be outcomes for each grantee, and ultimately all GRPA data will be entered in the TRAC (Transformation Accountability) system. Ms. Power said the development of the TRAC system is an expectation of Congress.

Ms. Abbate explained that the TRAC will be used for all discretionary programs. The data will be transparent and timely, and will be entered on a schedule by each grantee. The guiding principles are to standardize the data across programs, collect data once at the same source, support unique program data when needed, collect a limited number of measures from all clients, and show outcomes over time.

The issues confronting CMHS concerning the TRAC include decisions on who should have access to data, what types of targets support CMHS goals, what should happen if a grantee fails to make targets, and when data will be collected. There must be rules for complete data reporting, approvals for reporting exceptions, and decisions made on the reports needed by managers.

Ms. Abbate stated that a transition plan would be developed for each program as they move from current data collection efforts to TRAC. TRAC will co-exist with current data collection efforts in FY06 and will move to a single system in FY07. The goal is to train each project to enter data on a monthly basis. Grantees will have Web-based training, reference materials, and a help desk. An Operations Manual is in the process of being developed.

Summarizing TRAC capabilities, Ms. Abbate said it would house all information about each grantee, including grantee progress reports. It will allow for performance measurement and technical assistance management, including approval, tracking, and monitoring. TRAC will also create routine and custom management reports.

Ms. Abbate and Ms. Power clarified that the TRAC data will not be used punitively, but as an opportunity for discussion with grantees. This approach has worked effectively in the other SAMHSA Centers.

Jeff Buck, Ph.D., Associate Director for Organization and Financing, CMHS

Dr. Buck co-chairs a group that is developing a plan to guide CMHS data and information activities in compliance with FY 06 contract plan objectives. This process started with internal plan development, which will be followed by discussion and review by external stakeholders. The review is taking place in four areas:

- Policy;
- Management;
- Public system performance; and
- State data system improvement.

The factors motivating this review include the tightening budgets that lead to harder choices, demands for greater accountability, the data implications of mental health transformation, and changing service system trends. These trends are reflected in the increasing dominance of Medicaid and Medicare at the State level, the changing role of State mental health authorities because of the increased emphasis on community-based services, and the growing importance of non-specialty providers.

Dr. Buck described the key elements of mental health transformation. He said it is consumer- and family-driven, which affects the way data is collected. Transformation will also require paying close attention to how mental health care and general medical care systems work together. Dr. Buck noted that a comprehensive mental health plan is needed that reaches beyond the State authorities to address the full range of treatment and support service programs.

The objective for policy is to collect national data on the full breadth of services and providers and the characteristics and utilization patterns of consumers. This includes demographic and service utilization information on the SED and SMI populations (e.g., primary source of care and payment and most frequent type of service received). Data is also needed on the characteristics of specialty and non-specialty providers, their services and amount of services, their clients, and their revenue sources. Information is needed on the major payers (Medicaid, Medicare, private insurance, and other State/local sources) and the related spending characteristics for mental health services and service users.

State data system improvement is being piloted in the MHT SIG States. In addition, Dr. Buck is working on a CMS/SAMHSA data initiative that will be mutually beneficial to States and the Federal Government. It supports statewide, client-centric systems, rather than provider-based systems. One platform will serve multiple systems. The goal is to transform existing systems to create a richer information environment that will serve multiple needs and constituencies. It will increase stakeholders' "return on their investment" by reducing duplicative costs and improving management.

Oklahoma is the pilot State for this effort. Using the State's Medicaid claims system as the foundation, the initiative is integrating all behavioral health claims processing and payments. They are creating an integrated system of care for consumers, independent of treatment funding, with a single point of entry. They will implement information systems in support of the integrated care system and implement enhanced reporting systems that meet State and Federal requirements (e.g., the NOMS). Partial support from CMS is provided through its Medicaid IT Architecture Initiative, which integrates data systems that can link to or reside within the State's Medicaid Management Information System.

In summary, Dr. Buck said a variety of forces make it desirable for CMHS to review its information collection activities to improve its relevance and utility for all stakeholders. He said the outcome of this review offers the possibility of improving both policy making and the effectiveness of services. Ms. Power added that Dr. Buck's talk provided a snapshot of a complex area, but it was important for the NAC be aware of CMHS' commitment to meeting its management responsibilities.

Comments and Questions

Dr. Kelly asked what the most difficult impediment to this effort was. Dr. Buck said it was the concept of mental health transformation, because it represents a paradigm shift that will include services delivered in many additional settings. Ms. Becker added that it's important to have data on mental health and substance abuse treatment so they will be included when a national electronic health record is created. Ms. Power commented that transformation forces the agency to look closely at what is supported. Even though the field has expectations of certain continuations, some things have to be shed and these conflicting needs lead to important internal decisions.

Dr. Vergare said he was glad the agency is looking in non-traditional places for information because care is being delivered in many different sectors and it's important to gather that data.

PUBLIC COMMENT

As there were no public comments, the meeting adjourned for the day.

March 22, 2006

WELCOME AND ANNOUNCEMENTS
A. Kathryn Power, M.Ed., Director, CMHS and Chair, CMHS National Advisory Council

Ms. Power opened Day 2 by asking the National Advisory Council members to introduce themselves for the record. She asked those who wished to attend the Voice Awards to contact her. She also asked the group for their input on the Transformation Trends newsletter and for ideas on disseminating it more widely.

Ms. Power then raised the issue of nominations for the NAC, stating that the ideal number of members is 12, and 5 positions were open or would open later in the year. She noted that Larry Fricks, who had chaired the Consumer Subcommittee, stepped down because of a conflict of interest with SAMHSA activities and Ruth Edelman's position was still vacant. Dr. Cheryll Bowers-Stephens' term was ending, but she had asked to be re-appointed for one year. In addition, the terms

of Dr. Kelly, Ms. Randall, and Dr. Sally Satel were scheduled to end in '06. Culturally and geographically diverse representatives were needed to fill these vacated Council positions. Ms. Power explained that Ms. McSwain was building a resume database and would receive the nominations submitted.

Ms. Power introduced the representatives of the Consumer Subcommittee.

REPORT OF THE SUBCOMMITTEE ON CONSUMER AND SURVIVOR ISSUES

Ellen Awai, Member, Subcommittee on Consumer and Survivor Issues

Ms. Awai, a peer specialist from Hawaii, spoke about her history, including her struggles with bipolar illness. She initially refused to accept the diagnosis because she did not want to think of herself as mentally ill. After a period of years during which she was admitted to the hospital, spent her daughter's savings, was arrested for property damage, and faced other problems in her life, she sought help. Eventually, a social worker provided the support she needed and Ms. Awai became involved in a peer support program. In 1998, she attended an Alternatives conference and became aware of the national consumer advocacy movement. She became involved in a number of consumer organizations and learned more about her own recovery and how to help others. She worked to change the public mental health system in Hawaii, which was rated the worst in the U.S. and is now ranked significantly higher. Through training in a peer specialist program in Georgia, Ms. Awai received the tools she needed to conduct trainings for others who wish to become certified as peer specialists.

Chris Marshall, M.S.W., CMHS Consumer Affairs Specialist

Mr. Marshall thanked Ms. Awai and explained that he was standing in for former Subcommittee Chair Larry Fricks. He reported that the Subcommittee was looking forward to the appointment of a permanent Chair. Mr. Marshall then provided an update on the meeting of the Consumer Subcommittee that had taken place during the previous 2 days. He said the group had received sufficient input on the consumer-driven statement and was preparing a final draft. The Subcommittee heard presentations on the Consumer-Operated Services and Older Adult Evidence-Based Practices (EPB) Toolkits; discussed recovery and person-centered planning, including the new recovery statement; and examined the new IOM report on behavioral health care from a consumer perspective. He conveyed the Subcommittee request that CMHS work with the IOM to develop a consumer-friendly guide to the new report. Mr. Marshall then presented the Subcommittee's formal recommendations, as follows:

The CMHS National Advisory Council Subcommittee on Consumer/Survivor Issues recommended that the CMHS National Advisory Council advise CMHS to:

1. Recognize and understand the relationship between histories of abuse, neglect, and trauma and suicide attempts and completed suicide, and include programs and services that address issues of abuse, neglect, and trauma as a method to prevent suicide in the activities of the SAMHSA Matrix priority on Suicide Prevention.

2. Ensure that the activities of the SAMHSA Matrix priority on Workforce Development include and prioritize mental health consumers as providers, including support for career development, training, and opportunities; provide guidance on accountability; and require that consumers are

involved in all planning, design, training, implementation, evaluation, dissemination, and oversight activities of workforce development.

3. Ensure that mental health transformation is consumer- and family-driven and is concretely realized, support consumer and family leadership development and consumer- and family member-operated support and education structures, by prioritizing, restoring to current FY 2006 levels, and increasing funds for the CMHS Consumer State Network (CSN) grants and the Family State Network grants.

Mr. Marshall noted that the Consumer Subcommittee believed the reductions in the '07 budget for consumer and family networks were not consistent with the goals of transformation.

Comments and Questions

Dr. Kelly asked for clarification on what was meant by "consumer" in recommendation 3. He asked if the idea of tapping people in recovery who are not usually heard from (e.g., youth and the elderly) could be added, as he felt the same people were attending most meetings. Mr. Marshall said he understood Dr. Kelly's point, but said the CSN grants are for the grassroots and he was concerned that Dr. Kelly's suggestion might exclude people with a certain level of expertise. Ms. Awai added that it's through the stronger consumers that information is taken back to the States.

Ms Power said that Dr. Kelly was addressing how narrowly or broadly "consumer" is defined. She said that CMHS has a responsibility to the traditional consumer, but is also moving into a new role and forming partnerships with agencies such as the Veterans Administration (VA). The VA has 2.1 million people in their health care system and she said that perhaps the Consumer Subcommittee might benefit from having consumers from this or other agencies in an advisory role. Dr. Vergare pointed out that the same people tend to participate in national forums in many specialty areas, but agreed that it was important to ensure that the consumers heard from represent diverse groups.

Dr. Geller asked Mr. Marshall to take a request back to the Subcommittee to consider replacing the term "mental health consumers" in recommendation 2 with those who have "experiential knowledge as providers," as he felt the language would be less stigmatizing. Mr. Marshall agreed to take that idea back to the Subcommittee.

Ms Power noted that two of the recommendations were focused on Matrix areas in which groups had not yet been formed (suicide prevention and workforce development) and that CMHS is not leading each area. However, she said the suggestions would be communicated to the Chairs of the new Matrix groups. She also stated that Mr. Curie was open to suggestions about the '08 budget and that the Subcommittee could provide input in a formal way.

Dr. Vergare clarified with Mr. Marshall that all the activities listed in recommendation 2 related to the Matrix.

Dr. Geller felt it was a tactical mistake to ask for Federal-level funding in recommendation 3. He believed that money for consumer networks should be part of the Mental Health Block Grants and should be disbursed at the State level. He felt that would foster more State ownership and sustainability over time.

Dr. Vergare suggested incorporating the idea of a career ladder that provides opportunities for consumers into recommendation 2. Although they agreed with the concept of a career ladder, Ms. Power and Mr. Marshall said this was not the focus of recommendation 2.

The members present voted unanimously to accept recommendations 1 and 2. Since there was not a quorum, the voting was to be continued with other members through ballots sent out after the meeting.

The group discussed the fact that in recommendation 3, the Subcommittee was asking that '07 funding for the consumer networks be restored to '06 levels and that funding for the networks be increased in the '08 budget. Mr. Marshall clarified the language of recommendation 3 to strengthen those points. Some members felt that although it was unlikely that the '07 budget could be changed, it was important to communicate the sentiment of the Subcommittee by passing the recommendation. Others felt the Council should not pass a recommendation that was not feasible.

The Council voted on recommendation 3, which was defeated with three opposed and no abstentions. Since there was not a quorum, the voting was to be continued with other members through ballots sent out after the meeting.

Ms. Power encouraged the Consumer Subcommittee to come back to the next Council meeting with suggestions for influencing the '08 budget cycle.

Ms. Power introduced The Annapolis Coalition session. This organization conducted a SAMHSA-funded study of workforce development issues.

WORKFORCE DEVELOPMENT – A KEY TO TRANSFORMATION

Fran Randolph, Dr. P.H., Director, Division of Service and Systems Improvement, CMHS

Dr. Randolph provided some background on the formation of The Annapolis Coalition. She said a Santa Fe Summit in 2000 brought national leaders in the field together to address workforce development issues. Following that, the first meeting of The Annapolis Coalition took place in September of 2001 with 65 participants, including persons in recovery, family advocates, educators, providers, policymakers, and students with expertise in the treatment of substance use disorders and mental illnesses. Co-sponsored by the American College of Mental Health Administration (ACMHA) and the Academic Behavioral Health Consortium (ABHC), the initial purpose was to address concerns about the quality of education and training being offered within the behavioral health care field. This group laid the groundwork for a number of reports that later resulted in the draft National Strategic Plan on Behavioral Health Workforce Development that was submitted to SAMHSA in March 2006. Dr. Randolph introduced John Morris, Vice-Chair of the Coalition.

John A. Morris, M.S.W., Vice-Chair, The Annapolis Coalition on Behavioral Health Education

Mr. Morris spoke about changes in the behavioral health care field over the previous two decades, including the emerging awareness of co-occurring disorders, the rising emphasis on consumer participation in recovery, IOM concerns about patient safety, and the importance of cultural competence, outcome measures, and evidence-based practices. He said the response of provider organizations to these changes has been delayed and minimal and that training efforts have eroded

due to budget cuts. Mr. Morris listed a number of paradoxes that have contributed to workforce problems:

- Training takes place with outdated curricula for a world that no longer exists;
- Those who spend the most time with consumers receive the least training;
- Continuing education programs use ineffective teaching strategies;
- Training is not conducted in the settings where it is most needed;
- Consumers and families receive little educational support, including a lack of peer support and information on self care;
- Consumers and families are not being sufficiently used to train others in the workforce;
- The current workforce doesn't match the diversity of those served;
- Students are rewarded for "doing time" in the educational system;
- There is not enough planning to systematically recruit or retain staff;
- In spite of the size of the substance abuse problem, some continue to ignore it;
- Once hired, there is little supervision or mentoring of staff;
- Career ladders and leadership development are haphazard; and
- Service systems thwart rather than support the competent performance of individuals.

Mr. Morris described The Annapolis Coalition as a neutral convener of stakeholders, serving as a think tank for relevant literature and ideas on workforce development. It functions, in a sense, as a technical assistance center, and is a vehicle for strategic planning and collective action. Its representatives have consulted with the New Freedom Commission and the IOM and have been building a knowledge base in journals.

The current phase of work is focused on development of the National Strategic Plan. The Coalition sought input from the field to devise goals and action items for strengthening the workforce. More than 5000 people participated in the development of the draft that was presented to SAMHSA in March. The focus is on the common issues faced by all three centers within SAMHSA, while addressing the unique needs of each specialty area. A variety of planning vehicles were used to obtain input, including senior consultants, small expert panels, sessions in behavioral health care meetings and conferences, targeted requests for information, and a National Steering Committee composed of 32 members. The Steering Committee was beginning to integrate recommendations into the final version of the report. Mr. Morris said the desired results of the strategic plan are action-focused, with much work to be done at the Federal, State, regional, community, and individual levels.

Mr. Morris said some themes that have emerged from the feedback received include the need for an increased role in the workforce by people in recovery and the need to reduce disparities, whether caused by racial/ethnic barriers or geographic barriers (e.g., rural issues).

Several major areas are targeted for change. Infrastructure issues include:

- Continuous quality improvement on workforce issues;
- Strengthened Human Resources and training functions;
- Increased information technology (IT) support;

- Increased use of IT to track workforce activity; and
- A reduction in redundant and purposeless paperwork.

Concerning recruitment and retention, it will be important to implement and evaluate strategies tailored to organizations' needs. Areas for consideration include salary and benefits, non-financial incentives, job characteristics, and the work environment. Mr. Morris said the workforce recruited should match the population served. Mr. Morris also emphasized the importance of creating a career ladder so that organizations can "grow their own" leaders.

Training must be relevant, effective, and competency-based, with accountability built in. The Coalition is concerned that there aren't more competency-based training and workforce development strategies. Direct care workers should be trained using evidence-based practices. And although many people are beginning to use the Internet and distance learning methods, these techniques are still in the early stages in many areas. Mr. Morris stated that competencies in co-occurring disorders should be developed. More effective teaching strategies are needed, including interactive sessions, audit and feedback, and the use of opinion leaders. The definition of leadership should be broadened to include supervision, administration, and leadership; team and organizational leadership; transformational change management; sustained competency development; and succession planning.

Persons in recovery and their families need increased education and services, shared decision-making, more peer and family support services, greater opportunities for employment as paid staff, and formal engagement as educators of the workforce.

Community capacity needs to be strengthened through competency development in capacity building; planning, implementation, and evaluation; and community collaboration. Strengthened connections are needed between behavioral health care organizations and the larger community. Mr. Morris said four things that should NOT be done are:

- Hire, but not develop staff;
- Use untrained staff;
- Deliver unsupervised care; and
- Spend money on training that doesn't work.

The levers of change are financing and other incentives, accreditation and licensure, and performance monitoring. Mr. Morris said that people are hungry for TA on these issues. He said there is a need for targeted funding for workforce development, as in California with Proposition 63.

The next steps for the strategic plan include a formal rollout in 2006. The plan was already presented to the SAMHSA Center Directors. The Coalition wants to engage others in this long-term dynamic process, which has been focused on the specialty behavioral health workforce, persons in recovery, and their families. In a subsequent phase of work, the Coalition hopes to expand outside the specialty workforce, to include primary care providers, emergency room personnel, teachers, and correctional staff. Mr. Morris provided the Website address: www.annapoliscoalition.org

Comments and Questions

Ms. Power stated that she briefed Mr. Curie on the draft strategic plan and he was ready to move forward.

Dr. Vergare commented that he is on an accrediting body for psychiatry education, including residency training programs, and he struggles with stimulating interest in public sector issues from the right kind of individuals. He said economics drive what happens day to day and they are not doing a good enough job of creating economic pathways for people to enter the field. Dr. Vergare said there are fewer grants for community psychiatry and that no new internship sites are being developed that link to the kinds of transformation issues that SAMHSA is concerned with. There is therefore a need to finance grants and training initiatives in upcoming budgets. He also reported that the ACGME, which accredits residency programs, has shifted its language away from accreditation and credentialing to competency. Consumers of care want competent providers, not just people who have credentials.

Ms. Power emphasized that the strategic plan is moving in the direction of competencies and that the economic issues described by Dr. Vergare are very clearly identified in the plan's goals and objectives. Other participants described the cutbacks they had seen that affect training for students and they remarked on the need to reverse that trend. They said there's no incentive for students to be credentialed in areas in which services can't be billed. Because of this, slots for training are unfilled or students are placed in settings where they're not exposed to state-of-the-art services. Dr. Vergare commented that working with the commercial sector is a liability because reimbursement by the major behavioral health carve-outs is below Medicare levels.

Dr. Geller made several points, stating that the IMD issue causes systems to have untrained workforces across the country and that those who want a career in the behavioral health workforce must be taken out of direct service and placed in administrative positions. Mr. Morris agreed, stating that the only way a skillful clinician can stay in the field and earn a competitive salary is to move out of competent care.

Ms. Bowers-Stephens noted that few providers are trained in EBPs and asked Mr. Morris to address that. Mr. Morris expressed concern and said that most insurance models do not reimburse for practices that require a higher level of training, including EPBs.

Dr. Kelly said the system for continuing education credits is very loose, but could be revamped so that it has meaning. Mr. Morris agreed and said the Coalition was addressing that issue.

Dr. Van Stone commented that a problem with health care in general is that payers aren't willing to reimburse for services and that money is not going to the right places. He said there needs to be more accountability on the part of payers and this could be part of mental health transformation. Mr. Morris said the Coalition will eventually look at outcomes and consumer satisfaction. He said some industries are beginning to understand the problem and this will drive change.

PUBLIC COMMENT

J. Rock Johnson, J.D., Member, Subcommittee on Consumer/Survivor Issues

Ms. Johnson thanked the Coalition. She then addressed the funding cutbacks to the consumer network grants, stating that they are the foundation of the transformation effort. She said it is

through the work that takes place under these grants that recovery is modeled. She stated that the '07 budget cut the grants in half, which was a body blow to the consumer movement. Ms. Johnson said that without this funding, the voices that need to be heard wouldn't be brought forth and that the grants operate at a first-responder level. She emphasized that the grants need to stand alone, not as part of the Block Grant, so they will be channeled into consumer activities. Ms. Johnson said the grants help give people the belief that change is possible. She concluded by stating that the MHT SIGs will rest on a foundation of sand without strong consumer networks.

Glenn Koons, State of Pennsylvania, Advocate

Mr. Koons agreed with Ms. Johnson. He said he is paid by the State network grant in Pennsylvania and they are working to strengthen it. There were initially two network grants, which were decreased and merged into one. Mr. Koons said he had been diagnosed with bipolar illness, co-occurring substance abuse addiction, had been incarcerated, and had been homeless. He said his life had been changed because of the consumer movement, which helped him move forward and maintain his health. He said it was a slap in the face to stop the funding.

Mr. Koons then spoke about the young people in Pennsylvania who are 18 to 35 years old and have the potential to become empowerment leaders in 10 years. He said there will be a problem if they don't become involved in the consumer movement because of funding cuts. Mr. Koons thanked Ms. Power and Mr. Curie for their efforts in transforming mental health.

WRAP UP AND PREPARATION FOR NEXT MEETING

A. Kathryn Power, M.Ed., Director, CMHS and Chair, CMHS National Advisory Council

Ms. Power asked if the members were available to meet on July 26-27, 2006 at the same location for the next NAC meeting. She also asked participants to let her know about their availability for the Voice awards. Dr. Kelly suggested combining the two events and holding the next meeting in California. Ms. Power said she would look into it, but that there might be a conflict with the grant review process.

Dr. Kelly asked that a process be developed and included on the NAC agenda by which members could make formal resolutions/recommendations. Ms. Power agreed. Dr. Geller requested that formal resolutions be highlighted in bold in the minutes.

The members of the Council who were present voted unanimously to accept the minutes of the August 2005 NAC meeting. Because there was not a quorum, this vote was to be continued through ballots sent out after the meeting to the members who were not present.

Dr. Kelly moved that the FY 08 budget include a significant increase in funding for mental health transformation activities, such as funding for additional MHT SIG States. Ms. Randall seconded the motion. Although there was not a quorum and the voting was to be continued with other members through ballots sent out after the meeting, Ms. Power said she would communicate the request to Mr. Curie.

NAC members stated that they enjoyed the content of the meeting and appreciated the spirit of openness on the part of Ms. Powers. Concerning future meeting topics, they requested more

information about HIV/AIDS, the crisis counseling program, the experience in New York, and any information that comes out of the May debriefing on Katrina. Dr. Kelly noted that an orientation would be needed for new members.

Ms. Power thanked the Council members and conveyed best wishes to those who were absent for medical reasons. She asked for feedback on the Transformation Trends newsletter topics and suggestions on ways to disseminate it. She said it offered the Council an opportunity to discuss issues that are important to them. Members said they could take copies to professional meetings for distribution and asked to receive extra copies. They also suggested that an email be sent alerting them when an issue is published so they could post this information on listservs.

Ms. Power adjourned the Council meeting at 12:00 p.m.