

**Department of Health and Human Services  
Substance Abuse and Mental Health Service Administration**

**Minutes  
of the  
Sixth Joint Meeting**

**Substance Abuse and Mental Health Services Administration National Advisory Council  
Center for Mental Health Services National Advisory Council  
Center for Substance Abuse Prevention National Advisory Council  
Center for Substance Abuse Treatment National Advisory Council  
Advisory Committee on Women's Services  
SAMHSA Tribal Technical Advisory Committee**

**April 11, 2013  
Rockville, Maryland**

The National Advisory Councils of the Substance Abuse and Mental Health Services Administration (SAMHSA) and SAMHSA's Center for Mental Health Services (CMHS), Center for Substance Abuse Prevention (CSAP), and Center for Substance Abuse Treatment (CSAT), and SAMHSA's Advisory Committee on Women's Services (ACWS) and the SAMHSA Tribal Technical Advisory Committee (STTAC) convened in joint session on April 11, 2013, in Rockville, Maryland. SAMHSA Administrator Pamela S. Hyde chaired the meeting.

Advisory Committee Members Present (see Tab A, Council and Committee Rosters):

SAMHSA: Megan Gregory; Stephanie M. Le Melle, M.D.; Charles Olson; Elizabeth Pattullo; M.Ed.; Cassandra Price, M.B.A., GCADC-II; Dee Davis Roth, M.A.; Benjamin Springgate, M.D., M.P.H.; Christopher Wilkins, M.H.A.; Marleen Wong, Ph.D., M.S.W.

CMHS: Robert Friedman, Ph.D.; Laurie R. Garduque, Ph.D.; William R. McFarlane, M.D.; Diane Narasaki, M.N.P.L.; Patrick A. Risser

CSAP: John Clapp, Ph.D.; Michael Compton, M.D., M.P.H.; Eugenia Conolly, M.Ed., C.P.P.; Michael Couty; Kwesi Ronald Harris; Michael Montgomery, M.Ed.; Mary Ann Tulafono; Patricia Whitefoot, M.Ed.

CSAT: Sadé Ali, M.A., CADC, CCS; Victor A. Capoccia, Ph.D.; Emmitt W. Hayes, Jr.; Leighton Y. Huey, M.D.; Marco E. Jacome, M.A., LPC, CSADC, CEAP; Jeanne Miranda, Ph.D.; J. Paul Molloy, J.D.; Indira Paharia, Psy.D., M.B.A., M.S.; Lori Simon, M.D.; Christine Wendel, M.B.A; Mohammad Yunus

ACWS: Johanna Bergan; Yolanda B. Briscoe, Psy.D., M.Ed.; Jean Campbell, Ph.D.; Harriet C. Forman; Shelly Greenfield, M.D.; Carole Warshaw, M.D.; Rosalind Wiseman, M.A.

SSTAC: Joe Garcia; Rex Lee Jim; Andy Joseph, Jr.; L. Jace Killsback; Keith Massaway; Arthur Wilson

SAMHSA Administrator: Pamela S. Hyde, J.D.

Principal Deputy Administrator: Kana Enomoto, M.A.

Designated Federal Official: Geretta Wood

Non-SAMHSA Federal Staff Present: (see Tab B, Federal Attendees List)

Representatives of the Public Present: (see Tab B, Public Attendees List)

### **Call to Order**

Ms. Geretta Wood, Designated Federal Official, welcomed participants and called the meeting to order at 9:05 a.m.

### **Welcome and Introductions**

Ms. Pamela S. Hyde, SAMHSA Administrator, welcomed participants to the sixth joint meeting of SAMHSA's advisory committees. Ms. Hyde stressed the value to SAMHSA of Council members' advice and expressed appreciation for their contributions. Members of SAMHSA's senior staff introduced themselves, and Ms. Hyde introduced Ms. Jac Rivers, new Special Assistant to the Administrator. She also noted the retirement of her secretary, Debbie Crump.

### **Administrator's Remarks**

Ms. Hyde described several current SAMHSA issues. She stated that SAMHSA recently released to Congress a report on the behavioral health workforce, a growing concern with an unprecedented 62 million people slated to gain access to behavioral health coverage in January 2014; too few traditional, licensed professionals will be available to meet the burgeoning need for services, highlighting the need for innovative approaches. SAMHSA is devoting greater attention to ensuring that tribal programs can access SAMHSA funding, receive technical assistance, connect with best practices to address their most serious issues, and ensure that SAMHSA's American Indian/Alaska Native grantees' programs have the tools they need to manage their programs effectively. Ms. Hyde explained that SAMHSA also has been considering systems and strategies to manage and oversee the conferences and meetings that are a valuable aspect of SAMHSA's portfolio.

Ms. Hyde explained that SAMHSA's 4-year plan with eight strategic initiatives guides the agency through Fiscal Year (FY) 2014. The next strategic plan will cover FY 2015–18, and preparation for the FY 2015 budget is slated to begin in May 2013. Ms. Hyde asked advisory committee members for input on SAMHSA's direction for that period. Though funding amounts are relatively small, SAMHSA's grant-making role appears central to moving the field forward, and SAMHSA's influence, policy making, public voice, communications, and practice improvement efforts have taken on critical importance.

Members introduced themselves, and Ms. Hyde announced that Dr. Elinore F. McCance-Katz will join SAMHSA as Chief Medical Officer.

**Discussion.** Mr. Joe Garcia suggested that SAMHSA compile a chart that illustrates the focus and interrelationships of SAMHSA's and HHS's committees, and Dr. Yolanda Briscoe suggested that SAMHSA provide summaries of the key points made at each committee meeting. Ms. Hyde endorsed Mr. Pat Risser's appeal for SAMHSA to continue to recognize the primacy of the views of people with lived experience. Dr. Jean Campbell added that people with lived experience must participate in meetings of all sizes. Ms. Diane Narasaki urged SAMHSA to designate reduction of behavioral healthcare disparities as a high-priority strategic initiative. Ms. Patricia Whitefoot urged SAMHSA to focus on evidence-based and best practices for communities of color. She suggested that SAMHSA, the Department of Education, and other relevant agencies look into children failing in public schools. Mr. L. Jace KILLSBACK encouraged SAMHSA to include a focus on tribes in its strategic initiatives in the spirit of their government-to-government relationship.

## **SAMHSA's Budget: Update**

Ms. Kana Enomoto, SAMHSA Principal Deputy Administrator, described the agency's budget issues. Final FY 2013 budget decisions and congressional approval of SAMHSA's operating plan under a continuing resolution had not yet occurred. Nevertheless, Ms. Enomoto assured meeting participants of the Administration's and Congress's commitment to reduce the impact of mental health and substance use disorders in America's communities. She pointed also to the important role SAMHSA will continue to play in policy, services, and financing of healthcare services.

SAMHSA has maintained level funding since FY 2010, with the exception of a sequester-related dip in FY 2013. SAMHSA has cut 5% across all block grants and its discretionary portfolio under the sequester, though the agency was able to make some small shifts to protect grants' continuation funding. SAMHSA also reduced some contracts and operating costs, including travel and conferences; no personnel actions were anticipated. State block grants were to be reduced for the third and fourth quarters of FY 2013.

Ms. Enomoto noted favorable press reaction to the President's FY 2014 budget proposal of \$3.348 billion for SAMHSA, which represents a 3.5% increase over FY 2012 levels and maintains SAMHSA's historical 70/30 split between substance abuse and mental health. SAMHSA anticipates leveraging reductions in its discretionary portfolio to advance change and stimulate innovation at the state level.

Ms. Enomoto highlighted the proposed set of Now Is The Time grants that would allocate \$130 million to SAMHSA in FY 2014 to support the Administration's response to the Sandy Hook School shootings tragedy. Project AWARE would build on SAMHSA's successful Safe Schools/Healthy Students program. With funds from the Departments of Education and Justice, along with SAMHSA, the comprehensive program would involve local systems (education, justice, behavioral health) working collaboratively to improve school safety, reduce substance use, improve resilience, and facilitate access to behavioral health services. States would adopt statewide multi-tiered behavioral frameworks for making data-driven decisions about the best interventions for specific student populations. Law enforcement training would be provided to better identify mental health and substance use problems among young people and to familiarize officers with steps to get them the supports they need to keep kids in school, not suspended, and not in the juvenile justice system.

Other SAMHSA activities would offer incentives for states to provide support and information for emerging adults (ages 16–25), who are at high risk for binge drinking, serious mental illnesses, lack of help seeking behaviors, and suicidality. In a partnership with the Health Resources Services Administration, \$35 million would fund training of thousands of additional behavioral health professionals to work with students and young adults. SAMHSA also would allocate \$10 million to train peers with lived experience to work in behavioral health. SAMHSA hopes to partner with community colleges and states to create career ladders. SAMHSA would also double funding for its Minority Fellowship Program to add masters-level provider training.

**Discussion.** To a question from Dr. Lori Simon, Ms. Enomoto responded that in the FY 2014 budget SAMHSA has established health information technology as a separate line item. Mr. Andy Joseph, Jr., described multiple challenges encountered by Indian Country schools and asserted the need for increased educational and prevention resources. Ms. Enomoto noted that the FY 2014 budget includes a Department of Education program for children offered in school settings that addresses pervasive trauma in communities. Mr. Garcia advocated for grant funds to educate students in Bureau of Indian Affairs (BIA) and tribal-controlled schools. Ms. Enomoto stated that SAMHSA will discuss introduction of evidence-based practices with BIA and also with the Department of Defense, which has similar concerns about schooling of children of military personnel. To Ms. Cassandra Price's inquiry about SAMHSA's approach to maintaining behavioral health services in states slow to adopt healthcare reform, Ms.

Enomoto replied that SAMHSA has been working to increase providers' capacity to bill appropriately for services regardless of the reimbursement environment.

Once Congress acts on the budget, Ms. Whitefoot urged, SAMHSA should require American Indian/Alaska Native tribal involvement in developing new grant programs. Mr. Rex Lee Jim advocated for direct access to SAMHSA grant funding by tribes. Ms. Hyde stated that SAMHSA had proposed a prevention program for which only tribes would be eligible, but it garnered little congressional support and the proposal no longer appears in the SAMHSA budget. Ms. Johanna Bergan advocated for providing Mental Health First Aid to young people and for strengthening peer support services in schools. To Mr. Charles Olson's inquiry about the feasibility of incorporating funding for Mental Health First Aid and Emotional CPR in the new SAMHSA budget, Ms. Enomoto responded that the final appropriation will determine fund allocation.

### **National Dialogue on Mental Health**

Ms. Hyde explained that the President's Now Is The Time initiative will include a National Dialogue on Mental Health, in which communities will participate in structured conversations to enable residents to express themselves and to learn about the wide range of views held on mental health needs and treatment.

Dr. Carolyn Lukensmeyer, Executive Director, National Institute for Civil Discourse, stated that the nationwide community conversations would be connected in overall approach, with each "owned" by the locality in which it occurs. The conversations' goals are awareness and education in order to bring mental and substance use disorders out of the shadows and to debunk myths, plus development of community action plans to which coalitions of community organizations would commit to implement.

SAMHSA, the Department of Health and Human Services (HHS), and the White House are joined on the National Dialogue's steering committee by organizational leaders in deliberative democracy, including AmericaSpeaks, Deliberative Democracy Consortium, Everyday Democracy, Kettering Foundation, National Issues Forum, and the National Institute for Civil Discourse. Ten cities have been chosen for the initial dialogues whose mayors had expressed interest. A toolkit will include a fact sheet, discussion guide, and organizing guide designed to help other communities initiate their own local dialogues. The ten initial dialogues will be conducted by neutral trained facilitators; attended by diverse, representative populations with an oversampling of young people and mental health stakeholders; and aimed toward sustaining community engagement and replicating the process in many localities.

**Discussion.** Mr. Risser expressed concern about the view that people with mental health disorders represent a problem for which community dialogues must develop community solutions, and he took exception to making a link between high-profile shootings and people with mental health problems. He asserted the need for people with lived experience to have the primary voice in the dialogues. Dr. Lukensmeyer responded that half the participants in each community dialogue are anticipated to be people with diagnoses and stated that the dialogues will focus on community actions that support young people and emerging adults. Mr. Paolo del Vecchio, Director, Center for Mental Health Services, added that SAMHSA strongly supports inclusion of people with lived experience in helping to convene and participate in all the dialogues, which aim to help communities develop relationships to help people build resiliency and recovery. Mr. Paul Malloy echoed Mr. Risser's concerns as he described the Oxford House model of convening individuals and communities to develop solutions related to alcohol and drug abuse problems by taking personal responsibility. Dr. Lukensmeyer asserted that supported, civilized discussion can break through impasses and solve problems. Ms. Rosalind Wiseman suggested that understanding the protocols to be followed by the neutral facilitators may address some concerns. Ms. Chris Wendel urged SAMHSA to develop strategies to engage smaller communities in the process.

Dr. Vincent Capoccia highlighted the importance of communications to support sustainability. Dr. Lukensmeyer described a strategy that includes disseminating a consistent message via video and social media, updates to stakeholder groups nationwide on the process, talking points, a website that features dialogue outcomes on a map of participating localities, and identifying diverse media partners that commit to covering the initiative over time.

Ms. Hyde pointed out that the passion with which members participated in the foregoing conversation reflected the high passion across the country about polarizing mental health issues. Such disagreements have impeded Americans from addressing the issue of mental health in a positive, reforming way. The planned dialogues will capitalize on heightened awareness after the Newtown school shootings and will enable people to convene to sort through the issues. Ms. Hyde concurred with the need for rural, faith, and tribal communities to have conversations. She added that SAMHSA is developing public and private partnerships; no federal dollars will fund these meetings.

Participants divided themselves into small groups and responded to the following question: What attitudes and beliefs about mental health would you most like to influence in order to create a culture more supportive of people's need to connect to preventive and treatment services? Key themes among the responses included: (1) We're all in this, just on a different place on a continuum; emotional health and mental health are part of what it means to be a whole, healthy human being; (2) in Native communities, people are community more than they are individuals; infusing American culture with this world view may help to stop isolating people and approach mental health in the context of a community; (3) identify and treat issues early, reduce barriers to connect with services, and connect people to the right kinds of support; and (4) have hope. To those themes participants added that recovery is possible and sustainable, and may be found in multiple pathways that include treatment and other approaches. Appendix C lists the responses reported out by the small groups.

Several participants responded to the question: What innovative solutions or action do you feel could help more young people make a successful transition to adulthood? These are the responses: (1) Embrace culturally relevant rites of passage/cultural reclamation by young people who may not have understood their cultural identity and potential, to become initiated into adulthood and to become an asset and not a liability to the community; (2) create opportunities for community outreach for civic inclusion of a young person with mental illness, such as a community July 4th parade or involvement in community art mural projects; (3) acknowledge adult hypocrisy and the fact that adults contribute to young people's problems; avoid lecturing and patronizing children, and reminding them that "you've got it so lucky"; (4) recognize that it takes a village, and consistency in communities, to raise a child; (5) change terminology: mental illness to mental health; mental health challenges; and (6) it may be necessary to *create* community.

Dr. Lukensmeyer suggested that meeting participants who wish to stay involved in the project initiate a conversation in their own communities, become a national partner organization, and use communications tools, including traditional and social media. She observed that "Now is the time" was the call to action to join the civil rights march on Washington in 1963; the National Dialogue on Mental Health represents a step toward ensuring the civil rights of another important segment of the population.

Ms. Hyde described the evolution over recent decades of attitudes related to epilepsy, cancer, and HIV/AIDS. She observed that the more that is known about these conditions, which once were subject to negative stereotypes and fear, the more they are considered just public health problems to be solved.

## Mini-Sessions

Meeting participants chose to participate in informal lunchtime discussions with the experts on SAMHSA's international activities, disaster response activities, faith-based initiatives, and the Brady Bill Prohibitor List (individuals who should be prohibited from purchasing guns).

### Health Reform: Disparities and Evidence-Based Practices

Dr. Larke Huang, Director, SAMHSA's Office of Behavioral Health Equity, moderated a panel of advisory council members on the interplay between evidence-based practices and behavioral health equity. The Institute of Medicine defines *evidence-based practice* as the integration of best research evidence with clinical expertise and patient values.

Dr. Carolyn Clancy, Director, Administration on Health Research and Quality (AHRQ), stated that her agency's mission is to improve the safety, quality, effectiveness, and efficiency of healthcare for all Americans by supporting research with a practical focus and with a strong emphasis on disseminating results. AHRQ publishes annual reports to Congress on the state of healthcare quality and the state of healthcare disparities. Dr. Clancy noted that statistically significant, but not clinically meaningful, annual improvements of 1–2% over the past decade represents a disconnect with costs that are rising faster than quality. She stated that ending disparities requires more accelerated strategies, although certain areas have improved. The disparities report found no statistically significant changes from 2005 to 2008 in the percentage of people age 12 and over who completed treatment in those years. During that period blacks were significantly less likely to complete treatment than whites, and people with less than a high school education were significantly less likely to complete treatment than those with more education.

AHRQ invests in patient-centered outcomes research and makes information accessible to multiple audiences. A tension in evidence-based practices, whether in the context of disparities or alone, is the urgency in providing services balanced against the strength of the evidence. She invited Council members to participate in AHRQ's Web-based platform to share experiences and solve problems (<http://www.innovations.ahrq.gov>) and noted that her agency sponsors an academy for integrating behavioral health in primary care. Dr. Clancy explained that AHRQ's recent systematic review of applying quality improvement techniques to reduce disparities in healthcare found little evidence and posed the question of whether enough effort is expended toward this aim, whether different evidence is needed for some population groups, whether more effort is necessary to understand why disparity-reduction efforts are insufficient, whether unspoken expectations are at play, or whether adaptations are necessary. She asserted the urgency in addressing disparities by means of action research and acquiring evidence wherever it appears. She suggested enlisting the National Institute for Minority Health and Health Disparities, an agency with infrastructure and resources, as a partner.

Dr. Jeanne Miranda asserted that large, impressive trials have shown that standard treatments for mental health, with few modifications, work well with African American and Latino populations. Knowledge is growing about interventions for Asian populations, but studies have not yet been conducted with Native Americans. Successful strategies for adapting cognitive behavioral therapy have included lowering the language level, simplifying concepts using good examples, and careful, thoughtful translation. Dr. Miranda noted that the implementation of evidence-based practices in psychotherapy has eliminated disparities. She stated that data show that people are deprived of high-quality care by claims that evidence-based practices do not work; no studies of evidence-based care show that minorities do worse. She urged support for scientific study of interventions used in communities for minorities because they may also work well in the broader community. Little progress has been made, however, in increasing numbers of minority service providers. Dr. Miranda also noted that minority populations typically lack

insurance coverage. She asserted that though sufficient inroads have not yet been made in disparities, the tools and knowledge are available, and with the right workforce and training, progress can be made.

Ms. Diane Narasaki stated that she supports evidence-based practices, but not as the only tool in the box. She expressed concern over requirements for strict fidelity of evidence-based practices used with Asian populations, especially when experience shows that her agency's tools are more effective for its population. Many evidence-based practices are not designed by people of color or members of other populations that experience disparities, and population studies rarely include people of color. Ms. Narasaki asserted that evidence-based practices should be tested and culturally adapted when necessary; if standard evidence-based practices do not produce successful outcomes, programs should not be required to use them. She noted that adaptation of evidence-based practices can be expensive in terms of training, training time, and administrative effort. She also expressed support for practice-based and community-defined evidence.

In response to Dr. Huang's query about panelists' perspectives of *evidence*, Dr. Clancy stated that evidence refers to reducing uncertainty about options by which to treat patients. She endorsed the values of studying practice-based evidence and of conducting studies in relevant settings. Dr. Miranda endorsed formal, scientific study of practice-based evidence. Ms. Narasaki criticized ignoring successful outcomes that have not been subjected to randomized controlled trials. Her worst-case scenario involves all service providers required to use evidence-based practices that have not been normed on their populations, may not be culturally competent, and whose outcomes may be less effective than the community-based practices that have been successful for generations. Dr. Clancy pointed out that much of clinical care across all domains relates to beliefs, interactions, and the placebo effect, not necessarily evidence.

**Discussion.** Mr. Garcia noted the importance of an individual's culture, language, and environment, which may not come into play in a blind trial. He stated that interventions warranted in the early stages of a mental illness may be different from evidence-based practices typically applied in later stages. Dr. Miranda concurred and raised the issue of widespread poor implementation of evidence-based practices.

Dr. William McFarlane described great success in micro-adapting Family Psychoeducation, a successful intervention for schizophrenia; in every locality where the treatment has been implemented worldwide, leaders of the group were members of the culture of the individuals who received the services. He stated that prior to discarding evidence-based practices because they have not been adapted well for communities, community members themselves should be asked to adapt and test them. Dr. McFarlane also proposed developing evidence for public health practices in studies that compare those practices to standard treatment rather than controls. Dr. Miranda concurred, noting that much of adaptation relates to good clinical skills in communicating and understanding. Ms. Narasaki pointed out that her organization has served the community for 40 years because of its track record of working with their consumers, who consider the services to be effective. She noted disparities in who receives funding for research, who designs the studies, and who participates in the studies. She asserted that the issue of disparities is urgent and cannot rely solely on evidence-based practices or wait for them to be in place.

Dr. Carole Warshaw observed the challenge of conducting research on patient-centered outcomes in the trauma domain with small samples in order to develop flexible, multifaceted interventions useful when highly complex lives are changing rapidly. Dr. Clancy suggested contacting the new Patient-Centered Outcomes Research Institute. She noted that defining an intervention is important to enable replication. She also pointed out that pharmaceuticals have distribution infrastructure in place, but other approaches are much harder to disseminate broadly.

Ms. Chris Wendell noted that recovery from substance abuse has strong practice-based evidence and endorsed the importance of practice-based evidence. Dr. Stephanie Le Melle called attention to the

difference between culture, which involves learned experience and values, and ethnicity, which is genetically and biologically driven. She also noted disparities in the use of evidence, in that evidence may not fit all populations.

Dr. Campbell suggested framing the discussion of evidence as improving the scientific process to be more inclusive and grassroots oriented, and improving community engagement and consumer participation in the research process to be more culturally competent. She stated that randomized controlled trials may have the advantage of determining not only that an intervention works but also how and for whom. Researchers can make the adaptation process scientific and suggested using a fidelity tool for continuous quality improvement. Dr. Simon concurred on the need for research, but stated that clinicians must decide what works for any particular individual and that insurance companies should not be able to require use of specific evidence-based practices for certain patients. Mr. Rex Lee Jim urged that traditional Indian practices be involved in the research cycle and asserted that evidence-based, Western-based notions of healing are biased in terms of getting funding. Ms. Hyde contrasted the Western approach to quantification with traditional Native approaches that do not focus on that value. Science and all its complexities extend beyond randomized controlled trials.

To a question from the public regarding prescribing antipsychotics, Ms. Hyde stated that SAMHSA considers antipsychotics to be just one approach to treatment for psychotic issues. Traditional ceremonies, mutual aid, and medication-assisted treatment for substance use disorders all can play a therapeutic role.

### **Health Reform Update: Outreach and Enrollment Strategies**

Ms. Hyde stated that while the Affordable Care Act (ACA) already has generated benefits for the behavioral health field, states continue to make decisions about Medicaid expansion and exchanges. As of October 1, 2014, approximately 62 million people with mental and substance use disorders will become eligible for coverage. Ms. Suzanne Fields, SAMHSA's Senior Advisor on Health Financing, moderated a discussion by a panel of advisory council members on issues related to eligibility and enrollment for insurance coverage under the ACA.

Dr. Victor Capoccia explained that 26 million Americans would benefit from addictions interventions in a system that currently reaches just 2.4 million annually, offering SAMHSA an opportunity to expand systems of care and to devise innovative approaches. On the horizon insurance will be available through exchanges; Medicaid coverage will expand; and parity will drive new resources. Additional investment will be required for insurance coverage. Dr. Capoccia described Massachusetts' experience, where 97% of the population is insured following a strong outreach and navigation effort to help people enroll. About 25–30% of people in behavioral health treatment lack insurance coverage, representing a significant portion of the 3% in Massachusetts who remain without coverage.

Mr. Michael Couty stated that Missouri has covered most of the youth in the state's juvenile court system under the Children's Health Insurance Program, but their families may be ineligible for Medicaid. Reunification of families in the child welfare system may be impeded by ineligibility for insurance coverage or employment among parents who use substances. Mr. Couty pointed to the need for collaboration across systems to address such problems as homelessness, inconsistent school attendance, and poor school performance.

Ms. Elizabeth Pattullo stated that providers in Massachusetts have played a key role in enrolling newly insured people at the point of service, including emergency departments, community mental health centers, community health centers, grant programs, and outreach workers/navigators, but payment strategies for outreach work is not clear. She commented that other states should prepare to meet pent-up need. Ms. Pattullo cautioned that churning in the eligibility reverification process poses a large problem,

particularly among previously uninsured men, and at times when people enter and leave coverage as a result of employment changes. Outreach is needed to help in reinstatement (as well as recruitment), as are databases that electronically populate applications' fields from other sources. She stated that state policy makers and provider organizations should collaborate on more efficient processes. Dr. Capoccia identified financial consequences of disenrollment and reenrollment: state agencies' administrative costs to manage the reenrollment process, medical and physical costs of ill health among persons reluctant to continue care, free care offered by providers, and burden on states, philanthropies, and legal service organizations that cover additional costs.

Mr. Couty described the difficulty in redirecting existing block grant funds. Gaps may exist in mental health coverage under Medicaid, particularly for certain age groups and persons in the criminal justice system, and particularly for males age 17–21. Some states partner well with localities to fund services and provide programming.

Ms. Pattullo recommended universal and permanent eligibility in the future. Based on experience in both Massachusetts and New York, all stakeholders demonstrate a high level of motivation to engage in enrollment activities. Ms. Pattullo also asserted the need for automation, building community capacity, and cross-system collaboration. She noted that the criminal justice system remains fragmented at all levels. Dr. Capoccia stated that because permanent eligibility is not in place (Medicaid rules require regular eligibility verifications), states should consider an interim policy of targeted presumptive eligibility for categories of people who are eligible for subsidized and/or public insurance and who have chronic existing conditions that limit income eligibility. He suggested the need for a legal opinion on whether convicted felons have an implicit right to Medicaid.

Ms. Hyde proposed a scenario with a single eligibility form for any type of available insurance, administered in an automated system that connects to the Internal Revenue Service for income verification, assumes no asset tests, presumes the accuracy of an applicant's information, and assumes that eligibility endures unless cause is obvious. She noted that assumptions are changing about how to help people become eligible for coverage. Ms. Hyde observed that dealing with eligibility will be a greater challenge in states that choose not to expand Medicaid. She stated that the new form will take data from both the Internal Revenue Service and Social Security.

**Discussion.** Dr. Ben Springgate pointed to potential problems associated with an insufficient workforce and less economical service-delivery models. Ms. Pattullo observed the need for more young people to join the field and for practitioners to use their creativity to connect more efficiently with people. Ms. Price expressed concern about an expanding workforce and diminished quality of services. Mr. Couty stated that licensure and certification efforts may affect quality of care, but numbers of providers insufficient to meet demand must be addressed by new ways to deliver services. Ms. Hyde acknowledged the advent of competition in the behavioral health field and the need for providers to learn how to enroll and to bill for their services. Dr. Marleen Wong suggested tuition reimbursement and outreach to high school students as strategies to attract new providers. Mr. Marco Jacome inquired about levels of behavioral health providers who will be reimbursed and how care will be paid for for individuals ineligible for Medicaid. Ms. Hyde responded that all states will offer certain services that are not covered by benchmark plans or qualified health plans. Some services will be covered by some states and not by others, and block grants are likely to play a role in this issue. Dr. Fields noted the importance of conversations with managed behavioral health organizations.

Mr. Christopher Wilkins identified sources of anxiety experienced by behavioral health providers: more than 60 million individuals attaining access to care, limited available dollars in some managed care settings, and a full-risk-bearing model. Flash points include asking traditional providers with traditional boards of directors and limited resiliency to do fine, complete, and complex analysis of the risk

environment and to employ transformational models. Future rates will not account for risk management costs, compliance, and quality improvement; anticipated higher healthcare insurance premiums for providers; retirement of industry leaders and lack of younger leaders; not having articulated a viable market model for a transformation model and staying in the middle; and lack of information about consumer choice in their care experience. He observed the likelihood of large organizations' insensitivity to patient-centered care or possibly the advent of nontraditional, unregulated, unlicensed models that need not account for what happens to people. Dr. Capoccia noted the benefits of creating networks to influence policy, share knowledge, and draw strength from past experience. He stated that organizations that respond to the emerging needs of their communities will continue to serve those communities. Ms. Hyde responded that the discussion of anxieties in the field quieted her own anxiety that the field was not thinking about the issues. She acknowledged that the major shifts on the horizon will lead organizations to close their doors, to diversify, to create collaborations, and to change the provider mix.

### **Council Discussion**

Ms. Mary Ann Tulafono noted that she had been unaware of how territories were affected by Medicaid insurance coverage, particularly regarding eligibility based not on criminal background, but on income. She noted that the underage drinking prevention initiative in American Samoa is going well and suggested approaching states' first ladies as allies on prevention issues. Dr. Leighton Huey observed that civil discourse may involve organizations in addition to geographical communities. He suggested that SAMHSA work with accrediting bodies for medical schools and undergraduate education on issues related to the workforce training pipeline. Mr. Emmitt Hayes suggested that SAMHSA explore social impact bonds to enable the private sector to help fund good outcomes.

Dr. McFarlane called attention to the dwindling numbers of psychiatrists in the workforce who, as Dr. Simon asserted, have fallen victim to workforce and payment issues. Ms. Hyde suggested that Council members meet with SAMHSA's new Chief Medical Officer on this issue. Dr. LeMelle observed that some psychiatrists would prefer to span boundaries rather than dispense medications. Ms. Hyde stated that profound changes in practice, payments, and structures are forthcoming.

Ms. Wiseman asserted the need for outreach and education regarding some individuals' need for repeated episodes of rehabilitation. She also suggested the need for schools to find ways for teachers to communicate meaningfully with school counselors in ways that do not violate students' confidentiality. Mr. del Vecchio offered to provide information about effective models developed in SAMHSA's Safe Schools/Healthy Students program. Dr. Wong stated that the degree of communication openness depends in part on the views of school administrators and teacher bargaining units. Ms. Harriett Forman noted that teachers should be able to talk with parents about developmental and behavioral issues. Ms. Wiseman noted that teachers do not want to do IEPs (individual educational plans) and that they also experience anxiety about labeling children or doing something irresponsible. Dr. McFarlane suggested the strategy of having a teacher talk with a guidance counselor who then would contact parents. Ms. Frances Harding, Director, Center for Substance Abuse Prevention, stated that for common behavioral issues, reliance on school counselors and social workers in schools has proven successful. Mr. Couty described a child welfare support team model that includes the court, school, mental health professional, parent, and anyone else associated with a child's behavior. They each consent in writing to share information on behavioral issues and make suggestions about what could work for a student within the school. Ms. Hyde pointed out that establishing systems creates environments for successful communication.

Dr. Robert Friedman commended SAMHSA on its work on trauma and suggested that SAMHSA's advisors spend more time discussing prevention, especially prevention in schools; promoting organizational and systems accountability in terms of outcomes at a time of transformational change; and SAMHSA's strategies to continually leverage its resources to enhance its impact, particularly in terms of

training and technical assistance. He encouraged SAMHSA to become more of a learning community. Mr. Risser urged SAMHSA to focus on creating recovery plans with exit strategies for people who enter into treatment.

Dr. Huey stated that evidence-based practices do not drive change and asserted that experts in behavior change should be able to figure out how to change behavior in the workforce, such as linking evidence-based practices with quality improvement and performance incentives and disincentives. Mr. Garcia urged SAMHSA to focus on innovation. Dr. LeMelle suggested that SAMHSA harness predictive technology and outside databases to help discern patterns to inform future efforts; insurance companies and managed care programs already engage this technology.

Ms. Hyde informed meeting participants that the next series of SAMHSA advisory committee meetings is planned for August 14–16, 2013, in Rockville, Maryland.

### **Public Comment**

Time was set aside for public comment, but no one chose to speak.

### **Adjournment**

The meeting adjourned at 5:00 p.m.

## Appendix C. National Dialogue on Mental Health Small Group Discussions

1. What attitudes and beliefs about mental health would you most like to influence in order to create a culture more supportive of people's need to connect to preventive and treatment services?
  - Equal opportunity to affect everyone.
  - Does not represent immoral or bad behavior.
  - Different degrees of well-being, as in other conditions. We can do something about it to include a degree of well-being, assuming a person wants to.
  
  - Mental health exists on a continuum.
  - Mental health often has cultural considerations.
  - Prevention and early opportunities for community involvement and identification of children need to happen early.
  - Prevention does exist.
  
  - We are more the same than different, regardless of mental health diagnosis.
  - We need to work in units of community.
  - Community includes culturally competent healthcare providers.
  - Include mental health in the overarching healthcare conversation.
  
  - People with mental health issues are just like everyone else.
  - Most often people with mental health issues deal with issues of abuse, neglect, trauma, and the pain of being a person in society.
  - People with mental health issues need supports and not to be stigmatized.
  - Mental health should impact on the workforce and how we treat each other; we're all in this together.
  
  - The tribal cultural aspect holds that there are no individuals.
  - We are all together and we're stronger together, a value we try to impart to children and community.
  - People with mental health problem tend to separate themselves, but we don't allow that. We are part of a continuum and a process, and we educate that all are somewhere on that path.
  
  - Need an attitude of seeking help early.
  - Seeking any help is not seen as weakness but as strength.
  - Seeking help earlier will help us all.
  - Mental health treatment should be a human right, not be tied to financial ability to pay.
  - There is hope in seeking help and hope for changing lives for the better.
  
  - There are causes for people getting mentally ill; we should not just focus on the person.
  - External forces include family, friends, and social situations.
  - Prevention is good.
  - Mental illness is not hopeless.
  - It takes strength to get help, not weakness.
  - Violence is a huge stigma with mental illness, and the vast majority of people with mental health problems are not violent.

- Even if a person shows violent tendencies, those can be treatable.

Summary: Four themes

- We're all in this, just on a different place on continuum, and part of whole healthy human being.
- There is existential reality for the Native community: We are community more than we are individuals. We should stop isolating people and treat this in community.
- Early detection, if we identify people, can reduce barriers to connect with services. Get people connected to the right kinds of support.
- Hope.

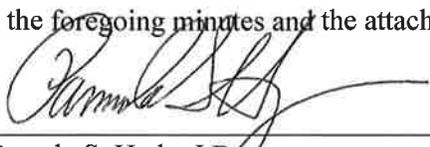
More:

- Recovery is possible and sustainable.
- Recovery is found in multiple pathways, including treatment and other methods.

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

JUL 15 2013

\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Pamela S. Hyde, J.D.  
Chair, SAMHSA National Advisory Council  
Administrator, SAMHSA

Minutes will be formally considered by the SAMHSA National Advisory Council at its next meeting, and any corrections or notations will be incorporated in the minutes of that meeting.

Attachments: Tab A – Roster of Members; Tab B – List of Attendees

**JAC Meeting – April 12, 2013**

**List of Attendees**

*0 Non-SAMHSA Federal Attendees*

*109 Public Attendees representing 105 Constituent Organizations*

Leonard Boyd	Lox Consulting Group
Sheila Harley	Harley Bus. Group
Jennifer Kasten	JBS International
Anthony Ryob	KADA
Karl White	JBS International
Edward Woffard	CRP
Mary Yakailis	Trillium
Karen Synergy	Enterprises
Jesse Abernathy	Great Plains Tribal Chairmen's Health Board
Julio Abreu	MHA
Joyce Allen	Wisconsin DMHSAS
Donna D Atkinson	Westat
Diana Avery	County staff
Pat Beauchemin	Treatment Communities of America
Richard Becker	AHP, Inc.
Sean Bennett	Advocate
Deborah Beste	Phoenix Programs
Margaret Black	Aquilent
Scott Bryant-Comstock	Children's Mental Health Network
Eric Buehlmann	National Disability Rights Network
Patty Cameron	TA
L. Diane Casto	State of Alaska
Hyacinth Charles	Very Loud Youth
Adam Chu	EDC
Jennifer Cooper	National Indian Health Board
Gabrielle de la Gueronniere	Legal Action Center
Phyllis DeRosa	CPS
Michelle Dirst	NASADAD
B Draley	Contractor
Ruth Dudley-Chippewa	Grand Traverse Band of Ottawa and Chippewa Indians
Marshall Ellis	Link2Health Solutions, Inc.
William Emmet	Magna Systems Inc
Philip Erickson	Loudoun County VA CSB

Alexandra Gasper	Advocates for Human Potential, Inc.
Ellen Gerrity	NCCTS
Gary Goetz	North Key Community Care
Al Guida	Guide Consulting Services
Tanya Guthrie	Texas Department of State Health Services, Austin, Texas
Judi Heffner	Probation
P Heller	Aquilent
Vicki Herndon	Hill Country MHDD Centers
Eugene Herrington	Morehouse School of Medicine
Charlene Herst	State Substance Abuse Agency
Charlene Howard	SAPTA
Karen James	Contractor
Andrea Jehly	Meta House
Miller Joel	NASMHPD
Alan Johnson	Treatment agency
Julie Jolly	Lewis-Burke Assoc
Gloria King	DBHS NRBHC
David Kittross	CD Pubs
Alison Knopf	Press
Katie Kostiuk	SDFSA
Michael Kramer	Noble Superior Court, Div. 2
Sheila Krishnan	SPRC
Kimberly Leonard	Envision
Carolyn Lichtenstein	WRMA
Kelly Lieupo	CADCA
Michael Linskey	AACAP
Scott Mackenzie	Winning Strategies Washington
Eddie Mann	UMDNJ-UBHC
Vanessa Masters-Jun	Advocate
Deborah McBride	Substance Abuse Prevention and Treatment Agency Nevada
Matthew McClain	McClain Associates
Tracy McPherson	NORC at the University of Chicago
Holly Merbaum	CDI
David Miller	NASMHPD
Keris Myrick	Project Return Peer Support Network
Katelyn Niel	El Hogar Community Services, Inc.
Jan Nishimura	Hawaii State Dept. of Health, Alcohol and Drug Abuse Division
Deborah Partridge	Loyola Recovery Foundation
Liz Pongia	New Horizon Treatment Services, Inc.
Esta Powell	MACC
Kristin Ptakowski	AACAP
Andy Rawdon	Compeer Rochester, Inc.
Lisa Ray	INCASE
Jerry Reed	SPRC
Steve Reeves	DMH State of Missouri
Lydia Richard	Advocacy Initiative Network of Maine
Joseph Rogers	Mental Health Assn
Clarke Ross	American Association on Health & Disability
Joe Samalin	Disaster Distress Helpline/MHA-NYC
Carole Schauer	Retired
David Schilling	Social Services

Erika Schnapp	Cascadia BHC
James Skinner	MayaTech Corporation
Dana Sleeper	Hanover Research
Shirley Smith Hill	SS&W Enterprises
Mary Sowder	Texas Department of State Health Services
Jim Stewart	Virginia DBHDS
Ellyson Stout	Education Development Center/SPRC
Karen Stubbs	La DHH
Trevor Summerfield	American Foundation for Suicide Prevention
Regina Surber	The Next Door, Inc.
Pat Taylor	Faces & Voices of Recovery
Ben Thomas	EDC
Nicole Truhe	Youth Villages
Laura Uttley	Lewis-Burke Associates
Kristopher Vilamaa	Alabama Dept of Mental Health
Tom Virag	RTI
Tonya Voelker	NADCP
Bethanie Wang	Avar Consulting, Inc.
Dave Wanser	JBS International
Madeline Weed	Tennessee Department of Mental Health and Substance Abuse Services
Marthagem Whitlock	TN Dept of MHSAS
Jay Whitman	Service Provider
Mark Zehner	University of Wisconsin
Kathleen Zemplachenko	OraSure Technologies
Rob Zucker	TCA