

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration**

Center for Mental Health Services

National Advisory Council Meeting

August 29, 2023

**SAMHSA
5600 Fishers Lane
Rockville, MD 20857**

Submitted by:

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Call To Order and Roll Call

Pamela Foote, Designated Federal Official, Center for Mental Health Services, National Advisory Council

Ms. Pamela Foote called the meeting of the Center for Mental Health Services (CMHS) National Advisory Council (NAC) to order. After conducting roll call and establishing a quorum, she turned the meeting over to Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS) and Chair of the National Advisory Council (NAC)

Chairperson:

Anita Everett, MD, DFAPA, Director, Center for Mental Health Services (CMHS)

Designated Federal Official:

Pamela Foote, Designated Federal Official, CMHS, National Advisory Council

Council Members Present:

Jane Adams, Ph.D.
Sergio Aguilar-Gaxiola, MD, Ph.D.
Leonard Bickman, Ph.D., M.A., B.S.
Charles Dike, MD, FRCPsych, MPH, DCP, GACHE
Anthony Fox
Lori Raney, MD
Michelle Reid, MD, DLFAPPA, FACPsych
David Shern, Ph.D.
Sampat Shivangi, MD, FICS
Khatera Aslami Tamplen
Conni Wells

Council Members Absent:

Lori Criss, MSW

Ex Officio Members:

Miriam E. Delphin-Rittmon, Ph.D.
The Honorable Xavier Becerra
Joshua A. Gordon, MD, Ph.D.
Robert K. Heinssen, Ph.D.
Chris Loftis, Ph.D.

Welcome, Introductions, Opening Remarks

Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS) and Chair of the National Advisory Council (NAC)

Dr. Everett opened the meeting with a moment of silence to honor those who lost their lives or a loved one in Jacksonville, Florida as well as on the University of North Carolina campus. She then welcomed the National Advisory Council (NAC) and thanked Michelle Bechard and Lora Fleetwood for their work.

Consideration of the August 18, 2022, Meeting Minutes

CMHS NAC Members

Ms. Foote asked for a motion to approve the April 25, 2023, meeting minutes, which were approved unanimously.

CMHS Director's Report – Program Updates

Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS), Chair, National Advisory Council (NAC)

Dr. Everett introduced CMHS Deputy Director Tison Thomas, who greeted the Council, stating he is fortunate to be a part of CMHS. Dr. Everett explained he manages the block grant and the Protection and Advocacy for Individuals with Mental Illness and the Path grant (PAIMI), one of largest grants focused on the homeless.

Dr. Everett discussed recent changes at SAMHSA, such as name changes for divisions, increasing the workforce to 150 staff, and the creation of new offices; the Office of Program Analysis and Coordination (OPAC) led by Michelle Bechard, and the Office of Policy Coordination and Innovation (OPCI) led by Karen Gentile, LCSW-C, JD.

OPCI fulfills a statutory requirement to promote innovation, design national goals, and set national priorities; ensure programming reflects the best available science and evidence-based practices; advance mental health components of SAMHSA's strategic plan; and coordinate CMHS activities and stakeholder collaboration through the Office of Communication and SAMHSA's legislative office. Dr. Ezer Kang from Howard University is also helping CMHS regarding the science of meaningful stakeholder engagement.

Dr. Everett highlighted the following staff members: Mogen "Bill" Baerentzen, Karen Gentile, Abdallah Ibrahim, Kim Reynolds, and Nima Sheth. Dr. Sheth is responsible for SAMHSA's Women's NAC and other activities.

As part of its grants management initiatives, CMHS engaged in three policy academies over the summer of 2023: supported employment for transitional age youth, black youth suicide, and behavioral health local crisis mapping. During the academies, teams from eight to ten states create worked with experts to create a plan to take back to their states and implement.

Dr. Everett explained a three-layer crisis system involves someone to talk to, someone to respond, and some place to go. The national 988 emergency number provides someone to talk to, while mobile crisis teams, sometimes with co-riding police officers, respond, and crisis receiving centers offer a place to go.

The Black Youth Suicide Policy Academy, specifically, had representatives from Georgia, Maryland, Louisiana, Kentucky, Pennsylvania, Ohio, Indiana, and Oregon. This academy convened in light of the tragic rise in suicides and suicidality (thoughts of suicide) among black youth. Emerging themes from the meeting included the need for targeted interventions, more disaggregated data, and the need for youth and communities to be involved in the processes.

When asked how states are selected, Dr. Everett explained there has been a different process for each academy. For the black youth suicide academy, states with the highest rates of incident and relevant population data were invited.

Dr. Everett discussed ways SAMHSA continues its cross-government collaboration by highlighting the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). Reauthorized for another five-year period, the ISMICC is a way for federal partners to also impact individuals with serious mental illness (SMI) and serious emotional disturbance (SED).

ISMICC working groups have different focal points. For instance, the Finance Working Group has been addressing parity and looking at the National Association of State Mental Health Program Directors' (NASMHPD) "Parity Playbook". The Data and Evaluation Working Group has been working on measurement-based care (MBC) in clinical settings. This group recently convened experts of providers and payers with the goal of payers paying for MBC because research reveals it improves outcomes. Further, the Treatment and Recovery Working Group played an important role in the Supported Employment Policy Academy.

Dr. Everett also discussed one of SAMHSA's largest programs, Certified Community Behavioral Health Centers (CCBHCs), which has received additional funding from Congress through COVID-19 and other resources. SAMHSA is working to expand to a cost-based payment for the operation of community mental health services to make it more competitive with private practice, particularly for master's-level therapists.

Currently, there are around 500 different CCBHCs; yet as many as 8,000 to 9,000 clinics are needed for national coverage. Dr. Everett noted more information, such as the development of the CCBHCs, is available in the slide deck shared via meeting materials.

Dr. Everett highlighted how the CCBHC model is geared toward access, quality improvement, recovery support services, (supported employment, supported housing, etc.), requirements to provide service within 10 days from the time of first call, (some CCBHCs have developed a walk-in clinic to meet this requirement); mobile crisis services; quality metrics; and access to medication-assisted treatment (MAT) for substance use disorders (SUDs) and smoking cessation, a huge risk factor for physical and mental health. Other criteria include staffing standards, care coordination, nine required services, and organizational authority and governance.

To support the expansion of CCBHCs, SAMHSA offered 15 new state planning grants and robust technical assistance (TA) on this cost-based payment model to Alabama, Delaware, Georgia, Iowa, Kansas, Maine, Mississippi, Montana, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island, Vermont, and West Virginia. With more applicants than they could accommodate, SAMHSA will be taking another round of states in 2025. As 2023 marks the 60th year anniversary of President Kennedy's signing of the Community Mental Health Services and Construction Act, this program is an opportunity to realize his vision.

In collaboration with the National Institute of Mental Health (NIMH), SAMHSA rigorously researching ways to implement service changes in community mental health centers so they can become a national model and laboratory to study longitudinal care of those with complex behavioral and physical health needs.

When Dr. David Shern asked if NIMH issued a program announcement for competitive awards in this area or if it is more of an informal collaboration, Dr. Everett stated that the initial informal collaboration has grown; a Notice of Special Interest was issued to create opportunities to participate in research in the CCBHCs. Later she welcomed ideas from the Council on other ways SAMHSA could partner with NIMH.

Dr. Shern also asked about working with states on Medicaid participation in the CCBHCs and wondered if that pertains solely to SAMHSA-funded CCBHCs. Dr. Everett explained all CCBHCs work within standards, however, there are two ways they can get funding: 1) States designated as "demonstration states" work with their state Medicaid program to create this cost-based payment; and 2) CCBHC-E centers receive a \$1 million grant and can be located outside of a demonstration state. However, states that are not pursuing demonstration status could find sustainability an issue at the end of their funding. Both types of CCBHCs work with their states to better integrate Medicaid into the cost base.

When Mr. Anthony Fox asked if people enrolled in a CCBHC can choose providers outside of that CCBHC, Dr. Everett replied it varies from state to state. There is a catchment area definition, limiting choice to some extent, while in other places it is wide open. Though person-centered planning is the goal, the consumer is not always meaningfully involved.

Dr. Sampat Shivangi asked what population-based outcomes are expected and noted mental health equity was not mentioned. He added NIMH might be able to help with that. Dr. Everett replied she will connect with David DeVoursney for those details and the evaluation results for some of the CCBHC-E components.

Circling back to Mr. Fox's question on choice, Dr. Michele Reid stated SAMHSA has been very clear that services are to be provided regardless of location. People can switch between CCBHCs in a demonstration state and other CCBHCs grantees. Further, in Michigan, a number of individuals receive outside services. For example, they may receive therapy and attend substance use groups at the clinic and also see an outside psychiatrist. They also have individuals getting supported employment or case management that also see an outside therapist.

Ms. Khatera Tamplen asked if 1) SAMHSA directs CCBHCs on staffing and ensuring peer support specialists are available; and 2) if there are policies for developing psychiatric advanced directives. Dr. Everett replied offering peer support and family support specialists is part of the certification requirements. Though advanced directives are not a requirement, almost all CCBHCs grantees include them. She added that it may be possible to hold a NAC meeting at a CCBHC site in the future.

Mr. Fox explained his concern is that peer and family support, supported employment, psychosocial rehab, and the choice to go to an outside provider is enforced within the CCBHC program. Dr. Everett welcomed the accountability, noting that Dr. Kang could research those components.

Dr. Everett then introduced the Social Media and Mental Health Technical Assistance (TA) Center of Excellence (COE). Through a competitive application process, the American Academy of Pediatrics was awarded \$2 million annually for five years to create a National Center of Excellence on Social Media and Wellness. The COE serves as a centralized trusted source of evidence and support for children and teens, parents, educators, pediatricians, and other professionals that help youth navigate social media. Questions regarding social media can be submitted and the COE is required to respond within a certain timeframe and will catalog those questions.

The primary aims of this COE are to:

- Improve pediatric well-being by reducing the risks and leveraging the benefits of social media, and to build the capacity of individuals who work with youth.
- Mitigate social media's impact on mental well-being and promote healthy social media use.
- Synthesize and promote the evidence base and best practices for healthy social media use via communication, guidance, and other resources.

Dr. Sergio Aguilar-Gaxiola asked if the COE is being coordinated with the U.S. Surgeon General, who released a report on social media and youth. He also inquired how improving pediatric mental well-being in this regard is being measured and what accountability mechanisms are in place. Dr. Everett said there is usage data; however, a more detailed evaluation is not available at this time. Regarding the Surgeon General, and others were briefed.

Yet, a second initiative directly involves the Surgeon General. On May 23, 2023, the White House established the Kids Online Health and Safety Task Force, co-chaired by the Assistant Secretary, Dr. Miriam Delphin-Rittmon, and Alan Davidson from the Department of Commerce. The goal is to discover how to prevent and mitigate the adverse health effects of online platforms on minors and identify current and emerging risks of harm. From this work, a report of findings will be available in 2024 and a toolkit will be developed. Numerous federal organizations are participating, including the Centers for Disease Control (CDC), NIMH, the National Institutes of Health (NIH), the Administration for Children and Families (ACF), the National Institute on Science and Technology (NIST), which creates national standards, the Department of Education (ED), and the Executive Office of the President.

Dr. Everett briefed the Council on the CMHS budget as well. CMHS manages around 2,539 distinct grants clustered in 55 different programs, including 691 new individual grants this year. Over the last couple of years, the budget has increased; however, this year's budget may turn into a continuing resolution, which means the budget of the previous year will be held in place. The President's 2024 proposed budget had a substantial increase for SAMHSA, and CMHS in particular; however, Dr. Everett related it will not come to fruition. Should there be a government shutdown, grantees would still be able to spend their money for their services, but SAMHSA staff will be ordered not to work until the issue is resolved. Currently, the total budget is about \$2.7 billion, and though considerable for SAMHSA, it is a small budget compared to other parts of government.

Discussion

Dr. Charles Dike concurred with Mr. Fox regarding the importance of patient choice, stating patients in Connecticut must leave their providers if they want services at the CCBHCs.

When Dr. Shivangi asked how to achieve the goals of the Social Media Center of Excellence, Dr. Everett explained that awareness and use of the site is important and asked members to help spread the word. Dr. Shivangi added there must be more exposure about the system. Dr. Everett stated there are some efforts like email blasts coming from SAMHSA's communications office.

Dr. Reid stated updates on how current efforts tie into the strategic plan well in advance of future council meetings would be useful so members can offer input when they convene. Ms. Foote noted the Assistant Secretary would speak to this during her talk.

Lastly, Dr. Reid also urged SAMHSA to set expectations with the demonstration states because grantees have helpful things in place that the state then tries to roll back and disband, such as telehealth. She stated some initiatives coming from the state are contrary to the CCBHC mission. Specifically, the State of Michigan decided on May 12th they would no longer pay for peer support services or dialectical behavior therapy (DBT) through telehealth.

Transitional Age Youth Policy Academy

Abdullah Ibrahim, DrPH, CPH, Public Health Advisor, Community Supports Branch (CSP), CMHS; Mogens "Bill" Baerentzen, PhD, CRC, LMPH, Public Health Advisor, (CSP); Jennifer Salach, MPH, Public Health Analyst, Policy Analysis, Development, and Implementation, National Mental Health and Substance Use Policy Laboratory

Dr. Abdullah Ibrahim

Dr. Ibrahim thanked Dr. Everett and acknowledged the planning and contracting teams that launched the Transitional Age Youth (TAY) Policy Academy.

The objectives of the academy were to enhance the capacity of participating states to implement evidence-based practice of supported employment for TAY by creating a written state action plan focused on:

- Leveraging federal and state resources to make supported employment for TAY more viable.
- Adapting evidence-based practice of supported employment for this age group.
- Using implementation science to maximize the program implementation and sustainability.

Evidence shows that employment is an important component of people’s recovery and improves clinical and personal outcomes and individual satisfaction. Studies reveal that between 55% and 75% of individuals with SMI want to work; however, under 15% of those individuals are in competitive employment. Further, only about 2% of individuals with SMI get access to supported employment, partly because the youth are largely unaware of these services.

Barriers inhibiting youth access to supported employment services include:

- Lack of collaboration between major state authorities, particularly vocational rehabilitation and mental health authorities.
- Lack of ownership or authority of specific services specific to this population.
- Engagement and motivation of youth in supported employment services.
- Lack of simple and sustainable funding for supported employment services.

Part of the state application package is to highlight existing gaps to TAY supported employment services. The majority of the states pointed to a limited infrastructure, while other states identified silos and fragmentation, and limited TAY specific resources.

Once the team reviewed applications, Alaska, Illinois, Ohio, Oklahoma, Mississippi, South Carolina, and Utah were chosen to participate. Noting their areas of interest, strengthening collaboration and addressing silos were the most common. Three states identified funding/sustainability and data collection and use as focus areas. Others identified strategic planning, state policy and practice, and TAY specific resources.

Participants and leadership collaborated to bring together subject matter experts to address identified barriers and help participants develop their state-specific plans. Dr. Ibrahim highlighted four internal stakeholders:

- Mary Blake, currently leading the CCBHC program and previously leading the supported employment program at CMHS.
- Lorie Lopez and Kisha Ledlow, who have years of experience working with TAY.
- Dr. Charlie Smith, the regional director for SAMHSA’s Region 8.

Some of the federal partners included Centers for Medicaid and Medicare (CMS) and representatives from their Children Health Insurance Program (CHIP), who explained the Medicaid waivers that pay for supported employment services in their states,. Academic representatives and researchers also served as experts. [Note: Refer to slides for a complete list of partners.]

Dr. Mogen “Bill” Baerentzen

Dr. Baerentzen stated the in-person convening addressed adaptation, funding, and implementation.

The adaptation of supported education is crucial because evidence-based supported employment requires specialized training and competencies to support secondary and postsecondary education students. Peer support is also lacking in traditional supported employment, which is an evidence-based practice for increasing engagement around work and school. Further, engaging TAY in career development helps them explore and create goals for themselves. Lastly, a different approach to engaging youth is needed and can be as simple as texting or using messenger apps.

Session topics focused on adapting supported education, peer support, career development, and youth engagement. In the breakout sessions that followed, participants collaborated within their state groups and across disciplines.

In highlighting implementation science, academy experts presented the barriers and drivers to individual, organization, and community level rehabilitation. They also discussed how to select implementation strategies and the importance of developing implementation teams at the state level. Experts specifically focused on how adhering to a supported employment TAY fidelity assessment advances implementation and identifies specific training and technical assistance gaps. Four implementation science presentations explored these topics.

Experts included a focus on non-traditional initiatives, such as peer support and supported education. They also explored an easier way to bill for supported employment. Sessions included braiding, blending, and sequencing funding sources (presented by Lisa Mills), Medicaid authorities (presented by CMS) and waivers (John O’Brien). Notably, two presentations were recorded distributed to the states.

Breakout sessions on funding focused on peer support, partnering with private industry, empowering youth voice and encouraging collaborative partnerships, existing funding streams, data collection and sharing, administrative barriers and inefficiencies, and incorporating education into individual plans of study (IPS).

Lastly, Dr. Baerentzen highlighted that the participant satisfaction survey revealed 79% of the 41 participants were satisfied with logistics and with the content.

Discussion

When Dr. Reid asked about the age range for TAY, Dr. Baerentzen stated it was undefined, but the academy focused on youth 16 to 25.

Ms. Wells asked if the academy provided parallel training of parents and caretakers. Dr. Baerentzen noted the restrictions of having a three-day event; however, including parents or families in services, planning, and care and delivery is critical and be a focus during the learning collaborative.

Ms. Jennifer Salach

Ms. Jennifer Salach introduced the activities and efforts underway since the June academy, noting each state had a different starting point and baseline level of experience. Participants met together post-event and discussed their plans. Further, most states received technical assistance from the Children’s Funding Project, and on September 20th, all participating state decision makers will convene for the first session of a year-long learning collaborative.

The learning collaborative comprises four virtual sessions, allowing states to refine and implement their policy plans. Several federal partner and subject matter experts are helping the planners develop content, including the Rehabilitation Services Administration (RSA), CMS, the Administration for Community Living (ACL), and the Children’s Funding Project. Daunting challenges and competing priorities for state leaders mean engagement is incredibly important, and requires flexibility, feedback loops, and quality improvement mechanisms to “translate lessons learned into progress”. Planners continue to seek feedback from partners on how best to sustain engagement and serve this population.

To keeping growing, three new initiatives are planned for the next policy academy: focusing on partnering with CCBHCs, updating SAMHSA’s Evidence-Based Practices Kit on supported employment, and developing a “lessons learned” document.

Ms. Salach explained CCBHCs would be a focal point because they are required to provide services that support individuals in securing and maintaining competitive integrated employment. Further, because 82% of CCBHCs offered employment services in 2020, there is an opportunity to leverage and strengthen what they are already doing. This is important because supported employment services foster improved mental health outcomes and service engagement, and mental health services improve work performance and vocational outcomes. Further, several components built into CCBHCs (person-centered planning, evidence-based practice, and psychiatric rehabilitation) align with supported employment and can strengthen the practice.

The team is also updating the 2008 Evidence-Based Practices KIT (“Knowledge Informing Transformation”) on supported employment to reflect innovation and current evidence and develop a takeaways and lessons learned document to help those implementing the service.

Ms. Salach stated, “Our hope is that in partnership with subject matter experts and federal partners, our combined efforts will improve supported employment and education access for emerging adults, which is a population that is often overlooked. It is one step that can make this important service more accessible and ultimately change the landscape of resources available to this population.”

Discussion

Ms. Wells asked how parents and families were included in shaping the activities described and how they would benefit. Dr. Baerentzen reiterated that the efforts are newly underway and the input of persons with lived experience and their families is crucial, which is often overlooked in many settings. Dr. Everett suggested having a special session or working with state family

networks on supported employment awareness, particularly states involved with the academy. A learning collaborative session on family engagement would also be useful.

Dr. Ibrahim added that identifying gaps and needed focus areas are part of the next academy. He also stated people with lived experience attended the first academy, and they will continue to be “at the table”.

Mr. Fox stated Tennessee has an IPS team and may be the only state to include people with lived experience on the team. He noted that updating the SAMHSA toolkit would be beneficial. He also suggested that credentialing, which currently requires a bachelor’s degree, be addressed if employment specialists will assist same age peers. He was adamant that supported education needs the same attention as supported employment. Dr. Ibrahim appreciated his comments, stating member input would be considered during the tool update.

SAMHSA Leadership Discussion with CMHS NAC Members

Miriam E. Delphin-Rittmon, Ph.D. Assistant Secretary for Mental Health and Substance Use (SAMHSA)

Dr. Miriam Delphin-Rittmon greeted and thanked the NAC and provided updates and noted 988, the national initiative just celebrated its one-year anniversary and received nearly 5 million calls, texts, and chats, which is about 2 million more than the previous year. Answer rates have decreased significantly, with people now connecting within 41 seconds on average. Chats have increased by 1,135% and texts have increased by 141%. Specific age ratios will be provided to the NAC at a later date; however, young people prefer chat and text over calls.

During the anniversary event held in New York City, leadership announced the launch of the Spanish text and chat function. Media coverage for the event increased awareness, which needs to continue to grow.

Dr. Delphin-Rittmon shared one of the many stories about 988: A caller related she had Googled how to kill herself painlessly. When 988 came up in the search, the person called and spoke to the crisis counselor. At the end of the call, the person told the counselor, “I am glad that I did not get what I was looking for. In fact, I got what was needed.”

To continue to raise awareness of 988, SAMHSA is holding events in major cities. During an upcoming event in St. Louis, they will announce additional services for deaf individuals and hard-of-hearing-related services and supports.

A White House initiative on Native American, Native Hawaiian and Pacific Islander mental health was held in August. With “standing room only”, people from across the nation participated in four different sessions addressing anti-Asian hate and racial violence, integrated care within Asian communities, 988 and CCBHCs, and improving language access. Emerging themes from the event included additional workforce funding, raising awareness about mental health services and supports within Asian communities, continuing to foster key partnerships in community health, connecting people to services and supports, and equity and access. Planning

for future events is underway with the long-term goal of creating a policy agenda for Asian Americans, Native Hawaiian and Pacific Islanders.

In closing, Dr. Delphin-Rittmon reminded members about the Joint National Advisory Council meeting the following day and looked forward to having everyone together. She added that a remembrance of Joe Garcia would take place and updates and presentations from the various councils would be offered.

Discussion

Members were asked to introduce themselves to the Assistant Secretary before sharing.

Dr. Sergio Aguilar-Gaxiola (University of California, Davis) emphasized the importance of 988. He stated he was inspired by Secretary Xavier Becerra's (HHS) keynote address at a Univision meeting focused on youth. When he asked for a copy of the slides, Dr. Delphin-Rittmon agreed and thanked him for his participation and input. She added that the Secretary has championed 988 from the start, attending the regular meetings and offering ideas to advance the effort. Further, the national embracing of 988 has been tremendous.

Dr. Shivangi (Chair, Board of Mental Health, Mississippi) stated 988 is the biggest gift from SAMHSA to mankind, noting that hospital admission rates have decreased 35% to 40%. Dr. Delphin-Rittmon thanked him, stating those metrics are important for SAMHSA to follow. She stated about 98% of the issues are addressed during the call, even if by providing additional resources, while only 2% need additional crisis support.

Dr. Shivangi asked if transportation could be linked to the caller if they need a clinic or hospital. Dr. Delphin-Rittmon explained many states are creating additional funding that would support the idea. Currently, only mobile crisis is available with emergency medical teams (EMTs) supplying that need.

Ms. Wells (Tennessee Voices) explained that without technical assistance (TA) on utilizing 988, statewide family networks are left figuring it out on their own. Sharing a personal story, she stated the homeless in her small rural community do not know about 988; she noted the network will continue to learn how to promote it. In response, Dr. Delphin-Rittmon expressed her thanks and concern, noting SAMHSA's "TA Center... is your center." When Ms. Wells followed up by suggesting SAMHSA attend a call and present on 988, Dr. Delphin-Rittmon stated they would do just that.

Dr. Shern stated CMS approved a designated billing code for first episode psychosis (FEP) services for coordinated specialty care. Beyond billing, it demonstrates that CMS endorses this team-based concept. He thanked Dr. Delphin-Rittmon for being instrumental in making it happen and highlighted the necessary collaboration of federal partners. He explained the next step is to get the states to use the code and pay for the full range of services, and to get commercial insurers to pay as well. Dr. Delphin-Rittmon also thanked Dr. Shern for his initiative, follow through, and championing the change.

Ms. Khatera Tamplen asked what SAMHSA is doing to elevate peer respites as an early intervention strategy. Dr. Delphin-Rittmon agreed that the model is making a difference with more programs that are launching across the country, adding the mental health block grant funds can be used for this purpose.

Dr. Jane Adams (family representative, Topeka, Kansas) spoke of the “life changing” experience she had at the last council meeting. She explained that families are not getting served at CCBHCs because of boundary lines. For example, a family may live a few miles from the mental health center they belong to and live 90 minutes from the center they are “supposed” to get the services from. She stated the hardship is extraordinary, especially when asking agencies to come in and work with the schools. She urged that CCBHCs be allowed to cross county lines.

Selected to represent children and families on the New Freedom Commission, Dr. Adams also shared that she chaired the vocational subcommittee. She expressed deep interest in helping the presenters access families, family organizations, or youth. Lastly, she hoped to see the in-person attendees in the future while attending virtually; Dr. Delphin-Rittmon said they would look into getting better technology to make viewing easier.

Dr. Delphin-Rittmon thanked Dr. Adams and was grateful to have met at the last meeting. She stated youth remain a priority area and are part of SAMHSA’s strategic plan. Regarding CCBHCs across county lines, she would look into it, stating the requirement is immediate same-day access. Dr. Everett added the issue may be how the states have defined their catchment areas and they will follow up. Further, she noted that presenters would be contacting Dr. Adams and Ms. Wells for their input.

Dr. Dike (Medical Director, Department of Mental Health and Addiction Services, Connecticut) stated Dr. Delphin-Rittmon’s work as Commissioner, which included establishing warm hand-offs and transportation, impacted the growth of 988 in the state. He explained the current challenge is managing “frequent callers” while ensuring everyone has access. Dr. Delphin-Rittmon understood the issue of individuals calling the line regularly and frequently for ongoing support, adding these callers may be open to other ongoing counseling or support. She also agreed that Connecticut’s crisis transportation contracts are extremely beneficial, though expensive.

Dr. Aguilar-Gaxiola was heartened that 988 is available in Spanish, noting that 40% of the 40 million Californians are Latino and 75% of that population speak Spanish at home. However, the level of suicide rates among youth in farm working families is rising. He invited Dr. Delphin-Rittmon to visit the underserved populations.

Dr. Delphin-Rittmon thanked him, noting that SAMHSA is hearing and doing more for farming communities, with one region hosting a related learning community or webinar. She stated she was open to finding a way to visit; Dr. Aguilar-Gaxiola later spoke of event dates that she might find of interest.

Dr. Sonia Chessen stated the 988 team is reaching the end of significant research on communities who either do not traditionally seek help or live far from services. She noted that using trusted

messengers, such as the faith community, is one angle they are looking at to reach people. When she welcomed input, Dr. Aguilar-Gaxiola replied he would be happy to provide that information. He explained that instead of waiting on people to seek help, they are seeking people through digital health and mobile units and providing services where people live, work, and congregate, especially in the historically underserved communities. Later, Dr. Chessen added Secretary Becerra's video might also be helpful to Spanish outreach efforts.

Dr. Delphin-Rittmon replied that in Washington State, teams go to encampments to share about 988. The state has also developed a "Press 4" option for American Indian and Alaska Native (AI/AN). Other grantees pay for "street psychiatry"; psychiatrists along with outreach and engagement teams meet people out in the community.

Dr. Michele Reid (VP, COO, CNS Healthcare, Michigan), representing a CCBHC, asked Dr. Delphin-Rittmon how council members can more intentionally provide input for the strategic planning process. Dr. Delphin-Rittmon thanked her for the question and replied that SAMHSA can continue to invite the councils to the coffee chats. Further, SAMHSA can be more deliberate by sharing public comments with all the councils and make discussion and ongoing feedback related to the plan an agenda item for future meetings.

Dr. Shivangi circled back to his previous comment on transportation, asking Dr. Delphin-Rittmon to look into the percentage of clinical admissions due to lack of transportation. Dr. Delphin-Rittmon stated that though SAMHSA does not conduct that type of research, they can work with NIMH to study the facilitators and barriers to accessing care across levels of care. Dr. Everett highlighted Dr. Shivangi's focus on post-partum depression and the related summit he hosted in Mississippi. Dr. Delphin-Rittmon stated SAMHSA has a task force on maternal mental health, adding the findings are troubling.

In closing the discussion, Dr. Delphin-Rittmon thanked every participant for their important feedback, calling them "critical partners" in SAMHSA's work.

Dr. Everett welcomed everyone back after the break and overviewed the afternoon presentations.

Potential Innovation

Leonard Bickman, Ph.D., M.A., B.S.

Dr. Bickman and Dr. Everett explained his presentation would require council members to consider his proposal and whether to move forward; if so, a motion and vote would follow.

Dr. Bickman began by sharing his concerns. First, access is lauded as a number one priority by certain politicians; yet increasing access to services that are not helpful for families, children, and consumers is not an improvement. Second, when people make a large purchase, like an appliance or vehicle, they have scores of research studies to pour over. However, that is not the case for mental health services. These notions, and the invitation at the last meeting for members to be more active, led him to write the forthcoming proposal. To emphasize his point, Dr. Bickman quoted Richard Branson: "The important thing is that you have to have a strong foundation before you start to save the world or help other people."

Dr. Bickman added that his proposal focuses on effective services in real-world scenarios, not laboratory-like situations. He pointed members back to the proposal document they received and the research therein, noting its goal is to build a better infrastructure to support the community services.

The limited evidence

The author of an important meta-analysis published in 2022 in *World Psychiatry* concluded that over 3,000 adult randomized clinical trials pointed to very small effects of these services on mental health outcomes. Similarly, in his study of youth and adolescence over a 50-year period, John Weisz (Harvard University) and his co-authors concluded there has been minimal progress in treating youth anxiety, ADHD, depression, and behavior. In fact, youth ADHD treatments showed no improvement and became less effective over time. Lastly, Kim Haugwin(ph.), found youth depression, anxiety, suicide rates, psychiatric admission, and risky behavior have surged.

The response

To improve the situation, accreditation, certification, and licensing procedures were implemented and touted to control quality and improve effectiveness. Yet, Dr. Bickman stated he was unable to find any studies demonstrating that these mechanisms affect outcomes.

Experience and training have also never been evaluated for effectiveness, though descriptive studies show income increases the longer clinician's practice. Further, there is little evidence that the HEDIS (Healthcare Effectiveness Data and Information Set) quality measurement system is related to clinical outcomes and electronic health records (EHR) do not usually contain them. For example, asking if a child received a follow-up after six months does not demonstrate improvement; it is an outcome quality measure unrelated to quality.

Despite all this, Dr. Bickman stated there are many strengths, or "universal solutions for improving effectiveness". The solutions are transtheoretical, transdiagnostic, and independent of the specific treatment for improvement, including:

- Value-based health care (income must be tied to outcome).
- Measurement-based care (MBC).
- Measurement feedback systems (MFS) to feed information back to those who need it.
- Task shifting, including having non-traditional people, like peers, to deliver services.
- Evidence-based treatment (EBT).
- Decision support systems (DSS) to give people feedback on what to do.
- Precision mental health (PMH) that recognizes treatment customization.
- Causal data sciences (CDS); using artificial intelligence (AI) to predict and design treatment.
- Using AI as a new way to solve old problems.

Dr. Bickman explained that implementation issues have impeded the use and impact of the aforementioned approaches. For example:

- Inadequate measurement of EBT implementation fidelity.

- Low adoption rate of causal data sciences.
- Typically flawed, incomplete, and poorly designed routine care data systems.
- Flawed implementation of MBC impedes learning; a meta-analysis of 200 programs reveals only 12% have effective implementation.
- Low adoption of management feedback systems; affordable implementation is elusive.
- Lack of a uniform data collection system to assess the benefits of treatment; no learning environment for analyzing the data, the treatment, and how to do it better.

Dr. Bickman noted precision mental health may be the next big breakthrough, but it requires a different data infrastructure. The Health Outcomes Observatory in Europe and the English National Health System may serve as models for the United States. And although New Zealand is much smaller than the US, they have an integrated data infrastructure model that could be useful.

What the infrastructure should contain

Dr. Bickman noted longitudinal mental health with outcome measures that include consumer and provider characteristics, implementation and fidelity measures, and cost and service use measures are all important components of a strong data infrastructure. Further, it has to be feasible, fitting into the cost and workflow structure, and provide easily accessible storage that can be shared across different entities while addressing privacy concerns. Automation, data integration, and other EHR are also critical. The infrastructure must also contain training, technical assistance, and financial incentives for data collection, training, and research partnerships.

Why now

Changes in the last two years in implementation and translational sciences and AI provide novel solutions to data collection. For example, chatbots can collect data at almost zero cost and assess mental health status and movement. Similarly, various adaptive technologies point to a solution. Further policy advancement, such as CMS moving to a value-based accountable care program by 2030, though not simple, is possible if the implementation efforts begin now.

Dr. Bickman stated innovative mental health treatment advancements exist; however, currently, the infrastructure is inadequate. Longitudinal intensive data is also needed for new technologies to be workable and developed.

The proposal

Dr. Bickman outlined a specific action plan for the NAC's consideration on two fronts: 1) Enhancing the existing infrastructure, and 2) supplying researchers with essential data to enhance service effectiveness.

The proposal calls for:

- The CMHS Director to form a subcommittee for infrastructure enhancement with expert working groups comprised of providers, consumers, and relevant agencies. Per the NAC Charter and CMHS approval, the subcommittee would offer workshops, conferences, publications, and research.
- Using CCBHCs as the cornerstone of the effort because a basic infrastructure already exists. Specifically:

- They provide broad mental health and substance services to 2.1 million people in 500 centers across 46 states.
- The National Council for Mental Wellbeing provides national technical assistance.
- Sites have contracted for EHR, which was always a barrier to moving forward. For example, Netsmart serves 178 centers in 38 states.

Dr. Bickman suggested the subcommittee explore financial support through existing or new grants; collaborate with the National Technical Assistance Center; and partner with the EHR contractors in capturing data. Though not a requirement, he also proposed voluntarily collaborating with researchers, providers, and community members to define data needs, noting community members includes families and consumers who should be involved from the start.

The proposal also calls for assessing and learning from other infrastructure efforts in the US and globally to produce a novel model implementation plan, including hosting ongoing workshops and conferences to break down the current silos and tap into expert perspectives.

The advantages

The advantages of adopting this proposal are many. First, it aligns with the goals of CMHS and CCBHCs.

Existing grants already fund many of the activities, an adaptable EHR system can handle the proposed activities, and the TAC can provide the training. Optional measures are also possible without alerting CMHS's reporting system, national outcomes measures, (NOMs).

Dr. Bickman highlighted the existing partnership between Netsmart and the National Council to create a data set from all the CCBHCs. There is the possibility of an implementation science project between SAMHSA and NIMH. Dr. Bickman also noted the ability to collaborate on the expansion grant implementation pilot projects. Lastly, exploring NIMH grants and possible interactions would be an advantage.

In closing, Dr. Bickman noted that 1) enhancing the infrastructure is vital for research, resource allocation, and outcome improvement; and 2) collaboration with CCBHCs is the most practical way to achieve and facilitate nationwide coordination of the current diverse enhancement activities and benefit from the combined power and expertise of stakeholders.

Discussion

Dr. Everett explained parliamentary procedure calls for a motion to be made followed by discussion. She added that subcommittee formation may be possible, noting the ISMICC as an example. It could meet autonomously, but decisions would be made through the NAC.

Dr. Aguilar-Gaxiola thanked Dr. Bickman for his significant contribution to the field and for crafting the proposal. He then made a motion, which was seconded by Dr. Shern.

Ms. Wells supported the proposal, emphasizing the need for workshops, conferences, and publications. She also noted defining what “good” service entails is critical and that providers neglect to ask what circumstances and events in the patient’s life may be causing them to feel depressed and anxious.

Dr. Shern concurred, suggesting incorporating a trauma-informed approach into the proposal. He favored and supported the proposal, although boundaries and specifics would need to be crafted.

Dr. Reid asked if data currently submitted by CCBHCs would meet the needs discussed in the proposal. Dr. Everett stated SAMHSA collects data on the number of people that are served and NOMs; grantees select which data to submit so that reporting does not overburden them. Demonstration states are also required to collect quality metrics, which are flawed because the metrics were largely developed in an era of assumed inpatient admissions.

The National Council on Wellbeing is looking at models, including Missouri’s aggregated data on its 66 CCBHCs. Some states look at CCBHC-specific Medicaid claims data; though it does not give the whole picture, it is still a possible source. SAMHSA is also talking with the National IT Office within the HHS Secretary’s Office about the health care information exchange (QHIPs). Further, the Coordinated Specialty Care for FEP grantees are part of EPINET, a network of services generating longitudinal data with a research framework to track outcomes; however, SAMHSA has not explored that opportunity yet.

Dr. Patel posed whether the problems are defined accurately enough to inform the creation of a plan, noting the scope could be quite large. He stated the proposal addresses the population health level (tracking, monitoring, and registries), and asked Dr. Bickman to speak to consumer health. Dr. Bickman replied the goal is to be “...close to the service as opposed to the population.” He stated the field must collect and then aggregate clinically useful data. Using a compliance example, he explained that the goal of collecting an outcome measure every six months (which may only happen yearly) would be worthwhile. However, his team collects data every two weeks because clinicians need constant feedback to know if their specific patient is improving. And because aggregation is not possible with bi-annual data (at best), providers are frustrated because useless data leads to attrition.

Dr. Adams supported the proposal and shared how she felt reading the literature Dr. Bickman shared with members before the meeting. She noted the importance of disseminating the information to ensure consumers can learn what to look for regarding “good” service, and the inclusion of families and family organizations. Based on comments from families she works with, she strongly urged support of the proposal.

Ms. Tamplen concurred with Dr. Adams and thanked Dr. Bickman for family inclusion. She added that data may not capture the increased stigma patients face from providers who should be helping people on their recovery and resiliency journey. She described “The Flourishing Scale”, as a helpful and supportive eight-item questionnaire addressing purpose, meaning, supportive relationships, engagement, and more.

Lastly, she explained people avoid “treatment” because it often means a long-term injectable instead of the needed support to build resiliency. However, bringing those with lived experience to the table and discussing “where we went wrong” can propel positive movement.

Dr. Dike found the proposal thought-provoking. He wondered if the almost singular focus on medication management during training, the lack of time providers are given to see a patient, and the social change and instability contribute to the lack of effective treatment and better outcomes. Data on those changes could inform the path forward.

Dr. Aguilar-Gaxiola pointed out that community engagement is missing from the composition of the subcommittee and Mr. Fox added he needed more time to digest the “good and precious information”, Dr. Everett explained the only thing on the table is whether to form the subcommittee; details would be worked out later after deep analysis and research.

Mr. Fox asked for clarification on “CMHS approval”. Dr. Everett stated the NAC has a charter with statutory language. If members vote to move forward, the next step would be to check with legal counsel.

Dr. Reid also asked for clarification on data analysis and collection, and the subcommittee’s efforts if it was found lacking. Dr. Everett replied that it can make recommendations and, with council approval, be entered in the public record and possibly be acted upon. Dr. Bickman added the proposal is highlighting that the infrastructure to support the data collection and use is more critical in some ways than the data itself.

Ms. Foote explained that per the charter, the NAC is permitted to form a subcommittee. If members vote to do that, subcommittee activities can be arranged (workshops, publications, etc.) and then reported back to the NAC for decision-making.

After opening the floor for voting, Dr. Everett stated the proposal was unanimously supported.

Olmstead Activity

Kim Reynolds, MPA, M.Ed., Public Health Advisor, Office of Policy Coordination and Innovation, SAMHSA

To set the stage for the session, Dr. Everett explained that in 1999, the Supreme Court ruled that the Americans with Disabilities Act (ADA) applied to people with mental illnesses and SUD. The Olmstead decision established people had the right to be treated in a community setting. She then introduced Kim Reynolds, who is heading up this revived work for SAMHSA after it was dormant for a few years.

Ms. Reynolds explained that most of the Olmstead-related initiatives she would highlight are part of the SAMHSA State TA Contract that builds on the previous contract from 2012 to 2017, which included developing and implementing the Community Integration Self-Assessment tool (CISA). A federal partner’s group also met to share information.

Once the CISA was completed and piloted, a community of practice was created with assistance from group experts. Monthly webinars on a variety of topics related to Olmstead were held, such as analyzing data from the mental health block grant and Medicaid was one of the webinars.

The current contractor was asked to provide an update on states and territories that have undergone DOJ-led inquiries resulting in lawsuits alleging failure to comply with Olmstead for persons with SMI or SED since 2018. Summarizing individual cases, they identified the following themes and subthemes:

- Insufficient Support for Transition cases included psychiatric hospitals, adult homes, board and care homes, and nursing home settings. Identified remedies included improved discharge planning and expansion of community-based services such as supported housing, supported employment, and peer support.
- Segregated Non-Residential Services cases included a suit against New York State for requiring people with disabilities to use one of three designated hubs to access public benefits rather than the closest public social services office. There were also a couple of cases involving youth with SED who were required to attend schools they would not have been required to attend if they did not have an SED.
- Inadequacy of Community-Based Services for Children and Youth cases identified youth with SEDs unnecessarily institutionalized in psychiatric hospitals, residential treatment facilities, or juvenile detention. In at least one case, the court found that insufficient community-based services led to child welfare involvement and academic failure.
- Differential Treatment in Justice Systems cases identified pre and post-release services lacked adequate community-based services to support discharge from the criminal justice setting and successful community reentry.
- Risk of Institutionalization cases identified a lack of community-based services. In the United States versus Mississippi, the court found that Mississippi violated the Americans with Disabilities Act (ADA) by failing to provide access to community-based programs such as Assertive Community Treatment (ACT), supported employment, and permanent housing to people at serious risk of state hospitalization.

A New York reversal of an Olmstead case followed plaintiffs' argument that an earlier Olmstead settlement requiring the placement of adults with SMI in adult homes violates the rights of individuals who choose institutional-level care. The DOJ's position is that the ADA requirement of community placement of institutionalized persons with disabilities does not logically require institutionalization if Olmstead criteria are unmet.

Ms. Reynolds expected the completion of a report addressing the impact of behavioral health workforce capacity on Olmstead compliance and states' adoption of remediation strategies in the next few weeks.

Next, Ms. Reynolds shared that the contractor evaluated the CISA tool, recommending adaptations to update it with changes in the national community mental health system over the past ten years. Ms. Reynolds explained that the CISA tool has two sections. The first is

qualitative, asking questions like what is the role of the state mental health authority in Olmstead planning? The second section quantitatively measures detailed metrics on seven domains: financing and resources, movement to the community and recidivism, housing, community capacity, well-being, at-risk populations, and policy.

Task 10.3 resulted in forming a seven-member Technical Expert Panel (TEP) to assess states' level of community integration for individuals with SMI/SEDs and to provide guidance. Before the TEP meeting on August 14, 2023, panelists provided feedback on Olmstead-related themes for:

- Training and TA of state mental health authorities on the topics of transition planning, housing availability, criminal justice settings, comprehensive crisis systems, peers - individuals with lived experience.
- Significant changes to the CISA tool related to criminal justice, older adults, people with co-occurring disorders other than SUD, the role of peer support, community transition and integration, and diversion programs.
- Gaining input from external stakeholders: the Bazelon Center, National Disability Rights Network, and National Homeless Law Center, representatives from people with dual intellectual and developmental disability diagnoses, direct service staff, crisis providers, first responders, peers with lived experience, and family members.

The team is considering standalone modules for each of the seven domains in response to the numerous changes and recommendations to the CISA tool to enable states outside the community of practice to select the domain they want to work on. Further, SAMHSA.gov has a resource page that includes all current state Olmstead plans to assist with community integration to complete Task 10.4.

States can also request TA on several topics, including Olmstead; currently, two states have requested TA related to Olmstead. There is a planned Olmstead-related policy academy within the next year or two, a SAMHSA Olmstead Workgroup that meets quarterly to share information related to community integration and Olmstead across SAMHSA, and a new Office of Civil Rights led Olmstead Interagency Coordination Meeting inclusive of HHS agencies shares information about what members are doing regarding community integration and Olmstead.

Discussion

Dr. Everett thanked Dr. Reynolds, reminding council members that Olmstead is administered and enforced by the DOJ. SAMHSA's role is to use the PAIMI programs to help states with risk management by doing assessments and providing active Olmstead plans for implementation to help prevent litigation.

Ms. Tamplen acknowledged the importance of Olmstead to the recovery, wellness, and community integration of people with mental health issues and their families. Noting that restrictive court-order treatment can lead to conservatorship, she asked if TA is assisting states to fulfill the goal of integration and inclusion. Dr. Everett replied this is a function of TA and asked Ms. Reynolds to comment on civil commitment or assisted outpatient treatment (AOT). Dr. Reynolds stated she was unaware of any cases, adding that the CISA tool collects some relevant

information asking how states monitor civil commitment and court-ordered treatment to ensure that individuals know about opportunities to end the court order. The details of what TA will be providing are still under consideration.

Dr. Dike shared his experience navigating the exorbitant annual cost of implementing the Olmstead plan for high-needs individuals, given the charge to care for many others, and asked how assessments and reviews address this capacity. Dr. Reynolds responded that rather than addressing an outlier, Olmstead cases typically involve a broader pattern of a lack of typical community-based services for housing, supported employment, ACT, and other community-based supportive services that would be available to the majority of consumers of CCBHCs who have an SMI or an SED.

When Dr. Dike followed up, about whether OPCI will assist, Dr. Everett emphasized interpretation is up to the legal experts. Along with the general trends and reasonable accommodation information discussed by Dr. Reynolds, there is a renewed focus on Olmstead's legal significance.

Public Comment

Pamela Foote, Designated Federal Official, CMHS, National Advisory Council

Ms. Foote opened the meeting for public comment, explaining that those who requested to speak were given up to three minutes to speak.

Ms. Foote first called on Dr. Edmond Creekmore, who did not respond. Ms. Foote explained that all public comments would become part of the meeting minutes and official record, posted to the SAMHSA website, and made available to our NAC members. She then called on Ann Corcoran, who shared the following:

Ann Corcoran RN, MSN
Assistant Coordinator, National Shattering Silence Coalition
Co-Chair Policy Action Committee

“Good afternoon. As a family member with lived experience and assistant coordinator for the National Shattering Silence Coalition, we are beyond grateful that SAMHSA now recognizes family members as peers. We are the voices for our loved ones that are too sick to advocate for themselves. Input is essential if we are to build a system that will help every person that lives with a mental illness or substance use disorder, to receive the medically necessary care that they need and deserve.

I wanted to point out that it is both disappointing and discriminatory in that the recipients of grant monies as detailed in the participation guidelines of individuals with lived experience and families provided by SAMHSA must have programs that require the services to be voluntary. This criterion would exclude existing AOT programs that our loved ones may often be involved with. We cannot ignore the fact that 40 percent of those living with bipolar disorder and 50 percent of those living with schizophrenia experience anosognosia, a symptom of the illness

itself, which prevents one from seeking treatment in the first place. Why would we not want to put money into programs that will improve the lives of those living with serious mental illness in the same way that we do for other mental illnesses.

SAMHSA's recent report on coordinated specialty care for first-episode psychosis acknowledges that those receiving treatment early through evidence-based recovery-oriented services can improve the outcomes of individuals who experience psychosis and that such services are cost effective. These same services should be afforded to every person living with a psychotic disorder.

NSSC and I propose that we rethink the language used. The requirements for applicant organizations should be that services are both person-centered and compassionate. This is possible for programs both voluntary and involuntary. AOT is evidence-based treatment as recognized by SAMHSA, yet grant monies are only available to implement new programs with none available to enhance the services for those that are already established. Again, why wouldn't we want to provide funds so that existing AOT programs can be involved in the same way the voluntary services and programs are afforded the opportunity to do so?

Identifying the needs of those with SMI and developing innovative approaches should not exclude involuntary programs that provide medically necessary treatment for a population that otherwise without treatment we see languishing in our jails or prisons or on our streets. Our lived experience can detail discriminatory practices that our loved ones so often face. Our lived experiences too should be valued.

Equity and inclusion cannot be accomplished if we fail to meet the needs of the most vulnerable. We ask that SAMHSA reconsider these guidelines to include involuntary programs so that the system no longer fails those that are the sickest.

As my fellow advocate, Teresa Paquini, recently said, nothing about us without all of us. We are excited to partner with individuals with lived experience so that we can work together to improve the outcomes for every person living with a mental illness and substance use disorder. Collaboration is needed and essential in working towards this goal. Thank you for the opportunity to be heard on behalf of every family like mine."

Edmund Creekmore, Jr., Ph.D., LCP

NSSC Statement to Be Presented to the August 29 SAMHSA Mental Health Services National Advisory Council Meeting

The NSSC is a volunteer, non-profit national organization of the families and Peers in support of adults with Serious Mental Illness and other related brain disorders.

We at the NSSC are excited by recent new guidance from SAMHSA which has revised the definition of "peer" for possible reimbursement purposes to include family members of those with serious mental illness and other serious health disabilities. These are chronic and difficult to treat mental disorders such as Schizophrenia, Bipolar, and Neurocognitive Disorders, such as TBI.

I quote from the recent SAMHSA Release: Peer and Family Support Services:

"Peer support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery. They also include services designed and delivered by the family members of those in recovery.... Peer support services are provided in a variety of settings and across different models of care. They may be provided in consumer and peer-run settings, and in agency or facility-based programs. While most states have established criteria for peer support specialists, the guidelines are less well established for family caregiver support and recovery coaches."

If adult "peers" of unrelated individuals may qualify to provide compensable home health services, involving mental health "support" under provision of Medicaid waiver regulations, then why not designated adult family members? In our view, SAMHSA through its Medicaid waiver provisions should tap this untapped reservoir of qualifying home health care talent and experience in support of the care of the mentally disabled population in their own homes.

Adult family members, particularly those with qualified professional training, are the most motivated and responsible advocates for their own adult loved ones who remain "at risk" to decompensate without appropriate care. These are the "special needs" populations that are most often underserved, neglected, and "marginalized" within the health care delivery system. These are the chronic care populations who often end up homeless and "on the street" who typically warrant long-term care in the home-- or, where there is a more hopeful prognosis-- transition to specialized outpatient treatment, residential care, and preparation for independent living.

Consider the potential advantages of providing home based "peer support" by certified family members for their own family members with serious mental illness, autism spectrum disorders, and neurocognitive disorders -- to name just a few of the "at risk" adult populations that could be served in this manner in their own homes:

- + Avoiding in many instances the hospital ED and acute, repeat inpatient hospitalizations.
- + Avoiding or minimizing police contact through preventive intervention by certified or certified eligible family "peer providers" in the home.
- + Diversion from, or in some instances, through civil and criminal "specialty" courts convened by a special judge or special justice in the community. The Bazelon Center's question "Diversion to What?" could in many instances be restated as, "Diversion to whom?".
- + Supplementing existing state funded residential housing and the professional workforce
- + Peer based certification and supervision, provided by "peer qualified" licensed professionals who are peer certified themselves, could be provided subject State licensing and certification requirements for long-term and transitional care in the home.

The Honorable Milton Mack, Michigan State Courts Administrator, recently informed me (personal communication July, 2023) "Even when the laws support this concept, it is necessary to change the culture of the system that has existed for the last 50 years." There is an age-old adage, "Charity begins in the home". So does "culture", in Judge Mack's sense of the term, in my view. With the proposed change in Medicaid Waiver Reimbursement, we, the families of the NSSC, no longer require "charity"; we seek to change the "culture".

Ms. Foote then returned the meeting to Dr. Anita Everett, who invited Mr. Paolo del Vecchio to the front.

Recovery Office

Paolo del Vecchio, MSW, Director, Office of Recovery, SAMHSA

Mr. del Vecchio greeted the council and appreciated the work of the CMHS staff, adding that the Office of Recovery will celebrate its first birthday in September.

Mr. del Vecchio stated that the National Survey on Drug Use and Health (NSDUH) released in 2023 revealed seven in 10 adults with an addiction problem and two in three adults with a mental health condition identify as being in recovery; this represents 59 million Americans and shows that recovery is possible. He added, “Recovery is our North Star, and the stars are aligning to promote and advance recovery nationwide.”

Recent changes within SAMHSA’s new strategic plan helped reestablish recovery as a priority by identifying it as a critical strategic principle and focus. For example, Congress changed the wording of our block grant and substance use to the Substance Use Prevention, Treatment, and Recovery Support Block Grant. The grant now requires states to report how much block grant funding is spent on recovery support services and how many people are served through those dollars. Further, the administration's ongoing focus on diversity, equity, inclusion, and accessibility promotes lived experience and the involvement of lived experience. HHS's harm reduction strategy, which includes recovery supports, is critical in reducing the number (110,000 people) of fatal overdoses each year.

SAMHSA leadership and Dr. Miriam Delphin-Rittmon announced the establishment of the Office of Recovery in September 2021. Initial dialogue with nationwide recovery leaders led to a recovery summit, which provided clear guidance to address both mental health and addictions through a lens of diversity and equity. Formally launching in September 2022, the office now has 12 full-time employees.

The National Recovery Agenda is to advance recovery, help build resilience, and promote wellness through inclusion, equity, peer services, social determinants of recovery, and wellness.

Inclusion – Nothing About Us Without Us: Foster the meaningful involvement of a wide array of people with lived experience, to improve behavioral health practice and policy, and to foster the social inclusion of people with behavioral health conditions. This goal recognizes the need for recovery to be self-determined and self-guided. Inclusion is a “nothing about us without us” practice. In June, SAMHSA modeled inclusion as an employer by including people with lived experience throughout the agency and expecting other agencies to follow suit. This goal supports social inclusion and the need to overcome the negative attitudes, discrimination, and bias associated with the conditions people experience. Recent social inclusion efforts include:

- The 34th annual observance of National Recovery Month.

- Partnering with Faces and Voices of Recovery on a luncheon with the Office of National Drug Control Policy on September 7, followed by a walk in Washington, D.C., for recovery celebrating people in recovery across the nation.
- Partnering with Mobilize Recovery on activities that included a September 20 release of the NSDUH data and the correlations of past treatment history, family supports, and social determinants identified by the Center for Behavioral Health Statistics and Quality (CBHSQ), and data indicating people who identify as being in recovery fared better with their behavioral health than the general population during the pandemic.
- Sponsoring a day of service on September 31 in partnership with Mobilize Recovery.
- A weekly focus on specific themes related to diverse, underreported, and underrepresented communities.
- SAMHSA's website has a recovery month toolkit containing graphics and zoom backgrounds developed to celebrate recovery month.

Equity – Recovery for All: Increase opportunities for recovery for underserved and under-resourced populations and communities, including people of color, youth, older adults, LGBTQI+, rural communities, veterans, and people with disabilities. This goal recognizes that culture must be an intentional focus for recovery.

In September 2023, SAMHSA convened the first Tribal Recovery Summit with support from CMHS. This summit highlighted the importance of culturally based healing practices, the importance of ceremony, and the importance of the use of elders. A compendium of recovery-based healing practices and practice-based evidence (efforts that have yet to rise to the level of an evidence-based practice) is in development.

Peer Service – Peers Helping Peers: Expand peer-provided services within every community.

The June 2023 SAMHSA-issued National Model Standards for Peer Support Certification (NMSPPSC) supports the goal of the President’s Unity Agency by offering commonality and quality assurance across state and territorial lines. The NMSPPSC creates a common set of standards to address the differences between states' Peer Support Certification standards, authenticity training, and DEIA (diversity, equity, inclusion, and accessibility) issues impacting examinations and background checks. Since its issuance, various states, accrediting bodies, private insurers, and Medicare have been positively impacted, with many committing to adopt the NMSPPSC.

Social Determinants of Recovery – Whole Health Care: Address key social determinants that support recovery, including access to housing, education, social supports, and employment.

SAMHSA released the Best Practices and Suggested Guidelines for Recovery Housing to support this goal. The guidelines, which are in revision, are based on the 2018 SUPPORT law. “Recovery housing” is defined as a shared living environment free from alcohol and illicit drug use and centered upon peer support and connection to services that promote sustained recovery from substance use disorders (SUDs). SAMHSA is also working with the Office of National Drug Control Policy on recovery-ready workplaces and recently convened a nationwide meeting on collegiate recovery efforts.

Center for Substance Abuse Treatment support grants have resulted in a significant increase in recovery housing for recovering individuals negatively impacted by the nationwide housing shortage. Further, an interagency meeting will evaluate the intersection of recovery housing and housing first approaches.

***Wellness – Individual, Family & Community Wellness:* Expand holistic, self-care strategies to improve health and behavioral health outcomes, including the reduction of early mortality and the impact of co-morbid chronic health conditions, and to integrate recovery-oriented practices and systemic reform into the full continuum of health and behavioral healthcare, including prevention, harm reduction, treatment, crisis care, and recovery support.**

SAMHSA recently supported this goal with a Family Caregiving Technical Expert Panel (TEP) recognizing families' critical role in supporting recovery and wellness and a TEP exploring digital innovations in recovery.

The Office of Recovery core principles are to:

***Data and Evidence:* Increase the collection, analysis, and reporting of data on recovery and expand the identification and use of evidence and practice-based policies and approaches.**

The Office of Recovery and CBHSQ recently convened research partners in the National Institute of Drug Abuse (NIDA) and NIMH to develop a SAMHSA recovery research agenda.

***Trauma-Informed:* Embed trauma-informed practices and approaches in recovery efforts. Data supports that trauma is a primary precursor to mental health and addiction issues.**

SAMHSA supports this principle by training managers, staff, and senior leadership on becoming a trauma-informed organization, by releasing a guidebook through the policy lab on how organizations can become trauma-informed, examining peer respite services as a trauma-informed crisis response approach, and convening a TEP on warm lines.

***Rights Protection:* Protect the human and civil rights of people with lived experience.**

SAMHSA supports this principle in its partnership with CMHS on the Olmstead initiative, current efforts to develop peer respite programs to assist people in crisis as alternatives to emergency rooms and hospital use and exploring the intersection of criminal justice and recovery efforts.

To advance national recovery, the Office of Recovery's year two budget includes a request for a 10% set-aside of the substance use block grant focused on recovery supports, updating Recovery-Oriented Systems of Care (ROSC) to be inclusive of mental health incorporating harm reduction approaches, and engaging national recovery leaders through a series of regional meetings with regional directors.

Dr. Everett thanked Mr. del Vecchio for his leadership in promoting the recovery focus at SAMHSA and nationally, then invited questions and discussion points.

Discussion

Ms. Wells inquired about state-to-state reciprocity for peer certification and family support specialists, asking what process will be required for Medicaid coverage and whether services covered under one state should be covered under the other. Mr. del Vecchio responded CMS only requires certification, adding some states, Oregon, and Washington, for instance, already have reciprocity. Dr. Everett added that NMSPPSC is optional, providing a national standard, and not intended for adherence because of each state's scope of practice in the state Medicaid offices.

Regarding higher incidences of addiction in Hispanic and Asian communities, Dr. Shivangi asked if predisposition to addiction is genetically or behaviorally driven. Dr. Aguilar-Gaxiola stated it is multifactorial. The referenced data measured who uses SUD services and for what reason, noting variances by race and ethnicity. There are several factors determining these variants. Access to care is a determinant for African Americans, Latinos, and Asians, with Asians generally utilizing SUD services infrequently. There are variants within population subgroups as well; for example, in individuals of Mexican origin with SMI, SED, or SUD, one out of three US-born individuals, one out of six Mexico-born individuals, and less than one in 10 of farm workers utilized services in the last 12 months.

Dr. Aguilar-Gaxiola acknowledged that social determinants may have a significant impact and suggested that structural, environmental, economic, and political determinants are critical. He cited a National Academy of Medicine assessment measuring health equity based on the context of meaningful community engagement in health and healthcare. He explained many people included in this diverse population stopped services during the last presidential administration when federal law threatened to determine if someone applying for permanent residence (a “green card”) or a visa to enter the United States would be likely to depend on the government as their primary source of support in the future.

Dr. Aguilar-Gaxiola inquired how the NSDUH defined recovery because the data conflicted with data from 2018, 2019, and 2020 showing the treatment gap grew from 90% to 91% for individuals with SUD and co-occurring disorders. Mr. del Vecchio clarified that the CBHSQ and the NSDUH team provided no standard definition of recovery, allowing respondents to self-defined recovery.

Dr. Aguilar-Gaxiola added that comorbidities are the rule rather than the exception, impacting all aspects of SUD. Mr. del Vecchio agreed, reiterating that the Office of Recovery’s “Big 10” approach incorporates SMI, SED, and SUD with co-occurring disorders.

Ms. Tamplen commented that having an Office of Recovery in every state and county would facilitate the immediate application of disseminated information at the local level. These offices would engage communities in creating local systems by utilizing people with lived experiences, enhancing and contributing to the national recovery effort. Minnesota Blue Cross Blue Shield health insurance adoption of peer support is exciting news because getting peer support services outside of the Medicaid/Medicare system is essential for the wellness of the workforce. Mr. del Vecchio added that 33 states currently have an Office of Recovery and that his office continues to work closely with NASMHPD to accomplish this in all 50 states.

Mr. Fox inquired about the continuation status of the Office of Recovery. Mr. del Vecchio clarified that the Office of Recovery, established by executive action, was not codified in the authoring language. The legislative and regulatory team is discussing potential pending legislation to address this.

Dr. Everett thanked Mr. del Vecchio for his presentation and leadership before moving to the final component of the agenda.

Advisory Committee for Women’s Services/SAMHSA Implementation of National Plan to End Gender-Based Violence

Karen Gentile, LCSW-C, JD, Director, Office of Policy Coordination and Innovation, CMHS;
Nima Sheth, MD, MPH, Senior Medical Advisor, CMHS

Karen Gentile, LCSW-C, JD, Director, Office of Policy Coordination and Innovation, CMHS

Ms. Gentile is the subject matter expert lead at SAMHSA for gender-based violence and human trafficking. Before joining SAMHSA, she had roughly 20 years of experience in legal representation and clinical practice in trauma, gender-based violence, interpersonal violence, victim advocacy, and prevention education.

The White House defines gender-based violence as sexual violence, intimate partner violence or domestic violence, stalking, and other forms of gender-based violence, collectively referred to as GBV. Interpersonal violence such as online harassment and abuse, human, sex, and labor trafficking, and teen dating violence are other forms because of a GBV component.

The rate of domestic violence (DV) among women accessing SUD treatment, the rate of DV among women accessing mental health treatment, and the increased risk of depression, PTSD, substance use, and suicidality in intimate partner victimization are evidence of the intersectional impact of DV and behavioral health. One study revealing that rape victims are more likely to use substances than non-victims is evidence of the intersectional impact of sexual assault and behavioral health. Victims of sexual assault, including childhood sexual abuse, may use alcohol or drugs to numb or escape from painful memories or PTSD symptoms. When they attempt to stop using the drug or alcohol, symptoms may reappear, and the likelihood of relapse may increase.

People with SMI and people with disabilities, including intellectual disabilities, have a significantly higher risk of violence victimization, including GBV, than the general population.

Another link between GBV and behavioral health is the high and often underreported incidences of drug and alcohol-related sexual assaults and substance use coercion involving domestic violence when the perpetrator undermines someone’s substance use recovery, even encouraging use as a means of control. This same link exists with mental health coercion with behaviors such as gaslighting to undermine someone’s treatment and recovery.

On May 25, 2023, the White House Gender Policy Council released the “U.S. National Plan to End Gender-Based Violence: Strategies for Action”. An executive order mandated its development as part of the National Strategy on Gender Equity and Equality. SAMHSA co-chaired one of the interagency workgroups to develop pillar two (addressing trauma-informed support for survivors) and provided additional input throughout the document. A plan calls to action for federal agencies to address specific goals with potential actions while leaving the implementation to each agency. Additionally, the document provides excellent background information to the public.

The National Plan on Gender-Based Violence has seven strategic pillars:

- Prevention
- Support, Healing, Safety, and Well-Being
- Economic Security and Housing Stability
- Online Safety
- Legal and Justice Systems
- Emergency Preparedness and Crisis Response
- Research and Data

Ms. Gentile stated that SAMHSA has equities in each pillar, though pillars one and two are priorities; other federal agencies have varying levels of direct engagement with each pillar. For instance, the Offices of Violence Against Women, Victims of Crime, Trafficking in Persons, the ACF, and the Family and Youth Services Bureau have high engagement. In contrast, the CDC and NIH focus more on the prevention, and research and data pillars.

Ms. Gentile emphasized the pervasive risk for GBV as both perpetrators and victimization exist throughout the populations SAMHSA serves.

Plan implementation is part of the National Strategy on Gender Equity and Equality to prevent and respond to GBV globally bringing the integration of broader equity efforts into a national and international focus.

The entire government implementation coordination is led by the Gender Policy Council in the White House and consists of the GBV Federal Interagency Working Group that includes HHS and various subgroups; SAMHSA is participating at the subject matter expert level. The federal agencies will provide input on the implementation plan development. They will meet regularly to coordinate activities, identify activities to align and accelerate federal efforts, apply lessons learned from data and research findings, address emerging issues, monitor progress toward the implementation plan’s goals and objectives, and report on national progress. Further, the White House demonstrated its commitment to accountability by requiring all agencies to report implementation progress in July 2023, two months after the National Plan release.

SAMHSA demonstrates its accountability by providing implementation progress, including this unofficial draft of SAMHSA’s vision statement: "All people are free from gender-based violence victimization. But if gender-based violence does occur, all survivors have full access to trauma-

informed, survivor-centered, culturally- and linguistically appropriate mental health and substance misuse treatment and recovery support for themselves and their families."

Other implementation efforts include an internal workgroup across all SAMHSA centers and offices, meeting biweekly to guide SAMHSA leadership and staff to implement the White House National Plan.

Workgroup goals include developing and maintaining an inventory of activities tracking progress towards implementation and then developing recommended actions for centers and offices to implement the strategic objectives of the National Plan and ensuring that all recommended actions align with SAMHSA's Strategic Plan.

Ms. Gentile provided an inconclusive list of opportunities for SAMHSA's implementation:

- Modifying language in notices of funding opportunity (NOFO), indicating required or allowable activities or general statements in grants solicitations.
- Modifying language in contract statements of work (SOW),
- Adding activities in the Tribal Training and Technical Assistance (TTA) centers such as training, white papers, and learning communities.
- Creating new service and infrastructure programming.
- Engaging in joint programming with our federal partners such as SAMHSA's partnership with ACF's Family and Youth Services Bureau.
- Enhancing the specificity of data collection.
- Hosting and participating in policy academies, technical expert panels, listening sessions, and requests for information to increase understanding of root causes and identify population and provider-specific solutions.
- Innovation challenges using funding available at challenge.gov to solicit and amplify innovations in this area.

Discussion

Mr. Fox commented that many employees in his small company are involved in DV situations, so it would be beneficial to have resources to guide him in correctly assisting them to understand the necessity to get help instead of letting it continue. Ms. Gentile responded that the National Domestic Violence Hotline and online searches for local DV resources would be general advice. She also recommended the infrastructure run by ACF's Family and Youth Services Bureau.

Mr. Fox clarified, asking how he might gain personal knowledge to help staff and program participants facing GBV or DV situations, Ms. Gentile stated that it is challenging because of privacy issues. Encouraging someone to leave outside the context of safety planning can be very dangerous, putting people at much greater risk. She reiterated that there are excellent resources that even talk about advice for employers and family members.

Dr. Aguilar-Gaxiola commented that the survivor-centered, culturally and linguistically informed services encourage him. He also expressed being unclear to what extent DV or GBV are related to child abuse and asked if there are repercussions to child abuse other than DV and GBV that providers need to be aware of.

Ms. Gentile concurred that attention to culture and linguistics is critical. She acknowledged a considerable tie between DV and GBV to child abuse, stating she lacked complex supporting data.

Ms. Gentile added that DV, GBV, and child abuse all happen in the context of family violence, highlighting that when adults are involved in DV, including sexual violence outside of an intimate partnership, there is trauma that invariably impacts family life and children. She stated that if the perpetrator feels power by asserting control over their partner, then children in the home often become another powerless person for the perpetrator to assert power over. She emphasized that a cycle of generational violence can be interrupted, reminding providers to include prevention in their approach.

Dr. Aguilar-Gaxiola shared the case in Sacramento, California, where a husband with a history of DV and GBV was granted supervised visitation and murdered his three children, the visitation supervisor, and then himself during a supervised visit. He shared that what was most remarkable is that the wife became an advocate for other women dealing with DV and GBV.

Ms. Gentile stated that this case demonstrates that people can overcome victimization with much support and therapy. She cautioned that while survivors of gender-based violence can become advocates, allowing an unhealed victim to speak to groups is re-traumatizing.

Dr. Adams's leads an organization that hires people from the population they serve. She asked if any training is available for employers on handling employees that discuss their extraordinary personal issues at work and stay within legal bounds. Ms. Gentile noted that state laws differ and acknowledged that it is a delicate balance to have those conversations, make sure the employee is okay, refer them to the proper resources, and provide support. She encouraged Dr. Adams to consider SAMHSA's efforts around creating a trauma-informed organization as a resource.

Dr. Everett thanked Ms. Gentile and then introduced Dr. Nima Sheth to speak briefly about the activities of the National Advisory Council on Women.

Nima Sheth, MD, MPH, Senior Medical Advisor, CMHS

Dr. Sheth presented a brief overview of the Advisory Committee for Women's Services and the new Maternal Mental Health Task Force outlined in the last Omnibus. SAMHSA's Advisory Committee on Women's Services has ten members serving four-year terms and advising the associate Administrator for Women's Services (a rotating role that Dr. Sheth holds currently) on women's substance abuse and mental health services, including multi-disciplinary approaches. For example, the National Hispanic and Latino Mental Health Technology Transfer Center presented on empowering Latino women; the 988 office discussed its impact on women; and the Early Diversion program presented its outreach program and ways to improve outreach to women of color. Various grant programs also discuss their services with and receive feedback from the Committee.

The last Omnibus called for a Maternal Mental Health Task Force. Congress outlined this task force to form and be co-chaired by the Assistant Secretary for Mental Health and Substance Use and SAMHSA's Assistant Secretary. Dr. Sheth stated that Admiral Levine and Dr. Delphin-

Rittmon are the co-chairs, while she and Dr. Dorothy Fink are the points of contact. This task force aims to identify, evaluate, and make recommendations to coordinate and improve federal activities related to addressing maternal mental health conditions, including co-occurring SUDs. The objectives are as follows:

- Year One: Prepare an updated report analyzing and evaluating the state of maternal mental health programs at the federal level, focusing on improving federal coordination and identifying best practices concerning maternal mental health.
- Year Two: Considering the initial report, create and annually update a national strategy for improving maternal mental health.

The committee is to solicit and include public comments from stakeholders in the report that will be sent to the National Strategy on Gender Equity and Equality, while continuously communicating with Congress and state governors. The task force sunsets September 30, 2027. The different focus areas outlined in the Omnibus include behavioral health interventions (prevention, screening, diagnosis, and treatment), mental health equity, community-based practices, federal coordination, and research and data.

Currently, leadership is considering holding the task force under a subcommittee of the Academy of Certified Social Workers (ACSW). Further, a Federal Register Notice has posted to obtain public representation on the subcommittee, especially individuals with lived experience.

Public comments from stakeholders will be solicited for the report and shared with the National Strategy, while the committee, which sunsets September 30, 2027, continuously communicates with Congress and governors.

Closing Remarks/Adjourn

Anita Everett, MD, DFAPA, Director, Center for Mental Health Services (CMHS)

Dr. Everett briefly recapped the highlights of the day, including unanimous agreement of the formation of the subcommittee. She stated interim meetings and phone calls facilitate progress.

Dr. Everett explained that though this meeting was Dr. Bickman's last, CMHS may ask him to serve awhile longer and certainly wants to acknowledge his contributions.

Dr. Dike circled back on the question of recovery, explaining the State of Connecticut views everyone as in recovery, and meets everyone where they are regardless of the degree or severity of illness.

After Dr. Everett thanked members, staff, and contractors, Ms. Foote adjourned the CMHS National Advisory Council at 4:32 p.m.

Certification

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

November 1, 2023

Date

/Anita Everett M.D. DFAPA/

Anita Everett M.D. DFAPA

Director

Center for Mental Health Services

Substance Abuse and Mental Health Services

Administration

Minutes will be formally considered by the CMHS NAC at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.