

**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration**

**Joint Meeting
of the
SAMHSA National Advisory Council (NAC),
Center for Mental Health Services (CMHS) NAC,
Center for Substance Abuse Prevention (CSAP) NAC,
Center for Substance Abuse Treatment (CSAT) NAC,
SAMHSA Advisory Committee for Women's Services
and
SAMHSA Tribal Technical Advisory Committee (STTAC)**

**April 11, 2013
1st Floor Conference Room
1 Choke Cherry Road
Rockville, MD**

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Committee Members Present

Geretta Wood, DFO
Pamela S. Hyde, SAMHSA Administrator
Omisade Ali
Deepa Avula
Mirtha R. Beadle
Johanna Bergan
Yolanda B. Briscoe
Jean Campbell
Victor A. Capoccia
Carolyn Clancy
John Clapp
H. Westley Clark
Michael Compton
Eugenia Conolly
Michael Couty
Debbie Crump
Peter J. Delany
Paolo del Vecchio
Kana Enomoto
Suzanne Fields
Harriet C. Forman
Robert M. Friedman
Joseph A. Garcia
Irene Goldstein
Shelly F. Greenfield
Megan Gregory
Frances M. Harding
Kweisi Ronald Harris
Emmitt W. Hayes Jr.
Larke Huang
Leighton Y. Huey
Marco E. Jacome
Rex Lee Jim
Andy Joseph Jr.
L. Jace Killsback
Stephanie M. Le Melle
Carolyn J. Lukensmeyer
Keith Massaway
William R. McFarlane
Jeanne Miranda
John Paul Molloy
Michael Montgomery
Diane Narasaki

Charles Olson
Participants (Continued)

Indira Paharia
Elizabeth A. Pattullo
Cassandra Price
Patrick A. Risser
Dee Davis Roth
Josh Shapiro
Lori Simon
Abby Smith
Benjamin Springgate
Mary Ann Taufa'asau Tulafono
Carole Warshaw
Christine Wendel
Patricia Whitefoot
Christopher R. Wilkins
Arthur Wilson
Rosalind Wiseman
Marleen Wong
Mohammad Yunus

PROCEEDINGS

Agenda Item: Welcome, Introductions, and Administrator's Remarks

MS. GERETTA WOOD: Good morning. I'm Geretta Wood, and I'm the Committee Management Officer for SAMHSA.

Welcome to all of you today. We're very happy that you're here, and we're glad that so many of our council members could join us.

The meeting is being recorded. So council members, please remember to speak into the microphone so that those listening can hear. Additionally, please identify yourself each time you speak so that the transcriptionist knows who was talking.

And for those in the room, as a courtesy to others, please silence your electronic devices.

I will now turn the meeting over to Pamela Hyde.

MS. PAMELA S. HYDE: Thank you, Geretta.

Good morning to everyone. I hope everyone made it in on time on whatever flights and things you were coming in on, and I hope all of you had a good day yesterday at your various councils.

We have a lot in store for you today, and hopefully, we want to make sure that we maintain lots of time for discussion even while giving you lots of information. So it's always a balance that we work on for these meetings to try to make sure that that happens.

I've already heard a little bit of feedback from yesterday's meetings. It sounds like things went well and people were engaged in a lot of good discussion and work. So, thank you.

I want to remind you that I feel very, very strongly about the role of advice and advisers. All of you are major and wonderful leaders in your fields, in your areas and what you do, and we know that we take your time to come here and work with us. And I can't stress enough that whatever and however you may experience these meetings -- some in small groups, some in larger groups, and maybe some frustrations that not enough discussion happens and maybe some other things -- but we spend lots of time in the weeks after you all have left us talking about ideas that have come out of these discussions.

So I don't know how well we feedback every single one of those pieces of information or every single one of those processes. But I want to let you know that it does matter a lot to us, and we appreciate your time. We appreciate your thought and your input, and we appreciate all the work that you're doing.

Some of you we talk to in between and ask your thoughts and advice on many things. So thanks again for all of that work.

I want to just take a moment up here to let everybody introduce themselves. Most of the folks you know, but in some cases, they are in new situations than the last time you were here, or there are a couple of new people.

So, Paolo, let's start over here.

MR. PAOLO DEL VECCHIO: Good morning. I'm Paolo del Vecchio, Director of the Center for Mental Health Services.

DR. H. WESTLEY CLARK: I'm Westley Clark, the Director of the Center for Substance Abuse Treatment.

MS. FRANCES M. HARDING: Good morning. I'm Fran Harding, the Director for the Center of Substance Abuse Prevention.

MS. PAMELA S. HYDE: We're getting just a little bit of feedback in this mike right here. Whoever is taking care of the mikes? Okay. Kana, can you talk some more?

MS. KANA ENOMOTO: One, two, three, four. Kana Enomoto, Principal Deputy.

MS. PAMELA S. HYDE: All right. Thank you. Kana's voice especially needs amplifying. So we need to make sure that one's good. Thank you.

Keep going on introductions.

MS. GERETTA WOOD: Geretta Wood, Committee Management Officer.

MS. MIRTHA R. BEADLE: And good morning. Mirtha Beadle, Deputy Administrator for Operations.

MS. PAMELA S. HYDE: Okay. I also want to introduce Jac Rivers. If you've not met her, she's my new special assistant and doing a bang-up job. She came to us from the Department of Justice and has significant experience, God forbid, as another lawyer, and that is wonderful.

[Laughter.]

MS. PAMELA S. HYDE: I know, but Wes, you're so many things. It's just -- anyway, Jac is a great addition to our team.

And Debbie Crump, who most of you, I think, know over the years. I've got to take just a minute to say this is probably Debbie's last advisory council meeting. She is retiring after more years than we even want to discuss, and it is going to be a major and huge loss for us.

So let me just take this opportunity to acknowledge her, and we will do that many times between now and August, but by the time you all get back with us, I think Debbie will be off on cruises or whatever else she's going to be doing. So please take a moment to thank her for her incredible work.

[Applause.]

MS. GERETTA WOOD: I also wanted to introduce Josh and Abby, two of our contractors who we couldn't manage the meeting without.

MS. PAMELA S. HYDE: As you know, there are also camera people, and there are also lots of electronic and other folks who work with us to make these meetings happen. We had to stop a long time ago putting these meetings in hotels. So we do them here, and I think this space is great for that purpose, but it does require that we get a lot of help in. So thanks to all the camera people and the contractors and others who help us with these meetings.

So my role for the next few minutes is to just talk through the agenda quickly and let you know what's coming up. And then -- both today and tomorrow. Again, lots of you had meetings yesterday. I hope they went well. I hope you share some of that work with each other as you go through the day.

This is an interesting time because the budget, the President's fiscal year 2014 budget, came out yesterday. You may have noticed -- and we'll come back to this in a minute, you may have noticed there were pre-budget rollout blogs and press releases and other things about mental health budgets and some substance abuse issues. We're going to give you some of that paper in a little bit and talk about some of it, and Kana's going to walk through the budget.

At a high level, we have a staff call -- we had staff call with budget yesterday. We have an all-stakeholders call about budget today at 5:30 p.m. We're going to do it from this room. So if you want to stay and listen, you can get more detail about SAMHSA's budget. If you're interested, you're welcome to stay and listen. There will be people all over the country calling in to that call.

Tomorrow, we're doing a special call with State commissioners. That's always an important group that we want to interact with, and then we have other things that we do over the course of the next few weeks, talking about our budget. There's lots of discussion about that. We will come back to it later.

The other thing that we have on the agenda today that we're really excited about is a little small group discussion about the national dialogue on mental health. For those of you who were able to join us on the call that we did just briefing you all on it, there is continued work on it. Some of the budget rollout and the mental health budget is part of that work.

We anticipate the actual launch of the national dialogue in -- sometime soon. I don't have a firm date, but Kana was in several meetings over at the White House this week talking about that. So it is actively moving. We've been interacting with a number of foundations and other potential donors, as well as mayors and community leaders around some community conversations, some electronic media, and other kinds of effort. So there's lots coming on that.

Carolyn Lukensmeyer, who is the point for us on the work with the Deliberative Democracy folks throughout the country, she'll be here shortly, and she'll be talking with you a little bit about how those processes are going to work.

At lunch, we're not going to let you have a minute's rest today. You have an option. You have five options at lunch. One is to have lunch and do nothing else. That's one option.

Another option is to sit and have a conversation, and these are really conversations. There's going to be information available to you, but it's really conversations. We've tried to pick some topics that you all have said to us over time that you'd be interested in more dialogue about. It's hard to get all of that on these agendas. So we want to give you an opportunity to do that.

One of the conversations is about international issues. So if you want to know what we do in that arena, we frankly don't do a lot relative to our overall portfolio because it's not a lot of our authority. And yet we do some very significant things in the international arena. So if you want to hear about that from Winnie Mitchell and Bob Lubran, you can do that.

Disaster response. We are doing an increasing amount of work there, have always done so, but doing other great work about that. Mirtha Beadle and Captain Maryann Robinson are going to lead that discussion.

Some of you have asked about what we do around faith-based initiatives. So we're going to do a breakout discussion about our faith-based initiatives, and I'll join folks for that.

And then our Brady bill prohibitor list issue. This is a huge issue that is arising out of the post Newtown, Connecticut, tragedy in which the discussion about control of guns and otherwise dealing with gun issues. One of the issues is who should be prohibited from having a gun or being able to purchase a gun. Wes Clark has been doing a lot of work, along with Paolo, as our representatives to the department's discussion about that, the Department of Justice's discussion about that, et cetera. So your advice about that would be very helpful.

Those are the four breakouts at lunch, and I want to take a really quick minute to see, because it matters where we sit, how many people want to talk about international issues?

[Show of hands.]

MS. PAMELA S. HYDE: A couple. Okay, two or three.

How many people want to talk about faith-based issues?

[Show of hands.]

MS. PAMELA S. HYDE: Okay. Two or three or four.

How many people want to talk about disaster response issues?

[Show of hands.]

MS. PAMELA S. HYDE: Again, two or three or four.

How many people want to talk about the prohibitor list?

[Show of hands.]

MS. PAMELA S. HYDE: A lot. That's what I figured. Okay. So, Wes, why don't you stay in here with the prohibitor list group, and the rest of the three groups. You've got assigned rooms. Terrific.

Do you have the prohibitor list one big? Okay. As long as it's got plenty of room. I sort of had a feeling that would be the one that people wanted to do the most.

All right. So when we get to lunch, we'll tell you where those breakout rooms are, make sure that you get your lunch and can go to those places that you want. I do encourage you, if you're willing, to use your lunch hour for that purpose, to have some conversation with us about those topics.

This afternoon, we have a great panel about disparities in evidence-based practices. Carolyn Clancy, who is the Administrator of the Administration on Health Research and Quality, is one of my colleagues in HHS, is going to join us, and she is terrific. And she is soon leaving that post. So it's a great opportunity for us to hear from her, as well as the other panel members on that panel this afternoon.

And then we'll have an update on health reform because it is moving quickly. And in each of these panels, some of you are going to join us, as well as the leadership of the staff in facilitating the conversation. In each case where you have a panel, but we also have time set aside for you to interact with us about those topics so we can hear your advice and thoughts about it.

I want to say just a couple of other issues that are going on in SAMHSA before we move to the rest of the agenda, tell you a little bit about what we're working on. We just released about a month or 6 weeks ago a workforce report to Congress that had been in the works for some time. I frequently do this in speeches, but I'll do it here, which is it really is pretty straightforward. You all know the issues.

People in our field are too old, too white, too unloved, and underpaid, which is part of the unloved part. But that's what it boils down to. It's not that simple. This report is not a set of recommendations, per se, although there is some feedback from a June -- last year June panel or a June listening session that Mary Wakefield from HRSA and I did for some of the major stakeholders around workforce.

I think this is going to be a growing issue as we have literally 62 million people who, come January 1st, are going to have access to coverage for behavioral health issues that they have not had before, 62 million people in this country. We anticipate about 11 million of them already have some form of need for mental health or substance abuse services. Some of them may be in the system and just shifting from one funding source to another. Others of them are going to be brand new to having a way to pay for their coverage.

This has a profound impact just literally on the numbers of workforce need. But it also has a profound impact on how we deliver that care because we can't possibly create enough of the traditional licensed professionals to do all of that work in the traditional ways. We're having to do new and different approaches.

So anyway, workforce is one of the areas that we are thinking about what to do with and about. Our colleagues at HRSA are working with us. So if you want to look at that report, it is -- I assume it's online. It should be on our Web site. So know that that's an issue that we're working on, thinking about.

I also know there was obviously our STTAC, our SAMHSA Tribal Technical Assistance Committee met yesterday, our council met yesterday. We're doing an increasing amount of thinking about how to best do work in the American Indian and Alaska Native area. Mirtha Beadle has been working on that, along with Sheila, our Native American liaison, and Rod, who hopefully you met yesterday if you were in that meeting, who works on our Office of Indian Alcohol and Substance Abuse.

We are thinking more and more about what's the best way to make sure tribal programs can access our dollars, can get our help through technical assistance and information, and can also get connected up with the other things that they need like best practices for doing alternatives to incarceration and other kinds of issues that we work on.

We're also trying to make sure that our grantees who are Alaska Native/American Indian grantees are able to do the business side of their work because we have, unfortunately, a higher proportion of those grantees who run into risk problems with managing Federal dollars. So we're working on that as well. I think there was some conversation about that yesterday, but I wanted all of you to know that if any of you have thoughts or comments about that, you can see either Mirtha or Sheila or Rod.

The other issue I wanted to raise to you is our favorite topic. Some of you have run into it, and that is the issue of conferences and meetings. It has consumed our lives over the last year or so, few months now. It's hard to believe it's probably only been, what, 8 months or something like that. But a few months ago, the issue rose from Congress, from the White House, from the public about the number of conferences and meetings and the type of conferences and meetings that the Federal Government contributes to or pays for or sends people to.

This has raised a series of activities and efforts all over not just SAMHSA -- we are just one piece of this pie -- about how we think about, how we deliver, how we approve, how we pay for, how we partner about conferences and meetings. I won't get into the details here, but suffice it to say if you are frustrated about working with us on those issues, it could not begin to meet the frustration that we have about those issues. So please bear with us. It is changing almost daily.

We were one of those administrations that didn't have a centralized way to manage this process. So we've had to sort of create our own centralized approach to managing this at the same time that the requirements from Congress, from the White House, and from OMB have come to us. And as the budgets get tighter, the issues about how we spend money in this arena has gotten bigger.

Now, again, I don't know if all of you have experienced this, but I've been in this field long enough to know some years it's cars. Some years it's paper. Some years it's conferences. This year it's conferences. So this is the one that has been picked as the example of "Federal abuse," and I say that in quotes.

We think that convening people and having people network has been a very valuable part of our portfolio, although we also acknowledge that there have been one or two or three cases that have gotten lots of attention in other departments and in other operating divisions, mostly, frankly, not in HHS. But nevertheless, people have been called to task about that, fired over it, whatever.

So we feel very good about the conferences that we do, but we've been doing a lot of work at trying to make sure that the way we do those conferences and meetings meets the new requirements, and as those requirements change, we have to change. Some of the changes that are happening is the amount of dollars that we can approve here is going down and down and down, which means that the cost as it goes up has to go down town for the Deputy Secretary personally to look at or the Secretary personally to look at. That, again, is not their choice. They have been told they have to do that.

And likewise, every conference that comes through SAMHSA at this point, either Kana or I personally have to look at. And most of them I have to look at. Kana looks at the smaller ones. She looks at all of them, big, small, or otherwise. There are a few that I have no choice but to look at personally. So that's the level of oversight they're asking us to do.

So I don't want to dwell on this too much more other than to say I know a lot of you interface with it. A lot of you are frustrated how long it takes us to make those decisions or what those decisions are and how we do them. So just bear with us. It is changing once more. So it will, I think, get tighter.

For example, one of the things that has been not required to go through that process has been advisory committee meetings like these. We are told that in the next round of changes, these conversations will have to go through that as well. So that's why last year we did anticipate a little bit. So that's why last year, last August, whenever it was that we did the last one of these, we toyed with or played with or tried the electronic do it over the phone process.

We learned a lot out of that. It worked well. We've done some things that way very successfully, other things not so well. So we're going to toy with that some more, and we'll be back to you about how we're doing that. So just so you know that there may be different and additional changes.

The other thing we may, frankly, do is try to do more phone calls in between, like we did with the national dialogue, which sometimes we think those can be

shorter, more specific about specific topics and maybe helpful as well.

All right. So enough about our favorite topic of conferences. You would not believe how much time, energy, and people it has taken to deal with that issue.

All right. The next thing I want to just say something to you about is recognition that we've been living with and I think you all are aware of a 4-year plan that has 8 strategic initiatives. I think you all know what those are. We use them to do everything from manage our daily work to manage our grants and contracts, to manage our budget requests, et cetera.

That strategic plan is linked to the Secretary's strategic plan. So the top three of our eight priorities are part of the Secretary's strategic work. Our plan, those eight strategic initiatives carry us through fiscal year '14. So it carries us through September 30th of 2014.

Now, believe it or not, the '14 budget came out from the President yesterday. We are a month away from preparing our 2015 budget proposal. I know. Victor laughs, and you are correct to do so. It's hard to even know where to start. It's just so silly.

But nevertheless, we will, and we will do that in a very strategic way because our strategic plan will have to change for 2015 through '18 in order for us to begin the 2015 budget process. So what that means is we are seriously considering what we have accomplished in those eight initiatives, whether or not they have moved from being a strategic initiative to being an ongoing set of work, or whether or not things are done and we just need to move on to something else, or whether something new is emerging that we need to have as a strategic initiative going forward.

We don't have a specific topic about that on the agenda for you all. But if you have advice, thoughts about that, I would urge you to give that to any one of the center directors or to Kana or myself, if you have thoughts about that. You know what the eight initiatives are. You know what's emerging in the landscape.

By 2014, we will be well underway with health reform enrollment and eligibility processes. It certainly won't be done, but we'll be well underway. So 2015 to '18 offers us an opportunity to think differently.

In that regard, one of the things that our executive leadership staff have been doing, it's not the same as the strategic initiatives, but it's related, which is how to think about SAMHSA going forward. So SAMHSA's role as a very unique Federal agency that is the voice and leader for behavioral health issues within the Federal Government and across the Nation, our funding is not that big, but our voice is loud and powerful.

And frankly, as the funding and grants and stuff go down, our role in grant making continues to be central to moving the field. But the rest of what we do is becoming more and more paramount. Our influence, our policymaking, our public voice out there, our communications efforts, our practice improvement efforts, all of those things have become more and more critical to us, and we're thinking about that.

So we're going through a process of thinking strategically about how to position SAMHSA to lead public health efforts to advance the behavioral health of the Nation. So we are thinking about a strategic set of work for SAMHSA as an organization, in addition to our strategic initiatives in the behavioral health arena. So both of those things are going on. They are consuming significant amounts of our time in a very positive way, and hopefully, you will see some things emerge about that soon.

Again, all of you have interacted with SAMHSA in many, many ways over the years. If you have thoughts about that and you want to say I really think SAMHSA doesn't do enough of X, and it really should. Or if you think there are some things that SAMHSA is doing that it should get rid of, just stop doing because it's not that helpful anymore, you should think about that for us and with us and, again, tell any one of the center directors or Kana or myself because these are active conversations in our own heads as well as with each other over the next few weeks.

All right. Those are some highlights of things going on. There are tons and tons of other things going on. I could probably talk for hours about that, but you don't want to hear from me all day. We want to hear from other people and hear from you.

Let me just take a few minutes to see if anybody has any questions at this point or things you've heard or things that happened yesterday or thoughts you want to share, anything. And remember, if you want to say anything, you have to punch the button here. Make it look red so people can hear you and say who you are and what organization you're from in order to comment.

So anybody got a comment at this point? Yes, Joe?

MR. JOSEPH A. GARCIA: Good morning, everyone. Joe Garcia from Ohkay Owingeh, New Mexico.

I think we're finding it harder and harder for many of us to deal with the number of committees that exist. And yesterday, one of our discussion points was there are all these organizations, a lot of other committees that are in the works, and each one may be doing substantial good work. But how do we work together

and know of all these other initiatives? It's sort of chaotic at times, and I think that we lose sight because someone, some committee may be doing something that may be contradictory or may be different than what we're doing.

And one of the points that we made a priority for us, the TTAC, I'm talking about, is how do we coordinate these efforts so that it's good for us to be here for one day. What we learn today and what we learned yesterday, we as advisory members have to go back to a larger crowd and try to get that information relayed back to, in our cases, the tribal leaders and the tribal entities that we represent. And so, the more in tune we are of how many other committees exist and what their roles are and their functions and all of that, the more -- the better we will be equipped to answer any question, but to relay it.

And I think that maybe a simple chart? I'm not seeing one, unless I haven't been to the right Web site, that lays out all of the different committees and how they tie back into not just SAMHSA, but how they tie back into the Health and Human Services Department. So we're all under that umbrella, and I think that the more we know about what other organizations are relevant to the effort, so much the better for all of us.

Thank you.

MS. PAMELA S. HYDE: Thanks, Joe.

Do you think that's just -- is that mainly in Indian Country, or is it about everything?

MR. JOSEPH A. GARCIA: It's a heavy effort for Indian Country, but if it's happening in Indian Country, I presume that it's also happening throughout the country for all of the services that are provided under the Health and Human Services Department.

MS. PAMELA S. HYDE: Okay. Thanks for that input and thought.

Yes, in the back. Pat?

MR. PATRICK A. RISSER: Yes, I applaud SAMHSA for all of your efforts to make sure that you hear and appreciate the voice of those of us with lived experience. And I would just urge you that in these difficult times to please continue those efforts to keep the voice of those of us with lived experience primary and not let discussions get hijacked by other issues that may not be related, such as gun control.

And in your national dialogues, please keep the voices of those of us with lived experience the primary focus and not other issues.

MS. PAMELA S. HYDE: Thanks, Pat.

We applaud you, and we're with you on that. We agree. Thanks.

Are there any other comments or things you'd like to have us in mind?

[No response.]

MS. PAMELA S. HYDE: Okay. I don't see other hands, and we've got just a couple of minutes. So I want to take just a few minutes to go around and have you all say your name slowly and maybe where you're from, a State, an organization, whatever you want to say. But just your name and that, and then which advisory council you are from. So people get a sense of who's in the room.

So, Michael, could we start over here with you?

MR. MICHAEL COUTY: Michael Couty from Missouri, and I'm with the CSAP Advisory Council.

MR. ARTHUR WILSON: Art Wilson from the Tucson area, Tohono O'odham Nation, and I sit on TTAC.

DR. INDIRA PAHARIA: Indira Palaria, Seattle, Washington, with CSAT.

MS. PAMELA S. HYDE: If you could say "prevention" or "treatment" rather than CSAP or CSAT, because it's hard to make that distinction, that would help us.

DR. YOLANDA B. BRISCOE: Yolanda Briscoe, Santa Fe, New Mexico. I'm with the Women's Services Advisory Committee, and I did come up with maybe one recommendation.

We did such wonderful work yesterday. I thought that we came up with some really good ideas and learned a lot. Maybe part of the meeting that when we all get together, a little synopsis or a little relaying of maybe the key points of what each committee came up with in our discussions might be helpful.

Thank you.

DR. VICTOR A. CAPOCCIA: Victor Capoccia with Westley or with treatment, and I'm from Boston. I'm semi-retired, and I work on projects like with NIATx.

MS. CASSANDRA PRICE: Good morning. I'm Cassandra Price. I'm the SSA from Georgia, and I'm with the National Advisory Council.

MS. ROSALIND WISEMAN: Rosalind Wiseman, new member to the women's advisory board, now from Boulder, Colorado. Native Washingtonian.

MR. JOSEPH A. GARCIA: Joe Garcia from Ohkay Owingeh, New Mexico. And I'm on the Tribal Technical Advisory Committee for SAMHSA.

DR. LORI SIMON: Lori Simon. I'm from the northern New Jersey/New York area, and I'm a new member on the substance abuse treatment council.

MS. DEE DAVIS ROTH: Dee Roth from Ohio, and I'm on National Advisory Council.

MR. MOHAMMAD YUNUS: Mohammad Yunus from Chicago. CSAT.

DR. MARLEEN WONG: Marleen Wong, Los Angeles, National Advisory Council.

MS. EUGENIA CONOLLY: Good morning. Eugenia Conolly, Anne Arundel County, Maryland. I'm with the prevention advisory council.

DR. WILLIAM R. MCFARLANE: William McFarlane, Center for Mental Health Services National Advisory Council, and from Portland, Maine, representing Maine Medical Center, Robert Wood Johnson Foundation, and Tufts University.

MR. JOHN PAUL MOLLOY: Paul Molloy, with Oxford House from Silver Spring, Maryland, and I'm on the Center for Substance Abuse Treatment National Advisory Council.

MR. CHARLES OLSON: Charlie Olson, the SAMHSA National Advisory Council.

MS. CHRISTINE WENDEL: Good morning. I'm Chris Wendel. I'm from Santa Fe, and I'm on the treatment.

DR. CAROLE WARSHAW: Carole Warshaw from Chicago National Center on Domestic Violence, Trauma, and Mental Health. I'm on the Advisory Committee on Women's Services.

MS. OMISADE ALI: Sade Ali, Philadelphia Department of Behavioral Health and Intellectual Disability Services with Dr. Clark on the treatment advisory committee.

MR. REX LEE JIM: I'm Rex Lee Jim, vice president of Navajo Nation. I'm on the Tribal Technical Advisory Committee.

MS. MEGAN GREGORY: Good morning. My name is Megan Gregory. I'm from Alaska, and I'm on the SAMHSA National Advisory Council.

DR. JEAN CAMPBELL: Jean Campbell, and I'm the Director of the Program in Consumer Studies and Training at the Missouri Institute of Mental Health, and I'm on the Advisory Committee for Women's Services.

And I just wanted to add to the comments a little bit earlier that when you take the strategy of breaking up into smaller groups or committees, there's a lot less transparency for the rest of us about what is going on. And I would concur with Pat about making sure that people with lived experiences are included.

It's more important that we make sure that people with lived experience are on those committees. Even though we have special groups that are convened to get their perspective, they need to be in the room at those small committees as the agendas and the discussions go on.

DR. STEPHANIE M. LE MELLE: Stephanie Le Melle, Co-Director of Public Psychiatry Education at Columbia University in New York, and I'm on the National Advisory Council.

MR. ANDY JOSEPH JR.: [Speaking native language.] Good morning. My name is Badger. I'm Andy Joseph Jr. I'm on the Tribal Council for the Colville Confederated Tribes in Washington State and I'm a member of the TTAC, Tribal Technical Advisory Council.

DR. LEIGHTON Y. HUEY: Good morning. Leighton Huey, University of Connecticut School of Medicine, treatment.

MR. CHRISTOPHER R. WILKINS: Good morning. I'm Chris Wilkins from Loyola Recovery Foundation in Rochester, New York, and a member of the SAMHSA National Advisory Council.

DR. MICHAEL COMPTON: Michael Compton, professor of psychiatry at the George Washington University in Washington, D.C. And I'm on CSAP, prevention.

DR. JEANNE MIRANDA: Jeanne Miranda, UCLA, on treatment.

MR. MICHAEL MONTGOMERY: Michael Montgomery from rural Maine on the prevention council.

MS. HARRIET C. FORMAN: Good morning. This is Harriet Forman from Santa Fe, New Mexico. I'm on the Advisory Committee for Women's Services.

DR. ROBERT M. FRIEDMAN: Hi, I'm Bob Friedman from Tampa, Florida, and I'm on the committee for Center for Mental Health Services.

DR. SHELLY F. GREENFIELD: Hi. I'm Shelly Greenfield from Boston, Massachusetts. I'm at McLean Hospital and Harvard Medical School, and I'm on the Advisory Committee for Women's Services.

MR. KWEISI RONALD HARRIS: Good morning. My name is Kweisi Ronald Harris, and I'm on the CSAP -- prevention -- National Advisory Council, from Chicago, Illinois.

MR. EMMITT W. HAYES JR.: Emmitt Hayes, Austin, Texas, Center for Substance Abuse Treatment.

MS. DIANE NARASAKI: Diane Narasaki, Executive Director of Asian Counseling and Referral Service from Seattle, with CMHS.

And I also have a recommendation regarding the strategic plan. I'd like to urge SAMHSA to be sure and include reduction of behavioral health care disparities as one of the prime initiatives. I know that cuts across most, if not all, of the areas. But I think there needs to be an initiative that focuses on that, particularly with the changing demographics of the country and with the severity of the disparities.

MR. MARCO E. JACOME: Good morning. Marco Jacome. Treatment provider from Healthcare Alternative Systems out of Chicago, Illinois. I'm part of the treatment advisory council.

MR. KEITH MASSAWAY: Keith Massaway, council member for the Sault Ste. Marie Tribe of Chippewa Indians in Michigan, and I'm a member of the TTAC, Technical Advisory Committee.

MS. ELIZABETH A. PATTULLO: Good morning. I'm Betsy Pattullo. I'm with Beacon Health Strategies, a managed behavioral health care company in Boston, Massachusetts, and a member of the National Advisory Council.

MS. JOHANNA BERGAN: Johanna Bergan, Director of Member Services at Youth MOVE National and a member of the Advisory Committee for Women's Services.

DR. JOHN CLAPP: John Clapp, San Diego State University, and I'm a member of the prevention advisory council.

MS. PATRICIA WHITEFOOT: [Speaking native language.] Good morning. I greet you in my Yakima name. My name is Patricia Whitefoot. I'm a member of

the Yakima Nation. I'm here with the prevention committee. I work with the Toppenish School District on the Yakima Indian Reservation.

I have a recommendation regarding again disparities, but I also want to take a look at evidence-based programs and best practices for communities of color. And also just want to highlight the fact that in our public school systems, we have a number of children that are failing and that I think that SAMHSA also needs to be taking a look at this with the Department of Education and those other Federal agencies that take a look at early childhood education from early childhood to higher education.

Thank you.

MR. PATRICK A. RISSER: I'm Pat Risser with CMHS Advisory Council, and I either belong to too many organizations or none. So I tell people I'm disorganized.

[Laughter.]

MR. L. JACE KILLSBACK: [Speaking native language.] I'm Jace Killsback. I'm a tribal council member for the Northern Cheyenne Tribe. Member of the Tribal Technical Advisory Committee.

And I do have a recommendation that refers to the national strategic plan that we encourage you to include tribes in that discussion, in that planning, of course, in the spirit of government-to-government relations and that you look at the Tribal Technical Advisory Committee for those recommendations.

MS. MARY ANN TAUFASAU TULAFONO: Good morning. Mary Tulafono, American Samoa, and I'm with the prevention council.

MS. PAMELA S. HYDE: It's hard to see back there. Did that get everybody? Great. Thank you.

All right. Well, we've got lots of new members. Could those of you who said you were new or are new, could you just raise your hands for a minute?

[Show of hands.]

MS. PAMELA S. HYDE: There was a lot of you that are new. So this is terrific. Those of you around them who have been here before, if you would just take a minute to introduce yourselves again and say hello because we want to make sure everybody is fully incorporated into the process.

So, thank you. We're really pleased to see you. We have several new tribal

members as well this time. So thank you for that.

All right. I did realize I overlooked making one announcement that we are very, very pleased about. We have literally been going through a process for over 2 years now, looking for a chief medical officer to join our team. That person has been selected. All the paperwork is signed, sealed, and delivered. So we can now announce it.

Her name is Ellie McCance-Katz. She comes to us from California. She will be joining us in June. She is a psychiatrist with significant mental health and substance abuse background and has been working in a variety of settings doing both research projects funded by NIH, as well as State-level leadership on medical and psychiatric and substance abuse issues in California.

So we're really pleased to have her join us in June. And once she does, we already have a ton of things on her plate to get ready to do. But next time we all meet, she should be here, and you'll be able to meet her as well.

This is going to -- we have psychiatrists around. We have medical professionals and internists and other people around in the organization. But they play a variety of different roles, and we sometimes honestly call on Wes to give us a little help every now and then on the medical front because he has that degree and capacity as well. But that's not really fair to him. He's got a lot going on on his plate.

So we're really pleased that Ellie is coming on soon, and we'll introduce you to her as soon as we get her onboard. She will be a great new capacity for us.

All right. I'm going to turn this over now to Kana. She's going to talk a fair amount about our current budget situation and issues. I don't know how much she's going to say about 2014. We'll probably deal with that a little bit more this afternoon, but know that the 2014 budget is a very strategic budget, and we will talk about that a little bit later.

But I'm going to step out for just a second to greet our next guest after this, but we're going to have budget now.

Agenda Item: Update on SAMHSA's Budget

MS. KANA ENOMOTO: Good morning. I realize, as I sit here, like a behavioral health nerd I am because I'm so excited. As you're going around introducing yourselves, I'm just like, wow, we have like the coolest people in this room, and I'm so lucky to sit here and get your advice. And I think SAMHSA is just privileged to have such a collection of incredible experts from around the

country, from all different walks of life, from different perspectives and different fields.

And it speaks to -- I also think it speaks to our commitment to diversity and making sure that we are informed in so many different aspects of behavioral health -- prevention, treatment, and recovery. So thank you all for being here, and I'm excited to talk to you also about our budget.

It is -- someone mentioned the chaos. Joe, you said you were feeling chaos with all the different committees. Well, you can imagine the chaos that we have been feeling. I'm going to talk to you about '13 and a little bit about '14. Unfortunately, I can't even give you a final number on our fiscal year '13 budget.

However, I can say that what we have today, both on '13 and '14, reflect a very firm commitment from the administration to reducing the impact of substance abuse and mental illnesses on America's communities. It has been incredible over the past year really to feel the support. Obviously, the push from our Administrator, but also all the way up from HHS to OMB to the White House directly, as well as from Congress, around our issues.

So what you'll see here is the culmination of several years of thoughtful work in the SAMHSA portfolio to prepare for the 62 million Americans who will have increased access to mental health and substance abuse services, thanks to the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, and the 11 million that we think will actually have a demonstrated need for our services.

And what you'll see in both '13 and '14 will reflect an increased and widespread awareness of the importance of behavioral health as it relates to overall health. So both in our response, in the Nation's response to Hurricane Sandy, as well as the President's initiative to reduce gun violence, improve -- increase safe schools, and improve access to mental health services. We have -- there is an increasing awareness across the administration and especially within the department, thanks to Administrator Hyde's great advocacy and leadership, of the important role that SAMHSA can play, both on a policy field as well as a services and financing.

[Pause.]

MS. KANA ENOMOTO: Okay. So, as you can see on the bar chart, SAMHSA has maintained approximately level funding since FY 2010, although you can see the first from the left -- first from the right bar, we have a dip, and that is the dip reflecting the sequester in FY '13.

So what our FY 2013 funding level includes is a continuing resolution off of 2012

enacted less a 0.00189 percent rescission, plus a 0.2 percent 2013 rescission, plus a 5 percent sequestration reduction. So the total of that is \$181.642 million in cuts. So \$186 million about from sequester in our direct budget authority and \$6.5 million in sequester cuts to the PHS evaluation funds. And the 0.2 percent rescission is about \$6.7 million coming out of our budget authority.

While the reason why we're unable to provide you a final number in 2013 is because there are other decisions that have yet to be made regarding the prevention fund and some other sources of funding available to the Secretary that where they're waiting, they're still trying to figure out final allocations to the operating divisions. So this, what you see in the blue and the red, you have the 3.173 in budget authority for 2013 and \$123 million in PHS evaluation funds. We don't yet know what we're going to see in prevention funds for 2013. We are likely to see a reduction there, and we may see some other sources of funding, including the appropriation, the emergency appropriation for the Sandy, the Hurricane Sandy response for SAMHSA will have some funding for services, crisis support, crisis services, treatment services, some medication-assisted treatment funding possibly for the affected areas.

So, again, this is our estimates are based on the original continuing resolution, and we are working with the department and OMB to finalize an operating plan. So the way it works under a continuing resolution rather than a final appropriation, the departments develop operating plans in which we have to shift money to show where we're going to put what. And then that goes through the department, through OMB to Congress for notification. So once the Hill has received our operating plan, we'll be able to share more information with you.

In terms of the impact of the sequester, obviously taking \$168 million suddenly out of your budget in the year of execution -- it's April already, fiscal year started in October -- can be somewhat challenging. So the way we are required to do it is pretty much across-the-board cuts. So it's sort of like a haircut. Everything gets cut by 5 percent.

We have four appropriations, as you know. Now we have two, three, possibly four sources of funding. So we had to take 5 percent reductions across the block grants and across our discretionary portfolios. We were able to make small shifts across lines in order to -- in an effort to protect continuation funding for grants. So we made every effort that we could to not have to discontinue or to reduce grant funding. I think we were successful in almost all cases on this.

We did have to make some reductions or eliminations to contracts, and we will be reducing our operating costs, our administrative costs. But we will not be doing that through any kind of furlough or reductions in force. So we're able to maintain our staffing level, but as Pam noted, we're doing less conferences. You may also see less travel, and we may be experiencing some other reductions on

the administrative front.

But I really thank our SAMHSA budget team as well as our center and office-level budget teams, who have worked very, very hard to try to do the least amount of harm when trying to take as drastic a cut as \$181 million in the middle of the fiscal year.

So the full impact of the sequestration will not be felt until the fiscal year has ended. What you'll likely see is where we thought we were going to do 20 grants, we're now doing 19 grants. Or where we thought we were going to have X number of the block grants had already -- some of the States had already received two quarters of funding. So they're going to see the reduction in their third and fourth quarter payments. So these we have operated under an assumption of level funding until now, and now we'll have to take all those reductions in the latter half of the year.

But now moving to '14, I think we have some articles to pass out about our '14 budget. One is the -- we were actually very excited to have our budget be seen as a piece of good news for 2014, and so, therefore, there was a little bit that got shared before the release of the President's budget about our mental health funding, and that was in the Washington Post blogs.

And okay. Okay. And the Secretary also posted a blog about the mental health piece, and it also got picked up by ABC News. So those are coming around to you. So these are some of the very positive response that we're getting for our investments in 2014.

Overall, SAMHSA is seeing a 3.5 percent increase over the 2012 level. Oh, God. That would be great. \$3.5 million, yes. It's modest. It is modest. But what it's not is a decrease, and that is the biggest news.

So what we've done in 2014 maintains more or less our 70/30 split between substance abuse and mental health. This is -- and it's been a historical distribution of SAMHSA's budget, which we have tried to maintain over the years. So it's 70/30, plus or minus. I think we're -- of course, obviously, there's some shift when we have the increased investment due to Now is the Time in mental health. But we have tried where we could to make those pieces available to folks with substance use disorders and are co-occurring, and the workforce piece is not limited to mental health.

And the way that we calculate. So we now have three appropriations -- mental health, substance abuse prevention, substance abuse treatment. Our health surveillance and program support budget is divided evenly across mental health and substance abuse, the way we calculate because you can't read this slide.

So, as you see, we have \$3.348 billion in budget authority. So we're staying relatively level on our BA with where we were at 2012. We have \$164 million and \$64.8 million in PHS evaluation funds, and \$58 million in prevention funds. Again, these are reflecting we have stayed true to the administration's priorities, even though these are tight and challenged economic times.

We have highlighted a commitment to States, tribes, and communities to reduce the impact of substance abuse and mental health -- of mental illnesses. And I believe what we have tried to do is take reductions in places where we see other opportunities for growth.

So, for example, there are some reductions in our SBIRT portfolio because this is, again, with the clinical preventive services being covered, based on the Affordable Care Act and SBIRT codes being available to States, we see opportunities for those services to be picked up in other ways and in other places where we have worked very hard over the past few years to increase third-party billing for certain services and supports. We're hoping that reductions in our discretionary portfolio in those areas can then be leveraged into new areas where we need to advance change and stimulate innovation at the State level.

DR. VICTOR A. CAPOCCIA: Kana, can you just quickly describe the difference between budget authority of PHS and prevention funds? I'm not sure what those categories are.

MS. KANA ENOMOTO: Sure. So the budget authority -- oh, sorry. The budget authority is the direct appropriation across SAMHSA's four appropriations. PHS evaluation is actually a tap that comes across the department. So we are both a giver and a recipient of PHS. Those are Public Health Service evaluation funds. And so, the President requests and the Congress approved a level of tap that the Secretary then taps across certain parts of the HHS portfolio. Those go into a central PHS evaluation fund, and those get reallocated for the purpose of data collection and evaluation, technical assistance activities.

So SAMHSA's programs are tapped for PHS evaluation, but then we also receive it back. It comprises a large part of the block grant set-asides and a large part of our health surveillance and program support budget.

And then the prevention funds obviously were authorized under the Affordable Care Act, and those are also allocated at the Secretary's discretion, together with -- in decision with the Congress.

So there had been -- so the blue part, I mean, I think the Administrator has noted a number of times before that's the big blue bar is our BA, and that part of our budget is shrinking. And as that part goes down, that means that these other sort of perhaps less certain sources of funding play a bigger and bigger role in

our budget. So we have to be more fluid and agile.

We cannot be more fluid and agile than we have been this year, I tell you. We're still being fluid and agile. We were almost in tears.

I think the beginning of April, as you still know, we do not have closure on our FY '13 budget. The President's FY '14 budget had not yet been released, and we hadn't even gone to print yet on our FY '14 budget. And in talking to our staff, I realized the FY '15 first draft of the budget is likely to be due around June 1st. Therefore, we need to be making our decisions around that in the month of April and May.

So we had actually three budget years in play at the same time, with a great deal of ambiguity. But moving forward nevertheless. So it's been very challenging at our level. So it is a great intellectual exercise as well as a budgeting exercise for us.

[Pause.]

MS. KANA ENOMOTO: And actually, for those of you who are able to stay, at 5:30 p.m., the Administrator will go into more depth about the FY '14 budget proposals. I just wanted to highlight one piece of this before then, for those of you who aren't able to stay, and that is the Now is the Time set of proposals to support the President's initiative to reduce gun violence and increase access to mental health services.

We're very excited about this effort. \$130 million is being proposed for SAMHSA. And there are four major pieces that are directly relevant to us. One of them is nonbudgetary, and you'll learn more about that in the next session of this meeting.

But for the budgetary pieces, we have \$55 million for Project AWARE. Project AWARE itself has two parts. One piece is a State program that will go to State education authorities in partnership with Departments of Mental Health and Substance Abuse and Departments of Justice or Corrections in the State level, and that will be coupled with mental health first aid funding.

So that we are going to ask States to build on the great success of our Safe Schools/Healthy Students program, which has shown excellent outcomes over the past dozen or so years to improve school safety, to reduce substance abuse, improve resilience, and then help children who have a need for behavioral health services to access them. And then -- and facilitating that with a program to increase mental health literacy.

The Department of Education funding that would be braided with that would be --

would focus on asking schools to -- or asking States to adopt statewide multi-tiered behavioral framework, such as PBIS, positive behavioral interventions in schools, so that schools have a data-driven way to make decisions about what kind of interventions would work best for their student populations. And we would be pairing that with our Safe Schools model, which builds school/family/student/community partnerships to make sure that all the systems that need to be working with our young people are working together.

And then the criminal justice funding, and someone had talked about we are failing too many of our students. The folks at Justice agree with that, and they want to see solutions, not suspension. They feel that if we can better identify mental health and substance abuse problems that we can train law enforcement to recognize those problems and find better solutions, help youth get to the services and supports they need to support one another, then we can keep kids in school and not have them suspended or enter into the criminal justice system.

So we've been -- so our piece of that is \$55 million. It will also involve partnering with Ed and Justice at the local level with grants to local education authorities, again to increase mental health literacy, to partner schools/communities/law enforcement, and to introduce PBIS and multi-tiered behavioral framework type of models.

We also recognize that that is on the sort of promotion, prevention, detection, or early intervention side of things. We also recognized as we were thinking about the Now is the Time proposals and the response to Sandy Hook that there is an age group, 16- to 25-year-olds, called youth in transition, emerging adults, where we know that that's a population that's at high risk for problems like binge drinking and the onset of certain serious mental illnesses. And it's also a population that's at risk for not getting treatment when they need. It's also high rates of suicidality.

So the Healthy Transitions program is to incentivize States to adopt innovative models for meeting the needs of that youth in transition age cohort and their families. There will be an emphasis on peer at the youth level as well as the family level supports because we believe that folks need that kind of support and information to realize that it's okay to seek services, how those services might work, and how those services might work better to meet the needs of youth and families.

We also recognize that there are innovative models coming out of the research that say that we can work to address certain problems earlier and better and, therefore, create a better trajectory for our young people's lives.

Finally, for the budget pieces, there is \$50 million for behavioral health workforce, which will help train 5,000 additional professionals to work with

students and young adults with mental illness and other behavioral health problems. Thirty-five million of those dollars will be a partnership between SAMHSA and HRSA. So the money will come to SAMHSA, and HRSA will administer it through their mental and behavioral health education and training program where they will train up to 3,000 master's level professionals as well as paraprofessionals, including community health workers.

Then 10 million of those dollars will stay at SAMHSA for a peer professionals program, which will look across the spectrum of prevention, treatment, and recovery as well as mental health and substance abuse to train peers, people with lived experience, including young people and adults, to work in behavioral health. We hope to partner with community colleges and States to create career ladders for folks in a much-needed area.

And finally, we will be expanding or even doubling the Minority Fellowship Program. This piece, the Minority Fellowship Program already invests in doctoral-level student training. This piece will focus on master's level training for psychologists, counselors, MFTs, and nurses. Again, to make sure that we have folks who are familiar with the treatment needs of communities of color and folks who want to focus on working with young people.

Finally, and the piece that is nonbudgetary but is consuming quite a bit of our time and energy and has a big space in our hearts is the national dialogue, which the President asked Secretary Duncan and Secretary Sebelius to convene. The national dialogue panel will talk to you more about it later, but it is an important part of the Now is the Time proposal and, I think, going to set the stage for many of these other activities.

Next slide. And finally, Victor, here is a little bit of a breakout of the prevention and public health funds. So the FY 2014 request on this, this is broken out for you. It is at \$58 million, a decrease of \$34 million from our FY 2012 funding levels.

And what you see here is -- and this doesn't have -- oh. No, '14 is finished. '13 is not. So this actually is only -- well, this is -- well, it tells you that we had \$92 million in FY '12. It also tells you that it's not finished for '13.

But, and I won't try to guess from my memory where we are. I know where some of these are, but I don't know where all of them are on the top of my head. But we will be seeing a reduction on a number of these lines where, again, we think that we can take advantage of other funding opportunities through the Affordable Care Act to bill for services and other supports.

So, with that, I will open it up for questions or discussion about the '13 or '14 budgets. Again, I hope many of you who are more interested in detail will stay

for the '14 conversation.

DR. LORI SIMON: This is Lori Simon. With regard to health information technology, that technology both certainly is a part of many of your programs, but it also transcends the programs in certain areas. I was wondering how you viewed the funding for that particular technology?

MS. KANA ENOMOTO: I think one testament to our commitment to health information technology is that in the '14 budget, we actually have it pulled out as a line within the block grant set-aside budget. So that is for the first time that we have done that.

Andy?

MR. ANDY JOSEPH JR.: [Speaking native language.] My name is Badger. I'm Andy Joseph. I also serve on a local school board at home and on the Colville Reservation, there are nine schools that are impacted by this sequestration also. And I imagine they're probably similar to all the rest of the schools that are funded by Impact Aid. Impact Aid is the same funding that funds our active service members' children that are in the military.

Because we live on a reservation and there's no -- we're similar because there's no -- they don't tax us for the land that was given to us by the -- I guess our treaty rights and our executive orders. But anyway, the federally impacted schools like my school, with the No Child Left Behind, it was never funded. And over the years, we've hardly ever been ever really fully funded. Under this administration, we was making some pretty good ground, but we've had to make a lot of cuts.

And just a couple weeks ago at our board meeting, we were trying to set our priorities on the budget, and we had -- you know, the union protects the employees. So the younger people that are trained to teach to the State standards are usually the ones that get let go of first.

We had actual people that were staff that weren't licensed nurses, providing care for some of our people. So we had to actually decide to let some of our teachers go so that we could actually hire a nurse to do that part of giving the medicine and stuff and also -- excuse me, to also to fund a counselor for the school.

And I'm really glad that we're looking at making schools safe. When you've got communities that are -- that there is this problem with methamphetamines that hit the whole U.S., well, they impact our areas as well. Now we have children that have -- that are in the school age that are children of mothers that use these types of drugs, and the children are really something to deal with for the teachers, for the classroom aides, and the need for more mental health

treatment is something really serious that needs to be put in our schools.

I would really think that if we're going to fund things that we look at our school age children to do more prevention so that they break that cycle. That's all I have to say.

Thank you.

MS. KANA ENOMOTO: One program that may be of interest to you that is also included in the 2014 budget for Department of Education is a program to address pervasive trauma in communities for kids within schools. So that that will be available for schools to look at community-wide interventions where there is a great deal of violence or trauma that's making learning challenging for students.

MS. CASSANDRA PRICE: Hi. This is Cassandra Price. I'm trying to think of the politically correct way to ask this question.

So dealing with the complexities of your budget, Kana, that you mentioned and your prevention portfolio and how you're predicting a cost shift, there are some States that have been a little bit slow to adopt healthcare reform. And so, how do you guys envision managing that issue when there is a cost shift, especially SBIRT specifically. Even without expansion, our Medicaid authority is not willing to expand or open up any new opportunities in the State plan.

So it kind of leaves us in a rock and a hard place. I just wanted to just comment on that. That makes it hard from a national perspective of maintaining services.

MS. KANA ENOMOTO: I think even before the Affordable Care Act, there was work that we could have been doing and have started to do about enhancing the ability of providers to do third-party billing. So even before the ACA, there were some providers who could bill, and there were some providers who weren't billing. And we need to work on that capacity for those services that are billable, regardless of whether you're expanding Medicaid or adopting a State exchange or a Federal exchange.

So I think that's how I would describe that. There are obviously opportunities that are afforded by the ACA, but there is some kind of remedial work that we needed to be doing anyway.

MS. PAMELA S. HYDE: SBIRT is a great example of you can either have the code called SBIRT, and you can bill it. That's the easiest, but it's not the only way to bill for SBIRT activities. So that's part of the helping providers be more aware of or creative or able to bill appropriately for services.

We've got lots of hands up, and we're already past time. So let's take a few of them and then we'll go on. I'm going to take people who haven't spoken yet. Patricia?

MS. PATRICIA WHITEFOOT: Thank you very much.

This is in response to part of the question that I asked, a recommendation that I made earlier. I work in a public school district, and I'm one of those union individuals as well, being a teacher.

But I just want to ask when will these funds be available is one question. And is there dialogue occurring currently with the schools and community-based perspectives similar to that of drug-free communities? I think that whole partnership model is important to make certain that we get diverse voices on these funding sources and that I would strongly recommend or require that SAMHSA, in its grant solicitation, require American Indians/Alaska Natives engagement in the entire grant application.

And the reason that I say that is over in the Department of Education, we have the White House initiative on American Indian and Alaska Native education. And under the No Child Left Behind, currently under all of its titles, there has been a strong push by tribes to include tribes even in the dialogue with State government. And unfortunately, what happens with State government, tribes, American Indian, and Alaska Natives are overlooked.

And so, as this grant solicitation goes forward, I would strongly recommend that tribes be engaged in the entire process similar to what you do with the drug-free communities under the Office of National Drug Control Policy. That's my recommendation and questions that I have regarding those funds.

And again, that goes from preschool to higher education. Currently, we're working with the University of Washington Indigenous Wellness Research Group, and we are doing a lot of work, but we're always having to go through the back door to be able to have even access to these types of resources. And one size does not fit all. The State government model does not fit all of our needs.

MS. PAMELA S. HYDE: Thanks for the feedback.

Let me be very clear. This is a proposal. Congress has to act. We can't do anything. These are great proposals. They are great programs. They are proposed by the President in his 2014 budget. But Congress has to act or it's not there, pure and simple. It's just not there.

So the discussion about what we put in the RFA is not even relevant unless Congress acts. So underscore Congress has to act. Okay?

MS. PATRICIA WHITEFOOT: I understand that.

MS. PAMELA S. HYDE: All right. Thank you.

MS. PATRICIA WHITEFOOT: I just want to say it right up front right now before Congress acts because --

MS. PAMELA S. HYDE: Yes, I know.

MS. PATRICIA WHITEFOOT: -- we're going to be advocating for it.

MS. PAMELA S. HYDE: Yes. Good for you. That's the words I was looking for. All right, thanks, Patricia.

Next, yes?

MS. JOHANNA BERGAN: In the President's response to Sandy -- oh, excuse me. This is Johanna Bergan, Advisory Committee for Women's Services.

In the President's response to Sandy Hook, specifically was listed mental health first aid for educators in our schools. Is there -- is part of this conversation mental health first aid for young people? And I'd like to encourage that to be part of a conversation to strengthen that organic peer support that can be encouraged to exist within the schools.

MS. KANA ENOMOTO: It absolutely is in the mandate. I think it's the sound bite that gets picked up is mental health first aid for teachers. But the way we have described it is that it is mental health first aid youth, which is a different model than the adult model, and that it would be for teachers, families, youth, and other adults who work with kids. So coaches, folks, you know, law enforcement, parole officers, everyone who's around in the system, faith groups.

But absolutely throughout most of the stuff we've proposed involves a strong peer support component, both at the youth level and for parents.

MS. PAMELA S. HYDE: Okay. One more question I'll take here. Yes? Rex Lee Jim?

MR. REX LEE JIM: Thank you. I'm Rex Lee Jim, vice president of Navajo Nation, sitting on TTAC.

Yesterday in our meeting, we talked about our priorities, and one of that is access to funding. And we also talk about direct funding to tribes. And looking at the proposed \$235 million new money and after Congress acts, how do you

plan to make this accessible to tribal organizations and nations?

MS. PAMELA S. HYDE: I want to say one comment, and then Kana might want to follow up. Unfortunately, and you may recall you came into this role, in both of the Secretary's TAC as well as ours, sort of half way through the prior 2 years where for 2 years, we proposed to Congress that there be direct funding to tribes for prevention and suicide prevention and substance abuse prevention specifically.

It would not have gone through States. It would have gone straight to tribes, any tribe who wanted it, totally open. We were willing to do that. We couldn't get anybody to pay a whole lot of attention to it, other than the President and the Secretary and myself.

We were running around talking about it. We had a few letters from a few tribal organizations saying, yes, this would be a good idea. We had a couple of Senators and congresspeople, Senator Udall of New Mexico and others, who signed on. Some of the Alaska legislators and others who sign on to wanting to support it. We just couldn't get anybody willing to fund it.

So this is why I underscore Congress has to act. We proposed something for 2 years that would have done exactly what you have always told us you want, and we couldn't get any movement on it. So, unfortunately, those proposals are no longer in the budget because there was not enough interest generated from stakeholders and others to get movement on that.

For the proposals that are in the budget, do you want to comment on that? I mean, normally, when say States, we make that available to tribes as well. So we don't probably have all the answers to that because some of it is blended with or braided with the way that Ed is going to do it. But we will take that as a proposal and see what we need to do about that as these come out.

So thank you for that.

I think both you and Patricia Whitefoot have both made that comment. So, thanks.

All right. All right, one more, and then we need to move on.

MR. CHARLES OLSON: This is Charlie Olson, National Advisory.

A quick question. Once the or if the proposed budget is approved, are you able to add additional things afterwards?

For example, the mental health first aid, there's a lot of programs that would be

really supplemental to that. For example, the emotional CPR. Are you able to add programs to that or not?

MS. KANA ENOMOTO: It would depend how the final appropriation comes across. It may not -- you know, I think we are not able to add more money to what Congress gives us. Whether or not they will appropriate it in a way that leaves it open to multiple models, I don't know.

MS. PAMELA S. HYDE: Okay. I've got two hands over here. We didn't realize we'd have so many questions about budget. I apologize. So, Joe, go ahead.

MR. JOSEPH A. GARCIA: Joe Garcia from Ohkay Owingeh.

Realizing that this is a new budget plan, in the Project AWARE, it's important for SAMHSA to know, to be aware that about 65 percent of our Indian students across the country attend public school. So they may be included if the project is funded.

However, the other 35 percent attend Bureau of Indian Education schools either run by the bureau or run by the tribes, called tribal controlled, and so we want to be ensured that those funds are also available, grants are available for those students and not let it be an afterthought or exclusion, if you will.

Thank you.

MS. KANA ENOMOTO: The other day we had an interesting conversation with folks from DoD who raised a similar -- expressed a similar concern that about 75 percent of military family kids go to school off the installation, but then there are those who are on installation schools. And how do we make sure that we can get these models to all those kids?

And I think we need to have further conversation probably with BIA and DoD because we have these models and we have technical assistance resources. And regardless of where these grants go or if we get these grants, there's certainly work that we can be doing between now and then to get these evidence-based models to try to help them reach kids at the BIA schools and the DoD schools.

MS. PAMELA S. HYDE: Rosalind, did you have your hand up? Okay.

All right. Thank you. This was great. We'll move on.

I think Kana mentioned in the budget discussion about the fact that we -- these budget proposals are part of a larger effort that came out in the President's Now is the Time plan back in January. One of the things, as she mentioned, and we

did have a call about it. So, hopefully, most of you are kind of up on it, this concept of a national dialogue on mental health, which we hope to have launched soon.

Part of that, and we had hoped we were further along with it, but we're not quite yet. So we can't share a paper with you. But we have a toolkit that we are working on that will be available when it's launched for communities to use in community conversations around mental health. We have some mayors and folks we are working with on national dialogue to try to do some structured community conversations.

And what we wanted to do today is introduce you to that concept and the people working on that. And with us today is Carolyn Lukensmeyer, who is the Executive Director of the National Institute on Civil Discourse. Carolyn has a long history. Her bio is in your folder so I'm not going to go through it. But she has a long history of working in and around government at all kinds of levels and also doing years' worth of work at how to bring communities together to talk about difficult issues and to talk about issues that may have controversy.

Now those of us who sit in the behavioral health world, we have a tendency to think, well, here's what people are going to think, and we just need to get them to talk about how to get services organized differently. I think you're seeing from the headlines, not so. There are a lot of people who want to talk about the fact that psychiatric medications are what caused the problem, not are something that should be used to assist the problem.

There are people who think that children shouldn't be identified as in need of mental health, as well as those people who think we do need to identify those kids who need that help and get it for them. There are people who think that the best way to deal with this is to lock all those children up and lock those adults up and get them out of the schools and out of the communities and provide forced treatment.

So there are a lot of different views about these issues, and those kinds of views are important to have recognized and dealt with. Otherwise, they will bubble up and become the conversation. So part of what we're trying to do is recognize that in many communities they have different views of different needs, and Carolyn and her colleagues around the country in what we call the Deliberative Democracy world are used to bringing very tough issues to communities and helping them work through those issues and come to some resolution.

So we're going to let Carolyn introduce this topic to you in a way that she feels best and, hopefully, get you all engaged in conversation that will give you just a little flavor of what may happen as we launch this process. So, Carolyn Lukensmeyer, thank you for being with us.

Agenda Item: Small Group Discussions: National Dialogue

DR. CAROLYN J. LUKENSMEYER: Thank you, Pam. It's a pleasure to be here.

I would like to -- in the time we have, I'd like to do two things with you, primarily. To fill out a little bit more the concept of the community conversations as part of the national dialogue on mental health, and then, as Pam said, actually do some discussions here that will be similar to what the public is going to do. But given who you all are and the networks who you represent, our group that is really leading the Deliberative Democracy part of the conversations feel quite confident that by the discussions that I'm going to ask you to participate in, it will further increase our ability to target exactly the right kinds of questions in the communities.

So, if you will, these conversations have as much value for how this will actually roll out a little bit later -- hopefully not too much later -- and hopefully it will be some value to you, too. But I'll spend about the first 10, 12 minutes just again giving you the parameters of how the community conversations are going to work. Have a couple of minutes for you to ask questions about that, and then we're actually going to do some discussions.

So when Pam Hyde and Secretary Sebelius approached the Deliberative Democracy community, they gave us a very clear sense of what they wanted to accomplish. That they wanted these community conversations to be really owned by the cities in which they occur, but they wanted them connected to the overall approach that is coming out of Now is the Time.

So the conversations in each of the cities have two goals -- awareness and education, which will be a good block of time in the work that the community does, and then for the community itself to develop an actual community action plan that a coalition of organizations in that community are committed to implementing. I'm sure many of you have had this experience many times across your career where some catalyzing event, a tragic one or not tragic one, but in this case, the tragedy of Newtown has lifted the Nation's consciousness on an issue, and there's lots of dialogue. There's lots of talk for a period of time.

Frankly, if I take the institute that I now lead, the University of Arizona created the National Institute for Civil Discourse 10 days after Gabby Giffords was shot and 6 people died in Tucson. All of you have had relations with universities. Universities never do anything in 10 days. So it was that catalyzing moment that

actually created the capacity for an institutional response.

But you will remember the same thing that I remember. Yes, there was a bit of a shift in civility inside Congress for a few weeks after Gabby was shot. There was a shift in the rhetoric in national ideologically based media for a few weeks after Gabby Giffords was shot. But then it became just another one of the mass shootings.

I literally feel a bit of a chill as I'm speaking to you. I think every American really has a sense of commitment to not letting Newtown fade away in the way that Tucson, Virginia Tech, et cetera. And that's the reason the community conversations are going to be so committed to creating the coalition in the community that even before the public comes together said, yes, we really want to do something to ensure that the community action plan is implemented over the next 2 years.

Okay. So two goals. Do something about -- I started my own career a lot in the mental health area, and I can say now at age 67 it is stunning to me that the attitudes in the country, the kind of stigma that still exists is one of the major barriers, particularly of why young people don't come forward to their family, to their friends, to the people that could help them when they have the first symptoms of an emotional disturbance or a mental health disturbance or a substance abuse issue.

So I don't know exactly what it is about our culture that we can't quite get mental health out of the shadows, but that I think is the primary first desire in terms of awareness and education. How can we in our community -- we can't take this on nationwide in our community. But what are the clear signals in our community that the myths about mental illness, the misinformation about mental illness, and therefore, the desire to hold it close to home is still the dominant ethos?

Okay. The steering committee that has been partnered with SAMHSA and HHS and the White House to pull this off exists of the six organizations that you see listed there. Our names and titles are not that important, but they are leaders.

Many of you have probably never even heard of the term "deliberative democracy." But it has been building over the last 20 years where there are places where we want Jeffersonian democracy to come alive in terms of "of the people, by the people, for the people." Where real people sit together across their differences and have spirited conversations -- that's what civil discourse is -- and yet comes out with a solution that is inclusive and moving forward as possible.

So these are the organizations -- AmericaSpeaks, the Deliberative Democracy Consortium, the Everyday Democracy, the Kettering Foundation, our institute,

and National Issues Forums. These organizations have worked all over the country. Several of them worked in many other countries. They have a track record of doing what the administration wants to accomplish.

Now, again, this initiative hasn't been launched by the White House, and I'm sharing this with you just so you can walk out of here with a concrete idea. But at this moment in time, this is not firm. This is not to be talked about other places, but to give you the idea.

If we're going to accomplish this, we need to, and it's almost impossible to cover the country in 10 cities, but we want to try to cover it culturally, geographically, politically. So these are sample cities where we're beginning to talk with the mayors, where there's clear potential interest.

If you start on the east coast, it's Washington, D.C.; Akron, Ohio; the western area of Kentucky; Birmingham, Alabama; Albuquerque; Missoula, Montana; Sacramento, California. Dialogue is in process with the mayors and other relative local leaders who would form this coalition in these kinds of communities.

As soon as this is launched nationally, what the 10 cities are or at least the ones that are ready to go will be announced, and you exactly are the kinds of leaders in your communities that should be watching for "Are we one of these communities?" There's a second layer, and Pam already said this, but I want to emphasize it.

Once this toolkit comes out, which is an information brief on critical facts that should help this education process, an actual discussion guide, and an organizing guide, our goal is for many other communities and organization or a partnership of organizations to take the leadership to initiate this on their own. They won't -- excuse me. It won't have quite the standards that we're setting for demographically representative in the 300-person meetings in the 10 cities, but it will be a way to have this conversation roll across the country.

I'm going to skip forward. Already these are organizations that have signed on to be our partners. You know many of them. Think about 4-H. They do fantastic leadership development for young people. There are clubs in practically every county in the United States. So they're an organization that can take this forward.

The YWCA has been moving itself into being a neutral convening organization in communities. I'll give you an example that I know is going to happen. The CEO of the Y in El Paso, Texas, is just passionate about this and particularly dealing with the violence across ethnic groups in El Paso.

They have already committed to come as close to doing in El Paso as what we're

doing in the 10 cities. So one of the things you might think about, does your organization or your network want to become one of these national partners?

I want to back up to the slide before this, if I understood how to do that. I should just be able to right click and go back, right? Would you take me back one slide?

So to give you a quick introduction to the key elements of how these community conversations will be designed. First of all, one of the problems in many of our contentious issues in the United States is people get into a discussion, their opinion is based on nonfact, and no facts are put into the discussion. So they continue to have the argument on "my facts" and "your facts." The information brief, the discussion guide will take care of that.

Trained neutral facilitators. I think in some ways it's sad, but you all know on contentious issues if there's not somebody holding the neutrality in the space and not somebody dealing with the extroversion/introversion styles of participation, what you end up with is a small number of people dominating a conversation. So we will be supplying the trained facilitators, and we will help supply those trained facilitators in any city beyond the 10 that really wants to do this.

Diverse participation. We've set an extraordinary standard. Let me just take Washington, D.C., is my home. In Washington, D.C., we hope to have 400 people. It will match the census in terms of age, gender, ethnicity, geography, with an oversampling for young people and ensuring that people whose lives are deeply enmeshed in mental health issues -- practitioners, family members, people with diagnosis who are high functioning.

The other goal is we don't just want this to be talk. We want these communities to actually discover, to develop the shared priorities that would then be embedded in the community action plan. So by the time the community engagement is finished, you've got a set of leaders of organizations who are sitting with these are the four things that this whole city is committed to having happen here in the next 2 years.

Sustaining community engagement. I know you've all seen this, where you do a good job of bringing the public together, a smaller group, sometimes it's just the government by itself, then it's taken away to do action, and the public never hears about it again. So one of the things we're setting up with these steering groups is that they have a cycle of information back to the whole community where the people who've been engaged get updated and a chance to react.

Okay. Let me stop there and for just a few minutes. We don't have a lot of time. But for a few minutes, I've kind of given you the overview of what we plan to do in these 10 cities with the ability for it to be replicated at some level in many other

cities. So I'm going to take a few questions, but I really want us to get to the discussion.

I saw the gentleman in the back first. If you'd please introduce yourself, and then I'll just move around.

MR. PATRICK A. RISSER: I'm Pat Risser from Ohio, and I'm on the CMHS Advisory Council.

And I got to tell you, I'm really alarmed and upset by a lot of what I've heard you say. First of all, the title on your first slide "creating community solutions." I hope you understand that mental health is not just a topic, but it's also a people. And if we were talking about solutions for women or people of color, you might understand that I would be equally alarmed that it sounds like we're talking about, you know, euthanasia or other kinds of things.

I mean, we are not a problem for which the community needs a solution. We are people who struggle with issues like any other people. And you already did something by linking Gabby Giffords and the shooting to our population, our people.

And mental health, we are a people who've been oppressed. We've suffered prejudice, discrimination, stigma, and I'm not hearing our voice being the primary voice in these dialogues to make sure that the education that happens is -- to me, it almost sounds like you're going to create an educational panel about women's issues, but you're going to have a panel of all middle-aged white men, and I really need you to hear that our voice needs to be up front and primary.

You don't talk about high functioning. That's such an offensive term within my community. And you know, you need to know the language. You need to know the people, and please don't talk about us as if we're something that needs to have a solution. We're not the problem.

DR. CAROLYN J. LUKENSMEYER: I want to say that, first of all, I really learned something important about language, which will be -- I will respond to immediately. I really am surprised about the response about creating community solutions, and maybe I just tried to do this too quickly. But we actually focus grouped with people in a couple of cities, and people who are in the mental health community-- I said this -- professionals, family members, and people with diagnoses.

And of the options that we were thinking of, that's the one they liked best because it didn't have any of the sense for them that they were being objectified. They felt like they were going to be part of the process. I didn't use the exact numbers, but 50 percent of the people at each of these meetings are going to be

exactly the community that you spoke about. But the point who needs the education are the rest of the community who are not part of your community. So that's the point of mixing those two.

I will go back to the Gabby Giffords, and this has been -- each of the mayors we're talking to have been very clear about this. I shared that only to say, and I could have spent more time with Newtown, it is the fact that that happened that has opened the possibility of a new discussion. But by full intention, this conversation is not going to be about gun control. This conversation is going to be literally what does our community need to do to more effectively support young people who are the most vulnerable to not having the kinds of support and services they need to transition to adulthood?

So I apologize for trying to do this too quickly, but frankly, the concerns that you mentioned have been deeply built into the design of this. And it --

MR. PAOLO DEL VECCHIO: Carolyn, can I just add to that, if I can?

DR. CAROLYN J. LUKENSMEYER: Please.

MR. PAOLO DEL VECCHIO: Two things, Pat, and thank you, first of all, for raising the issue.

Two things. One, certainly in all the materials that we're developing, we're certainly encouraging and strongly supporting the inclusion of people with lived experiences as helping to convene and fully participating in all these dialogues.

The second aspect I'd raise is I think those of us who've been in recovery and are in recovery, we know there are many problems that we experience. And yes, there's a need for solutions, huge need for solutions, and that's really what the purpose of these dialogues are. It's about how we can try to identify how the issues that we face as a people, Pat, can better be a solution.

You presented yesterday about the need for all aspects of a community to get together to help with prevention and help people develop as you really articulately put it, develop those human contacts and relationships to help people build resiliency and recovery. And that's what these dialogues are really largely about.

MR. JOHN PAUL MOLLOY: Yes, I'm Paul Molloy.

MS. PAMELA S. HYDE: Let me just remind you that, while he's starting, the reason we force you, literally force you, to use the mikes is there are people listening all over the country. So you need to be able to talk into the mike so they can hear. So that's why we really push you to do that.

So go ahead, Paul.

MR. JOHN PAUL MOLLOY: My name is Paul Molloy with Oxford House.

For the last 20 years, we've been going around the country into city after city and getting dialogues going, mostly because neighbors and communities would say we do not want an Oxford House in our backyard. I've taken people on in large groups, as our people have, in city after city, 482 of them at my last count. And we have reached those who most needed to be reached, the people who objected to recovering alcoholics and drug addicts living in their neighborhood.

And academically, the notion of having civilized discussion in a democracy is a wonderful idea, and I would love to teach it in a seminar. As a practical matter, it's a cosmetic cover for not dealing with a problem. And the better approach, and I'm very sympathetic to what Pat said, and I don't know Pat until I came here. But a better approach would be to challenge individuals in communities across the country to roll up their sleeves and begin solving problems that can be best solved by individuals.

I mean, I mentioned yesterday in the smaller group I have the disadvantage of having come from a little town, Arlington, Vermont, where Normal Rockwell lived and was brought up. And I believed all those pictures that were on the Saturday Evening Post. And I helped collect the tin foil that we put in big balls during World War II and the victory gardens and all that kind of stuff.

But the one thing that permeated the population then was that we could solve any problem that needed solving, and we should do it as a community. So there's a lot of stuff that's happening out there unrelated to government, although some of it's related because universities like DePaul get Federal grants to study us in a test tube. But they come up with a notion of communities, and so much more can be built around communities.

I worry a whole lot about stage managing discussions. And I love Bill Moyers, who I can see is a wonderful person and a facilitator for this sort of thing, or Charlie Rose. But God help us, Bill Moyers and Charlie Rose, although they've done a lot in the world, have not solved these problems affected with folks who have mental illness or who have substance abuse or who need to have the community understand what it takes to be changing, transforming from being a drunk that wants to kill your wife all the time to becoming a fairly responsible individual.

So I do worry. I share Pat's worry. I don't have any great solution.

DR. CAROLYN J. LUKENSMEYER: Well, I do think your final phrase around an

understanding that this only going to get solved in community and by individuals in communities actually coming together to do that, it is the essence of the design. And I'm going to take just a minute to give an example in a completely different arena to just show you that there actually is a track record of this kind of bringing together the people who have the biggest difficulties about it and have different views.

AmericaSpeaks, one of these organizations, did debt and deficit with 3,500 people in 2010. And it was Tea Party people and Moveon.org people. You couldn't be any more polarized in this country on those issues than no new taxes and don't touch Social Security. Well, those 3,500 people, when they saw the facts and when they were seated together, despite the fact of how profoundly differently they started out, they actually solved the problem. They cut \$1.2 trillion from the deficit by 2025.

And in the morning -- MacArthur happened to be who funded the research about this. In the morning, all the conservatives said, "I won't cut taxes. I will raise taxes." And all the liberals said, "I won't cut Social Security." But by the end of the day, they got it that there's no solution that doesn't do both.

So I just want to say that your notion that a civilized discussion can't be created, we can do that. We can give people enough support that they can talk about why I don't want someone with a mental illness to live in my neighborhood, and what can we do in our community to ensure that everybody in this community has access to housing and services?

MR. JOHN PAUL MOLLOY: Just let me make one remark.

DR. CAROLYN J. LUKENSMEYER I: Okay.

MS. PAMELA S. HYDE: Paul, can you use your --

MR. JOHN PAUL MOLLOY: Yes. A civilized discussion can be achieved, you know, at 92nd Street Y, Arlington Vermont, and lots of other places. The fact of the matter is that leadership doesn't require these kinds of exercises to bring people together. But it does require that people understand there are problems that can be solved and must be solved and that those individuals have a responsibility to solve some of those problems.

I mentioned yesterday, this is the 50th anniversary of President Kennedy's signing the comprehensive mental health act in 1963. We honestly thought then that every little town and every big city would get their act together and have community mental health centers. I expected to find them 20 years ago when I started wandering the country, creating these Oxford Houses.

What I found instead was that the establishment in community after community - and by establishment, I mean lawyers and doctors and Indian chiefs -- had grand committees that planned wonderful buildings and that talked about all kinds of "Let's get the best architect for this building." We went into North Carolina. North Carolina did not have a single halfway house for drunks and druggies. But the recovery community in North Carolina had pushed the legislature so they needed to do something.

They started plans on the first halfway house. They hired an architect, paid him \$80,000 to do plans for a facility that would cost \$1.8 million to build and about \$3 million a year to staff. And then, suddenly, they heard about Oxford House, and it was a different story.

But it was the legislature, and then it was community after community that had to learn it and be motivated to act and be told you folks living in this community have a responsibility. Last lecture.

DR. CAROLYN J. LUKENSMEYER: Yes, please, Rosalind?

MS. ROSALIND WISEMAN: Rosalind Wiseman. Can you just explain the process you were thinking about for the criteria of the trained neutral facilitators? I'm really curious about that.

DR. CAROLYN J. LUKENSMEYER: There actually are a set of networks across the country that do this sort of work all the time that have networks of trained facilitators that are experienced in doing this. So the criteria is the ability to listen very openly, the ability not to impose your own opinion in any way, shape, or form. They will, in this case, go through specific training on some of the elements that people who work in this world all the time know may be challenges that come from people who are carrying attitudes and beliefs.

I'd be happy to -- it is a pretty long list of criteria, and I'm happy to share with Pam and she could put it out as part of the point after this meeting.

MS. ROSALIND WISEMAN: It seems to me that this would -- that having a very transparent criteria and understanding of what that was going to look like for people would, hopefully, address some of the concerns that people are raising.

DR. CAROLYN J. LUKENSMEYER: Great point. Thank you.

MS. PAMELA S. HYDE: We're going to take, again, just a couple more comments. I think, Chris, you had your hand up, and then Victor.

MS. CHRISTINE WENDEL: Okay. Thank you. Good morning. I'm Chris Wendel. I'm from Santa Fe, New Mexico.

I appreciate that one of the locations may be Albuquerque. I just want to share with you, Carolyn, that in the State of New Mexico, the perception is that Albuquerque gets everything and has everything. And New Mexico is rural and frontier, 2 million people in the fifth largest geographic State in the country. Two million people, more than a quarter of which live in Albuquerque.

We are all about rural and frontier. We are all about places that don't have providers, that it has to be communities that come up with these ideas and these solutions. It has to be the people at the grassroots who really solve the problems.

So I really encourage you when you're talking about major cities to please develop some locations and come up with some systems, if you will, for the 12,000-people communities of Taos or Roswell or Tucumcari, New Mexico, okay? Because that's where the real issues -- in my personal opinion, that's where I see the real issues.

Thank you.

DR. CAROLYN J. LUKENSMEYER: That's a really important point, and one of the spots on the map is western Kentucky, which is a geographic area that communities are all about the size you're talking about. We're hoping to do that in at least two places in the country. Thank you.

MS. PAMELA S. HYDE: Victor?

DR. VICTOR A. CAPOCCIA: Victor Capoccia, CSAT.

Could you talk a little bit about the communications dimension of this and the communications support? With particularly the point of looking for action and sustainability of this, and it seems to me that the communication element is essential, and I haven't heard much about that.

DR. CAROLYN J. LUKENSMEYER: You're right. I didn't speak about it at all. We think that the communication aspect of this is incredibly important and are thinking about I would call it a four-tiered strategy. One is a sort of consistent message that will go out in video and social media that will be run by SAMHSA and the Department of Health and Human Services so that there's a message that is the kind of broadest, most encompassing message about the importance of the work.

A second layer of it is actually stakeholder groups all over the country, not just the ones I was talking about that will, in fact, help with the conversations. But I think there are about 200 that have already been tapped to have talking points,

messaging, be updated on the outcomes of this.

Then a third tier of this is the National Institute for Civic Discourse is creating a Web site where all of the community outcomes, the 10 cities and every other city that participates in this, will all be shown via maps. So it would be clicking on maps in terms of following outcomes, but that should be a single source where any media system could interface with it and have the facts that they need to continue to talk about what's happening in this in terms of sustaining it over time.

The most critical, the most critical, which is not fully in place yet, but is identifying some partners in the media that from the very beginning really commit to following this initiative over time. And in our current fragmented media environment, that has to be from every medium.

That has to be literally for sure the major blogging voices in this arena that people would look to, the social media outlets that really are initiated by citizens themselves. We're going to spend a lot of work on that one. And then, of course, print, television, radio, picking out trusted voices that do want to participate in megaphoning out what happens with this.

It's the hardest one to do in American society today, no matter what the issue is. We have shortened attention spans by virtue of how our information comes to us. We have less dollars committed to the following of actual news stories. So none of us think this will be easy, but we completely agree with you that that has to be done.

MS. PAMELA S. HYDE: Okay. I'm going to take one more comment, and then I'm going to make a comment, and then we're going to move on to the dialogue part of this.

Yolanda?

DR. YOLANDA B. BRISCOE: Hi. I'm all about community and applaud you for embarking on this, and the community is so important. However, I would caution also against the use of "high functioning." I have a bachelor's, a master's, and a doctorate and executive director, and it goes on and on and on.

I have cousins back in El Paso, Texas, who have no mortgage because their house is paid for. They have no car payment because they pay cash for their cars and have pensions. So, oh, and no student loans of \$150,000. So I would who's high functioning in that picture? So I would just caution against that.

DR. CAROLYN J. LUKENSMEYER: I am humbled in a sincere and thank you way. I took it seriously from Pat. That word will never be used again.

MS. PAMELA S. HYDE: All right. So thanks for your comments.

Let me just make a comment here about what we're trying to accomplish, and then I want to ask Carolyn part of what our goal was here, and again, there's never enough time to do these things. But part of our goal is to let you have some of the conversation and use that as some of the experience of it, as well as some of the advice to us about it.

But the passion with which some of you reacted to even simple words as well as concepts and constructs is the point. The United States of America is reacting passionately in a variety of ways to what happened in Newtown, Connecticut. And Pat, you are absolutely right. What they are reacting to is we need to get guns out of the hands of people with mental health issues, or they don't say it that nicely. They say out of the hands of mentally ill people. That's what they say.

DR. JEAN CAMPBELL: Crazy people.

MS. PAMELA S. HYDE: They say lots of things, Jean. You know that. The point here is as passionate as you feel about how wrong that is, they feel equally passionate that you are wrong and that they are right. They feel equally passionate that Oxford House is not the solution, that something else is.

They feel equally passionate that methadone is just a way to keep people in addiction and is not a solution. They feel equally passionate that the way to deal with this is get those sick kids out of our schools. There are people who have these passionate responses.

Some people feel passionately that psychotropic medication is the problem. Some people feel passionately that forcing people to take psychiatric medication is the solution. I'm telling you I feel passionate about the disagreements that have caused America to be unable to take on mental health issues in a positive and reforming way. And whether we like it or not, now is the time, as the President said.

There is an opening because some people with mental health problems shot some people. And in a couple of cases, those shootings were so highly visible, a Gabby Giffords, you notice who gets talked about in that context. Not the six who died, but Gabby Giffords, who lived, thank goodness. But she had some notoriety.

In Newtown, it's the children. It's innocent children that got shot that have raised the awareness in a way that we have to take advantage of, folks. And believe me, you cannot even imagine how much time I spend talking with people from the White House to Congress, to my friends and neighbors, to my mother in the

elevator about the bad use of language and what it means.

Even the use of the word "stigma." You all know I hate that word. It ties the negativity to the mental health problem instead of to the attitudes and behavior of people who are approaching this in the wrong way.

All right. So that's my passion about that. My passion about this, and I think the President shares this. I think the President --

[Applause.]

MS. PAMELA S. HYDE: Thank you. I think the President and the Secretary share this that if we don't take the Time is Now to let these differences of opinion get aired and voiced in some way that is structured and that we can bring people to the table, and the President is the best one about saying this isn't going to get solved in Washington, D.C. It's going to get solved out there in each individual community, about how they think about this stuff, how they're willing to come together with their neighbors about this stuff, how they're willing to sort through the issue that you said, Pat, and that you said, Paul, all of you. You're right.

But if we don't create the place and the space for people to say these awful things as well as to say the things that are going to make a difference and say how can we come together about this, then we've missed our opportunity. And sometimes in doing that, it's not comfortable, believe me. Some of the things I hear are not comfortable.

So I just want to tell you that what we're trying to do, and Chris, you are right, too. Rural communities have to have these conversations. Church communities have to have these conversations. Tribal communities have to have these conversations. We cannot, as a Federal Government, make that happen in 20,000 communities across the country.

What we can do and are trying to do is partner up. And frankly, if you'll remember the earlier conversation, not have one dollar of Federal money in this because we are not going to go through the conference and meetings process for every one of these dialogues. Yes, you can clap for that, too.

So we are trying to create the partnerships with the Deliberative Democracy folks. We're trying to create the toolkit, and I can assure you it won't be perfect. And when the toolkit comes out, every one of you will react and say you forgot this or you said that or you shouldn't have done this. But the fact is we're trying to create something that everybody can use and adapt to their own situation. So tribal leaders can go do it in their communities. So people can go do it in the Tukumcaris of the world. So people can go do it wherever they want, in the church basements of the world.

Wherever, in the Oxford Houses of the world. Wherever you want to have these conversations. We're just trying to seed this event and trying to get at dialogue. So your passion, please, keep it coming. Carolyn's passion, you heard her, about this process.

My passion is we have got to change the conversation. We can't just keep going at each other about "You should be locked up. You should get over yourself." I mean, it should not be that kind of conversation any more. So all right, my sermon is done.

And now we've had lots of sermons today. I'm going to turn it back to Carolyn and let her do a little bit of the getting you to talk to each other, not just to us.

DR. CAROLYN J. LUKENSMEYER: Thank you, Pam. I would say the country is very, very fortunate to have the lady at my right sitting in the job that she is sitting in.

[Applause.]

DR. CAROLYN J. LUKENSMEYER: Recognizing time limits, I'm going to ask your cooperation. Remember, the primary reason we're doing this is we actually think it could still influence how we get at the attitudes and behaviors and how we put together the community action plans. So I'm going to ask in terms of in the interest of time, as soon as I stop talking --

Can you hear me if I'm not so close to the mike? I'm going to ask you to turn around like these foursomes so that you're facing the table right behind you. So you're going to be in a conversation with seven or eight people. Okay? So turn around and make a small group of seven or eight people. Very, very quickly.

MS. PAMELA S. HYDE: Okay. Just quickly settle in.

DR. CAROLYN J. LUKENSMEYER: We aren't going to have the trained process facilitators at each table so you're going to have to monitor yourselves here. But I'm going to ask you to do the following. Please everybody just stay focused here for a minute.

I'm going to ask you to quickly -- I'm going to put a question up on the screen in a moment, and I'm going to ask nobody to talk when the question goes up on the screen. I'm going to ask you all to answer the question very directly in a short response yourself so you're very clear what your own answer is. You might want to jot it on a piece of paper.

One of the things that happens when people in small groups talk, I don't really

hear what you said because I'm thinking up what I'm going to say next. So that's one of the processes we will use in these conversations. At every stage, people will have a chance to think and answer the question themselves first.

So once you've got the question answered, when you open it up, I want you to quickly go around the table. Your name, your organization, and your answer to the question. All of you be listening to the combination of answers to the questions and see if a theme jumps out, see if several of you have similar territory. And please, someone in the group keep track of all the responses because we won't have time to hear them, but we'll pick them up, and they will go to the teams that are designing these community conversations.

You got it? Okay. Here --

Okay. Here's the question. What attitudes and beliefs about mental health would you most like to influence in order to create a culture that is more supportive of people's need to connect to prevention and treatment services?

So there's a lot of issues out there in terms of attitudes, misinformation. I'm asking you to drop back in. This is a harder question probably for this group than for just ordinary people because you probably have 15 things you want to say here. But I'm asking each of you if you could influence in our culture, in the minds of Americans in communities that we live in the attitudes and beliefs that you most think we need to do something about, what would they be?

So take a minute. Answer it for yourself. I'd say no more than two or three for each person in your own response. Okay? Just quickly answer it yourself, and when everybody is ready, we'll open up the discussion.

[Pause.]

DR. CAROLYN J. LUKENSMEYER: Yes, I'm keeping you to three if I can. Okay. That's even better. If you did one, that's even better. That's even better. Sorry. I was being influenced. Sorry.

Okay. So introduce yourselves, share your one, see what you as a table come up with if we could through this process influence these attitudes and beliefs, these are the ones we want to change. Go for it.

[Pause.]

DR. CAROLYN J. LUKENSMEYER I: Okay. I realize that we're doing this in an unrealistic timeframe, but I want to ask you to turn your attention back up front, and I'm going to ask each table, just someone at each table. You may not even have come to complete agreement. I would guess you haven't. But if someone

at each table would take the risk of sharing one of the top priorities in terms of attitude and belief that you want to see this process impact the American people in terms of how the talk about mental health.

Okay. What table is ready to go? All right.

MS. PAMELA S. HYDE: Okay. We're going to need you all to stop talking so that the people around the country can now hear what you're reporting out. So --

DR. CAROLYN J. LUKENSMEYER: And be sure Cassandra is at a mike. Okay. Victor. Go, Victor, and come to a mike. Heads up, folks.

DR. VICTOR A. CAPOCCIA: Okay. So, themes. One theme, the six people, several statements, probably three themes.

These conditions are equal opportunity. They affect everybody. The second, they do not represent either moral or bad behavior. They represent different degree of well-being just as different degrees of well-being are represented in all kinds of other conditions. And third, we can do something about it to improve the degree of well-being, assuming that that's what the person wants to engage with.

DR. CAROLYN J. LUKENSMEYER: Excellent. Thank you very much, Victor.

I'm going to shift over to this table, and whoever is going to report, please us the mike and share your name.

MS. OMISADE ALI: Sade Ali. We came up with the fact that mental health exists on a continuum as well. Often has cultural considerations. And that prevention and early opportunities for community involvement and identification of children needs to happen early, and prevention really does exist.

DR. CAROLYN J. LUKENSMEYER: Thank you. I'm going to go the table right behind that group of eight people.

MS. JOHANNA BERGAN: We are more the same than different, regardless of mental health diagnoses or not. And because of this, we need to work in a unit of community, and this community needs to include culturally responsive healthcare providers and include the mental health aspects into the overarching healthcare conversation.

DR. CAROLYN J. LUKENSMEYER I: Thank you very much.

As this is happening, I think some of these phrases could actually find its way into what we're doing very directly. I want to go to the back corner table there, and I'll come around.

MR. PATRICK A. RISSER: Pat Risser with the CMHS Council, and our group talked about several things.

But the common theme, I sort of said that people with mental health issues are just like everybody else, that most often they're dealing with issues of abuse, neglect, or trauma and just the pain of being another human being in our society, and they sometimes need support around those issues, not to be stigmatized or treated as different than everybody else. And we sort of felt like that was a theme that should impact on the workforce and how everybody relates to each other.

DR. CAROLYN J. LUKENSMEYER: It's interesting. That theme is coming up in different language, I think, in virtually every report we've heard. That we need to think of this as we're all in this together and are just in a different place on a continuum, if I can say it that way.

Next table?

MR. KEITH MASSAWAY: Keith Massaway, Sault Ste. Marie Tribe of Chippewa Indians, Michigan.

Exactly the same thing. We took it and we discussed it a little more in a tribal cultural aspect, where in our culture there's no individuals. We are all together, and we're stronger together. And we try to impart that into the children and impart that into our community. And when there is a mental health problem, they tend to individualize themselves and separate themselves, and we don't allow that.

So it's part of, I think, the continuum part of the process, part of understanding and education that everybody is somewhere on that path, and we are all in it together. So that's what we came up with ours.

DR. CAROLYN J. LUKENSMEYER: Thank you very much.

The next group, please?

MS. HARRIET C. FORMAN: We had amazing agreement in our group about the need for the attitude of seeking help early, that seeking any kind of help should not be seen as a weakness, but as a strength. That seeking help should not be - - we should seek earlier treatment will help us all, that mental health treatment should be a human right, that it should not be tied to financial -- financial ability to pay, that there is hope in seeking help. And that there's hope for changing lives for the better.

DR. CAROLYN J. LUKENSMEYER: Thank you very much.

Last group?

DR. LORI SIMON: I think one thing that we definitely had was that there are causes to people getting mentally ill. It's not just focusing on the person themselves with the mental illness, but what external forces, whether it's family, friends, whatever social situations are influencing that person's mental illness? And so, to look at those as well because if you can treat that and look at that, you can help go a long way perhaps towards helping the person who does -- or even preventing somebody from getting mental illness. That there is a preventable component to mental illness as well.

So that was one major thing that we had, that mental illness is not hopeless. That it takes strength to get help, not weakness, echoed what was said earlier.

Also, violence is a huge -- a huge stigma with mental illness, and the fact that the vast, vast majority of people who are mentally ill are not violent. And even if there is a person who shows some kind of violent tendencies at some point in time, that's potentially treatable. That's not something that, oh, that person is violent for the rest of their life.

DR. CAROLYN J. LUKENSMEYER: Thank you very much.

I will not try to summarize everything, but so the four themes seem to me to come up in a lot of the discussions. Almost the first thing that was said at the first table, which is we're all in this. We're just on a different place in the continuum. Emotional health and mental health is just part of what it means to be a whole, healthy human being.

Incredibly strong theme about and most expressed by one of the core I would even call it an existential reality for the Native American community that we are a community more than we are individuals and bringing some of that sense into the American culture around we should stop isolating people and treat this in the context of a community.

The issue of early detection came up many times in terms of if we could identify people and if we had reduced the barriers to getting to connect for support services, it would make a big difference.

And hope. I think hope was mentioned in at least four or five of these. None of these things are forever, and if we could get people connected to the right kind of support. I guess one other thing that came from your group. I think you're the only one that said it, but I think it's essential, which is this all happens in a context. There are many, many factors outside of an individual's behavior that

are very much part of what creates my choices behaviorally.

Okay. This is what I'd like -- I think I'm going to take one comment only.

MS. CASSANDRA PRICE: I can't pass it up to say that one thing that I didn't hear that I think we did talk about is that recovery is possible and sustainable and that recovery is found in multiple pathways, through sometimes treatment, medication, social, and natural supports that really is about strength-based communities. And so, I just want to make sure that recovery is part of the conversation.

DR. CAROLYN J. LUKENSMEYER: Excellent. Thank you.

So very important step when you leave to your next meetings. Irene, if you'll stand up, she's the writer for this particular meeting, and if someone in your group would please give your document to Irene. I'm dead serious when I think some of the phrases that were used on these core themes could actually be very useful to us in terms of how we take this out to communities.

Because we got started late and had a longer Q&A than we might have if I had been more articulate about how this was going to operate and my word choice, I want to show you the next question we were going to ask you. We don't have time to fully discuss it. But the reason I want to show it to you is because it's so important on the second goal of these community conversations.

What can the community come together to do to impact this? So I'm going to put the slide up, give you a moment just like I did before to jot it could just be one idea down, and then in the same manner just make sure that if you have an idea you want to be in the mix, make sure that paper gets to Irene.

The question is we know it's difficult for anybody to successfully transition from youth to adulthood. We know that people who are challenged with emotional and mental health challenges have an even more difficult struggle with that transition. The most important phrase here is what innovative solutions -- and really think about your own community at this point in time because we really believe the solutions are going to come locally.

So what action, what innovation solution do you feel actually could help more young people successfully make that transition to adulthood? So I'm going to give you just a minute. Again, if you have a notion you really want to become part of how we're thinking about this, put it on a piece of paper and give it to Irene. So a moment to think and write.

[Pause.]

DR. CAROLYN J. LUKENSMEYER: There's a few people still writing, but I'm going to take a moment or maybe 2 minutes max for just a small number of you who want to use your mike and again give us your name and shout out your innovative solution. It's one that you're excited about, passionate about, that you'd love to see in the mix. So just a few of the ideas are heard before I go on to my last slide.

MR. KWEISI RONALD HARRIS: Yes. My name is Kweisi Ronald Harris. I'm from Chicago Illinois. I'm a member of the CSAP NAC committee.

And I think one of the pieces, reading this, that comes to my mind right away would be instituting or embracing the notion of rites of passage for our young people, particularly from a cultural-specific model, and also introduce the notion of cultural reclamation.

A lot of times, our young people are growing up in environments that they don't actually get reaffirmed of who they are, whose they are, and who they ought to be, and what are their possibilities and potentialities. Well, the rites would give them that opportunity.

And to move away from even the word "rites of passage" but create an idea or notion of initiation because in cultural communities, that is what it is. It's not so much rites of passage, but initiation, initiating into the realm of manhood, womanhood, peoplehood so that you can become an asset to the community and not a liability.

So that comes to my mind right away. Thank you.

DR. CAROLYN J. LUKENSMEYER: Really well said. Yes, ma'am?

DR. JEAN CAMPBELL: I recommend community -- Jean Campbell from Missouri.

I recommend community outreach specific inclusion of a young person with mental illness such as the Fourth of July parade, participating in a Fourth of July parade in a community or being involved in community art, like mural projects. So approaching it from a slightly different perspective.

DR. CAROLYN J. LUKENSMEYER: Very interesting idea. A couple more.

Yes, Rosalind? And again, for the record, state your name.

MS. ROSALIND WISEMAN: Rosalind Wiseman, author, educator.

I feel so passionately about this question. I think we will do -- we will -- this -- I

just feel so passionately about this. We have to acknowledge adult hypocrisy. We have to acknowledge that adults are contributing to the problem with young people. We have to acknowledge that life is messy for these kids and that we are part of the problem.

The way in which children are lectured, are patronized, are disrespected or assumed that they have not gone through difficult problems, or they're just kids so you've got it so lucky. Not acknowledging or not even thinking about the life experiences those children have and bring to the conversation, if we don't do that, and I would go back to the facilitators that I asked you about earlier. If we don't have a really clear acknowledgment and presence about that when we engage young people, the only thing they will understandably do is disengage.

DR. CAROLYN J. LUKENSMEYER: Very, very, very well said.

I've got to take one more. That's a function of time. Please?

MR. MARCO E. JACOME: So Marco Jacome from Chicago, Illinois.

And we discussed that I think it takes a village to raise a child, and we need to create consistency in our communities to support those kids. And that involves adults and everybody else, including the kids.

DR. CAROLYN J. LUKENSMEYER: Thank you. All right. One more and then we're done. I got lobbied, what can I say?

MS. OMISADE ALI: Sade Ali. We need to change "mental illness" to "mental health" and talk about mental health challenges instead of mental illness.

DR. CAROLYN J. LUKENSMEYER: Right. So I want to show one more slide because one of the things that I profoundly respect about what's happened in this room, and no surprise, is the level of commitment, the level of passion that you have to what happens to people in our communities.

So it may well be that some of you in the association that you're representing here or in your community have a desire to stay involved with this to ensure that we do it in the way that will match what you know has to happen for the country. So here's a few ways you could stay involved.

Initiate one of these conversations in your community. The toolkit will be available to you. We will help you link up to process facilitators. The outcomes will have a home. So that is one very proactive important thing that could take this across the country.

Become a national partner. Where if you're sitting in an organization that could

actually do this because you have local partners in many places, be one of those organizations that's going to push this out to a lot more communities.

And in some ways, this comes right back to Victor's excellent question in the earlier part of the discussion. Once this initiative is formally launched, use all of your communication tools -- traditional, social media -- to help get this message above the din.

I said it before, but I'll say it again. It is extremely problematic in this country to keep a national narrative on the importance of something that impacts our lives really consistently followed for enough time for the seeds that are planted to take root and really make a difference.

So, Victor, I appreciated the way you asked it before, and I think that is the place in some ways that this particular set of advisory panels could be the most helpful to us.

DR. LORI SIMON: I just would like to say one thing about the word "community" and putting a little bit of a damper on it. Because I've heard a lot about the word "community" over yesterday and today, and I think in many cases, it's absolutely right on target.

However, I've worked with the homeless in New York City. The word "community" is not certainly a traditional one in something as large as New York City. One of the problems is that people with mental illness and substance abuse don't have a community.

DR. CAROLYN J. LUKENSMEYER: Absolutely.

DR. LORI SIMON: And with regard to children, the schools may be their community because there is so much dysfunctionality at home. So one of the things that needs to be kept in mind, and with the homeless, the community may be other homeless people who they're out on the street with. That's their community.

So we need to take a step back and take a look in certain circumstances that, first, you've got to create the community and then provide the help.

DR. CAROLYN J. LUKENSMEYER: I think that is eloquently said. I think there is no question, but one of the biggest changes in the United States of America in my lifetime is literally how you feel connected to community or if this sense of community even exists for you at this stage of the game. So very well said.

I really have to close, but I actually want to take a moment to try to put this back in a larger context, and it was evoked for me by your comment about rights.

Most of you are not from Washington, D.C. I don't know how long you stay around after these advisory council meetings are over, but if you happen to, I last night had the privilege of a tour in the National Museum of American History of a current -- what's the word I'm looking for? Thank you. That is commemorating the 150th year anniversary of the Emancipation Proclamation and the 50th year anniversary of the March on Washington in 1963.

And some of you may have really thought of this when President Obama announced this. Remember the overall statement of all of the actions that this administration intends to take post Newtown is Now is the Time. For those of you who don't remember, the phrase "now is the time" was the call to action to join the March on Washington in 1963, and it was the moment when there was a catalyst for the largest demonstration that had ever happened in this city about taking civil rights to a huge portion of our population.

And at its heart, I think the whole point of this national discussion on mental health is to take another step forward in terms of ensuring the civil rights of a very, very important portion of our population.

Thank you very much.

[Applause.]

MS. PAMELA S. HYDE: All right. Join me, yes, in thanking Carolyn. And thank you, Carolyn.

She was trying to give you a flavor of what would happen in a whole day in what amounted to 45 minutes with a passionate crew.

I want to tell you just one story before we end on this, and thank you for giving me a moment to talk to you about it. Many of you know that I grew up in a very religious home, a Southern Baptist home in which they had very strong feelings about lots of things and the morality of them. I can remember as a young person that there was a person in our church who had epilepsy.

So I'm in my 60s. So this was back 50 years ago. There is no question that when that young man had an epileptic seizure in the church environment, there was a significant portion of that congregation that thought this was, yes, it was possession. It was something obviously less different than what we understand today epilepsy to be.

I think about that situation a lot because I was very close to the man in the pew when it happened, and of course, it was scary to me as a young child. But over the years, I've thought about the number of people who have epilepsy who were put into State hospitals because they were considered to be crazy or mentally ill

or whatever word you want to use. I can also remember lots of conversations with good colleagues of mine who have said, you know, once a condition is understood to be actually a medical condition, it's no longer considered to be a mental illness.

So if that's the case, then all of these conditions that we experience today as labeling them as mental illness may someday just be considered a part of our health and medical set of conditions. Maybe so. Maybe our job is to work ourselves out of a job. But today, you don't talk about epilepsy in the context of mental health. It's a neurological issue, and it's dealt with in that way.

I can also remember in my lifetime. That's one of the nice things about getting older. I can remember in my lifetime when women just would not talk about breast cancer. It was not okay. It was not acceptable. I don't know that it was considered possession or demonism or anything else, but it was certainly not okay to talk about and not okay to have other people talk about. And today the amount of pride, if you will, not in having breast cancer, but in being able to say I've overcome it or there's treatment that has worked, having NFL players wear pink gloves in commemoration of that is a pretty profound shift in my lifetime.

I've also used this a number of times. So you've probably heard me say I can remember when HIV/AIDS was a first beginning issue. I can remember lots of people just basically saying if those two guys would stop having sex in restrooms, we wouldn't have this problem. That was really it was their problem. It was a moral problem. It was a behavior problem as opposed to it was a public health issue. And I know that many of you have heard me talk about this, but I feel profoundly about that.

In the last couple of days, if you've been watching the papers, you've seen that Rick Warren and his wife, who is the -- Rick Warren is the head of a major mega church out in California. Lost their son, 27-year-old son to suicide. He had been experiencing depression for a long time and had been suicidal actually for a long time.

Rick Warren and his wife came out, if you will, about that and said very few people knew about my family's problems. Very few people knew about my son. After that, and in the newspaper this morning, if you pick up the Washington Post, there's an article about it. But the faith community across a number of denominations is having a profoundly different conversation right now about suicide, about depression, about how they as spiritual leaders may have inadvertently communicated that it's not okay to talk about, that it's a spiritual issue with God, that that's the issue.

And a lot of them are starting to say we need to talk about this differently. To me, being raised in a faith community and coming through some of that

experientially says to me if we can have and see that kind of profound difference in a faith community that we need. We know that consumers and people in recovery tell us that the faith community, hope, those issues have to be part of recovery. But if it serves to separate us, then it is not helpful.

So I'm using that as an example to say this whole point about the national dialogue is to try to get at some of the profound differences that we understand and in ways that we have inadvertently -- and Rosalind, your comments about how we as adults have inadvertently said to kids, you know, it's your problem or just sit down and be quiet. We have got to deal with those issues as a country.

So, anyway, thank you for participating in this. Thanks to Carolyn and her group for helping. Make sure that the stuff that you wrote down at your tables gets to Irene over here because she's going to capture some of that.

And then I want to also tell you where to go for your lunch things. The Senate votes to allow gun violence bill to move forward. Now interestingly, it's called the gun violence bill, but is this a Senate committee? The background checks, okay.

Today, there is a markup today about the Senate mental health bill, and the strategy in the Senate may be to try to put -- I know you're going to hate this, but you have to think about the strategy getting something through the Congress. Are thinking about putting the mental health bill, which adds programs and dollars, in the gun violence bill or background check bill together to move it through Congress. So that those people who are able to say "I voted for mental health" can vote for those things.

So it will be interesting to watch. So today is an important day around all of those issues.

All right. For lunch, you get to talk about something else. International activities will be in Rock Creek, which is down at that end of the hall. The disaster response update will be in VTC, which is our video room, which you go out to the front where the security -- don't go past the security, but where the security is and turn left down that hall and then right into a first little room.

The faith-based initiatives is in Great Falls, which is also down this hall that we're on. And then the Brady bill prohibitor issue with Wes and Paolo will be staying in this room.

Your lunches are in the back, I believe. So go get your lunch. Go to the room you want. If you don't want to participate in any of those things, there's a cafeteria over here you can go sit in, and we will start back here at 1:00 p.m. sharp. So please try to be on time.

[Break.]

MS. PAMELA S. HYDE: Okay. We're going to get started. I want to try to get people in their chairs. I know there will be people filtering in. But I'm going to get us started by talking a little bit about why we decided to have this panel today. It's because you asked us to do that.

There are several things that keep coming up in our conversations every time we have an advisory group meeting. One is the issue of disparities and minorities and whatever word you want to put to those things, but how we address behavioral health equity and disparities. And as you know and you've heard presentations, we created an Office of Behavioral Health Equity some time ago. Larke Huang runs that office for us, among other hats that she wears.

And we also have a person named Miriam Delphin-Rittmon, who may be on the phone. I'm not sure she is. But she is working also in the area of looking at the evidence behind some of the service delivery models that we use.

So Miriam was actually going to help us with this panel today, and she had a health issue. So she's not with us in person, but she may be listening in. So I want to thank her, and I also want to thank Larke for stepping in at the last moment and facilitating this panel.

So you've asked a lot about disparity. So that's part of the reason we're doing this. The other thing that has come up in our conversations quite a bit is the role of evidence-based practices, and are we making sure that our money is being spent that way in the use of evidence-based practices?

And every time we have that conversation, the issues of "yes, but" does it work for people of other than the main culture in our -- to the extent there is such a thing as a main culture in our nation at this point. So this interplay between evidence-based practices and behavioral health equity is issues that you raised and asked us to have some conversation about. So that's why we have this panel.

The other thing you asked us about is how are we interacting with our sister/brother agencies? And we do a lot of work. You've heard people from HRSA. You've heard people from CMS. You've heard people from Education. We've had people from lots of different agencies. We are really pleased today to have somebody with us, in fact, the Administrator with us from AHRQ, the Administration on Health Research and Quality.

So I'm going to turn this over to Larke to introduce the other folks, and I also will just say that Steven Green, who is another member of one of our councils, was going to be on the panel. He represents a Native American program. He had a

death in the family, unfortunately, so is not able to be here. So the panel has emerged and evolved in a great way, and I thank all of you that are on the panel. Thank you for doing this.

Larke, I'm going to turn it over to you, and I assume you'll introduce the rest of the panelists.

Agenda Item: Panel Discussion: Disparities and Evidence-Based Practices

DR. LARKE HUANG: Okay. Thanks, Pam.

Okay. So Pam has given you the foundation for this particular panel coming together. I also wanted to just remind you of the evidence-based practice definition that came out of the Institute of Medicine in their Crossing the Quality Chasm in 2001. And just for those of you who can't see it. It's evidence-based practice is the integration of best research evidence with clinical expertise and patient values. I think that's an important thing because it really is going to encompass a lot of what you'll hear on the panel today.

So Dr. Clancy is here with us from AHRQ, and we're really pleased to have her, as Pam said. Sitting next to her is Jeanne Miranda. Dr. Miranda is on one of our advisory councils here and is a professor in the Department of Psychiatry and Biobehavioral Health Sciences at UCLA and has often from her perspective as a researcher addressed this issue of evidence-based practice and diverse racial and ethnic and other populations.

And sitting to her right is Diane Narasaki, who is the Executive Director of the Asian Community Counseling and Referral Services in Seattle, Washington. And Diane is also on one of our national advisory councils, the CMHS. And she also comes to this from a perspective of someone who's running a very mature, sophisticated, advanced -- I've been to it many times in Seattle -- community-based organization that also looks at the issue of what's evidence for their populations and what works with their particular populations in their particular agency.

So we've asked each panelist to give 5 to 10 minutes from their perspective on looking at the interface of evidence-based practices and disparities issues. Then we have some questions we're going to pose to them as a discussion among the panelists, and then the bulk of the time will be for you also to engage in discussions and pepper them with questions and your ideas so we can get a good discussion going about these really kind of different trains going down tracks around what is evidence, levels of evidence? What's evidence-based

practice? How do we address issues of disparities for our diverse racial, ethnic, LGBT population?

So we're going to start off with Dr. Clancy and then proceed down the panel.

DR. CAROLYN CLANCY: Well, thank you, and good afternoon. And it's really a pleasure to be here today. And to say it's been a pleasure to work with Pam Hyde would be a profound understatement. So thank you for inviting me.

AHRQ and the research that we support, we see ourselves as a vital component of transforming the healthcare system -- I should put that in quotes -- that we have to a 21st century enterprise that's both information rich and patient focused. As Pam noted, we're another division of the department, and our mission is to improve the safety, quality, effectiveness, and efficiency of healthcare for all Americans. So that's where the disparities piece comes in.

And we do this by supporting research and research that's got a very practical focus on it. What are you going to do with the answer? What kinds of tools would you need to actually put these results into practice if the study is successful as hoped for, and so forth.

And as many of you know, some researchers are gifted at communicating with multiple audiences. Others are not. So I'll just leave it at that way. So we put a very, very strong focus on dissemination, and we're relentless. If you go to the right supermarket around here, you might hear my voice making a public service announcement. Because if we're really patient centered, than that means we have to go where people are rather than insisting that they navigate our byzantine enterprise. We're changing that, though.

So among the two more popular reports or products from AHRQ are the annual reports to the Congress on the state of healthcare quality and the state of healthcare disparities. This year will be the 10th year coming out in just a few weeks. In fact, I got like an emergency email about clearance just before I came over here this afternoon.

What we've seen in the quality report is every year for 10 years statistically significant improvements, arguably not clinically meaningful, in the ballpark of 1 to 2 percent. If you compare that with how rapidly costs are increasing even in the past few years, it's a little bit of a disconnect. Costs going up much faster than quality, but still headed in the right direction.

Disparities in care have been much more pervasive, and not immutable. There are areas that have improved, but it's more discouraging and I think is going to require much more accelerated strategies. So the disparities report tracked, for example, completion of substance abuse treatment from 2005 to 2008. And

according to the findings, there were no statistically significant changes in the percentage of people age 12 and over who completed treatment during those years.

I do have to note that was before Pam Hyde came to SAMHSA. That's all I'm going to say. And in addition, blacks were significantly less likely to complete the treatment than whites, and people with less than a high school education significantly less likely to complete treatment than those with more education.

By the way, education and less of it is a disparity we have known about for a really, really long time and haven't, I would say, even addressed it with enough gusto yet. Certainly, a lot of incredibly important work to do there.

Now another area that we are heavily invested in is patient-centered outcomes research, which is basically which treatments work for which patients under what circumstances. Focusing on the evidence, understanding that this overarching definition -- and thank you for putting that up -- is very, very important. Our authority actually directs us to make the information available in ways that are accessible to multiple audiences.

Remember I said a few minutes ago some researchers are good at this. Some aren't. We actually have a very dedicated center, dedicated with expertise in communication and clinical decision sciences that actually helps us develop these products. So, for example, we've got a product out, Therapies for Children with Autism Spectrum Disorders: A Review of the Research for Parents and Caregivers. And this is something we worked on extensively with Autism Speaks and many, many advocates.

So one of the tensions that comes up in evidence-based practice, whether we're talking about disparities in care or just evidence-based practice writ large is if you're providing services, you see the urgency right in front of your face every day. As a physician, I know this all too well. If you are reviewing the evidence, you're trying to be very rigorous and quantitative about what can I really say? How rock solid are the conclusions?

And by the way, if they're not rock solid, that doesn't mean you, as a program leader or a clinician, can just say, hey, we're not going to do anything because we're still waiting for science, right? So that tension is ongoing and has been going on for a really long period of time. And we know that very, very well.

At the same time, we also recognize that there are people in healthcare writ large who are desperate and passionate about solving problems. They do not write grants. Stunningly enough in the Washington, D.C., area, they don't even like to be near a microphone. But we have created a Web-based platform for them to share their experiences. So I'm hoping that many from your community

would be interested. It's innovations.ahrq.gov.

And one other area we've made some investments is an academy for integrating behavioral health in primary care. Pam, really one remarkable facet of her leadership has been raising the issue of integrating behavioral health in primary care really to a new level. We talked about it before. Now we're doing something about it. So we've had the privilege of actually working closely with Pam and her colleagues, as well as HRSA.

So I wanted to talk about -- make two specific points before closing. One is this tension about evidence and practice. So a few years ago, I got this very dramatic, urgent call from one of the Deputy Directors at the Office of the National -- ONDCP, the drug czar's office. And very, very upset because she got wind and was getting the drift from what she had heard that the U.S. Preventive Services Task Force, an independent task force who we support scientifically and administratively, was probably going to -- they were going to be reviewing the evidence for screening all comers, everyone walking into the door in primary care, for evidence of substance use and that they probably were going to give it an "I" recommendation again, insufficient evidence to recommend for or against.

Now needless to say, not surprisingly, given the focus of her position, this seemed like an outrageous insult. And she kept saying we're collecting data from SAMHSA programs and so forth, and I know we've got good data. Now the difference in population here, right? All comers in primary care is everybody. People coming to SAMHSA programs are a different segment of the population. The task force tends to focus on the all comers kind of question.

And ultimately what grew out of this was a collaboration with NIDA where they finally understood what the task force felt like they needed to say. This test, we'd recommend this test based on evidence not only that it detects the substance that we're trying to detect, but also that detecting that actually makes a difference in terms of subsequent actions and the patient outcomes.

It's a pretty high bar for evidence, and those grants should be done in a year. I'd love to tell you this happens all the time strategically, and this was a bit more serendipitous than this required. It was based on an informal collaboration and kind of networking. Nonetheless, I think a nice success story. I'd just like to see more of them.

The other area where we've made an investment and recently published a systematic review is what do we know about applying quality improvement techniques to reduce disparities in healthcare? The short answer is we don't have very much evidence. And the question is, is that because we haven't tried hard enough?

One of our grantees a few years ago did something astonishingly sophisticated. She was working with underserved women getting treatment for breast cancer who kept getting lost to follow-up. And she created a very simple tracking tool. You could call it a registry if you wanted to. It doesn't even need to have that fancy a word. And you know what? It didn't entirely solve the problem, but it did about 90 percent.

So I think we are still a little unclear about whether we need different evidence for some population groups or whether we've got to work a whole lot harder and understand why it is that we're not trying so hard in some of those population groups, whether that's our implicit and unspoken and maybe even unacknowledged expectations for some people sitting before us versus others or if there are really adaptations we need to make to the evidence-based processes.

Unfortunately, I had hoped our systematic review would offer more clarifying insight than that, but it didn't. This does not mean in any way that we can possibly afford to say, well, we'll just keep trying, but we need a definitive study. Uh-uh.

The urgency of addressing disparities I think is far more important than that, and it's going to be much more a matter of sort of action, research, and learning as we go. So we'll take good information and evidence wherever we can get it.

And I'll just close by saying another partner we might bring to this conversation is the National Institute for Minority Health and Health Disparities. I spoke at one of their centers. We think of them as graduates, of an AHRQ grad, which is loosely true. But they're doing phenomenal work engaging the community. And not only that, the institute had sufficient resources to give them a 10-year grant for a very impressive center. So might as well partner up with the people who've already got infrastructure and resources on the ground.

So, again, thank you for the opportunity, and I look forward to the discussion.

DR. JEANNE MIRANDA: Well, I want to promise you that if I didn't have a tremendous amount of loyalty to my good friend Pam Hyde, I would never be here trying to summarize everything I've studied in an almost 30-year career in 10 minutes sitting down without slides.

And worse, I'm going to be telling you something that many of you don't want to hear. I know you're very invested in saying that we don't know enough and we can't treat ethnic minorities with evidence-based care. In the mental health field, we actually have quite a bit of evidence now.

We had none. Ten years ago, a little over 10 years ago when we did the

Surgeon General's report, we literally -- Kana, I guess, is not here, she and I sat around and counted the number of minorities that were ever listed in any of the major trials. And we couldn't find any. They were by the handfuls. And certainly, no one had looked at the data. At this time, it's very different.

Since that time, a number of large impressive trials, some funded by AHRQ, that we worked on have really shown that with very little modification the standard treatments for mental health work exceedingly well in African-American populations, in Latino populations, and increasingly, we're learning more about Asian populations. I would have to say that certainly Native Americans have not at this point been included in these trials or been looked at nearly as much.

But in terms of quality improvement, the Partners in Care study that Kana and I did, we looked at improving care for depression in large managed care organizations. We made sure that we overrepresented Latinos and African Americans in the trial. And at the beginning, we had huge disparities in outcomes and access to care for the minorities. Ten years later, our 10-year follow-up found no disparities at this point.

That what we had done -- I could send you that study, because I'm hoping you would cite that. Ten years later, we had actually wiped out the disparities between the African Americans and Latinos by doing care. Now we did a standard CBT. We used the manual that I developed with in English and Spanish with Ricardo Munoz at San Francisco General a million years ago, and that manual, we did modify, I have to say.

Being thoughtful, we were working at San Francisco General, we had it in English and Spanish. We changed the language level from what you saw in the CBT done in trials with college-educated people to -- Ricardo and I both grew up in uneducated, poor, Latino families. It was really easy for us to put it in language we would talk to our parents in.

So they talk about altering dysfunctional thinking in college-level CBT. We talk about catch it, check it, change it. Catch your thoughts. Check them. Are they accurate? And change them if they're hurting you.

So we made it all simple. So we did so some very -- but we didn't, you know, it wasn't rocket science. And what we found at the end of the day, again, is using the medication arm and psychotherapy, we were able to eliminate disparities using good evidence-based care.

We've been looking at African Americans and psychotic disorders. There's large studies of Latinos now across a number of evidence-based care in psychiatry, and in fact, the outcomes are quite good. I've just been mentoring a young man who we're sending a manuscript off. It's the first one I've ever known where we

looked at Chinese Americans, and we used the manual Ricardo and I developed at San Francisco General. Just we translated it into Chinese, and then he looked at that versus a really culturally adapted version.

And again, it wasn't rocket science. It was using good examples, being thoughtful. And what you find is the standard care translated did well. People did well. With the adapted care that took some thought into the population, it did just a bit better statistically. Maybe not hugely clinically, but statistically better.

Now we tend to do this when we do our care. We adapt it for whatever population we're in. So we take our standard treatment. We don't quit doing it, and we don't do it even if it's not -- like Latina women aren't generally taught to be very assertive, and part of we know that the less assertive you are, the more likely you are to be depressed.

So we know it's a little not with culture, but we teach, and we often find Latina women telling us, you know, I'm empowered for the first time in my life. You've given a voice to me. So we do the standard treatment, but we are thoughtful about it.

So when I did a trial here -- I was at Georgetown for a while in Washington, D.C. -- of four young women, I took all the examples and made them around free pleasant activities you could do with your children, for example, and parenting issues. When we work in primary care populations, we use having diabetes and doing pleasant activities, and how being so ill you can't work affects your mood and your self-esteem.

So I believe in tailoring interventions for populations. But within that, the data to date looks like we're really depriving people of high-quality care by saying it hasn't been tested exactly on my group. Because it looks, we haven't had -- we've had examples where in the Partners in Care study, our major findings were in the low-income minorities. They did better statistically in that trial than did the white population.

So that's the only point. We never have found in all the studies that have been done now, you don't find that when you do evidence-based care, the minorities do worse.

So I think we could use -- we could certainly learn and we need to study scientifically some of the interventions that are out there in minority communities and see if they maybe would work for larger populations. Certainly that we need an evidence base. I mean, I do believe those interventions done in the community, it's imperative that we test them scientifically.

I thought estrogen was my friend for a very long time, and the first clinical trial

told me it was not my friend. I should not like that stuff. So I do think we need to test these interventions, and I think we should do more of that.

I'm really excited. In the last few years, I've been working in the area of developing interventions for families adopting older kids from foster care, and we've gone to the two best community organizations. We've manualized what they do, and we're now testing it. So I believe in community generated, but then I think we need to partner with science and find out if they work or not.

But I'm very excited. So that's the good news. The bad news is we haven't made much progress on disparities in mental health, and we've published a number of papers now where we looked and we're just not making a big dent.

And two things that stand out for me, and I just have a paper out where I've looked at 10 years of progress in getting minority providers. And this has been talked about since I was a young pup just entering the field, and looking at me, you know that's been a lot of years ago. And we're not making progress in that area. It's still predominantly a white service population.

And you know, I love to treat African-American women. I don't think you have to be exactly matched. But I do think it doesn't feel good to come in somewhere where no one looks like you and no one speaks your language. So we have to make progress on that area. We absolutely have to make progress on that.

The other issue that's been a huge issue forever is lack of insurance among low-income minority populations, and I'm really excited to see what the Affordable Care Act will do. I mean, I think that could make a huge, huge, huge difference.

So I'm very optimistic that although we haven't made inroads in disparities that we have the tools now and we have the knowledge now. With the right workforce and training, I think we can make a huge difference.

MS. DIANE NARASAKI: Hi. I'm not an expert on this subject, and I know that there are many in the room who do have much more expertise than I. So I hope you'll jump in when we get to the discussion.

I want to give a little bit of context. I work for Asian Counseling and Referral Service, and every year we serve over 27,000 people who speak 40 languages spoken by Asians and Pacific Islanders. And we have a whole range of health, behavioral health, and human services and like to provide holistic and integrated culturally competent care.

We support the use of evidence-based practices, but not as the only tool in the box. And we get concerned when evidence-based practices are not allowed to be adapted, and we also feel caution whenever mandated EBPs are -- whenever

EBPs are required for us, when we know that in some cases tools that we have developed are even more effective on our population.

So I think that there are challenges with many EBPs to address disparities, notwithstanding Jeanne's information, which I respect. And part of this has to do with the fact that many EBPs aren't designed by in this case I'll use people of color and other populations that are experiencing the disparities, and the population studies usually don't include people of color, as you heard earlier.

One of my colleagues took a sample of 15 EBPs off of the SAMHSA National Registry and found that less than 2 percent of the populations studied in these EBP studies included Asian Americans and Pacific Islanders, who are a very diverse group.

Since most of the EBPs are proven to work with the dominant racial group in the U.S., but not people of color, I don't think we should assume that they will work with people of color. I think they do need to be tested and culturally adapted when necessary. And if they prove to not work as well as the practices used by people of color that have not been scientifically tested but which nonetheless produce successful outcomes, I don't think that they should be mandated.

Evidence-based practices can be very expensive to adopt in terms of the cost of training time and administrative costs. They can also be very expensive to culturally adapt when adaptations are required.

And also inflexible adherence to fidelity, which I know Jeanne doesn't agree with -- so I appreciate that -- for practices that are not culturally competent can actually exacerbate rather than reduce disparities. When policymakers and funders mandate the use of EBPs that have not been normed on people's color, service providers are pressured to leave behind practices which have not been scientifically studied, which but nonetheless have successful outcomes.

Service providers would be required in some cases to adopt EBPs which may be less culturally competent and less effective. I can give you an example of this. One example is that the GAIN assessment and treatment tool, or the global appraisal of individual needs for substance abuse. One of my program directors actually coauthored an article on adapting the GAIN.

The same recovery services director had developed a culturally competent assessment and treatment tool, which --

Okay. The same recovery services director had developed a culturally competent assessment and treatment tool, which took our staff about 2 hours to administer. The treatment retention rate of consumers involved and assessed with this tool averaged close to 100 percent, and the completion rate averaged

close to 95 percent. Random UAs were also done to gauge effectiveness.

When our government funder required us to use the GAIN, it took twice as long. It took 4 hours to administer and additional time to adapt and to seek permission for and to record adaptation. The retention rate dropped from close to 100 percent to 95 percent, and the completion rate dropped from 95 percent to 80 percent. Even with reduced effectiveness, consumers at ACRS still fared better than at mainstream agencies in the rest of our county whose treatment retention and completion rates generally averaged 65 percent.

When we pointed out to our funder that it was taking us around 4 hours to administered the GAIN, we were told that mainstream agencies generally take under 2 hours, and so we were paid \$10 for each GAIN assessment, although it cost us over \$400 to do the assessment for each consumer and the assessment is less effective.

In another example in the supported employment EBP, in our mental health and employment programs, we see a similar disparate impact on agencies. Most of the people who come to us for services are refugees and immigrants, and many are here in the United States for the first time, don't speak English or speak very little English, have no work history that's translatable to our society. For instance, one recent client was a yak herder for the last 15 years.

Because our clients face -- our consumers face barriers of language and other sorts of barriers, they are oftentimes going to find jobs in the hospitality industry. We have been scored lower even though we have a higher retention rate and are successful in placing people in jobs because the job is hospitality and not a higher-skilled job.

We feel this doesn't take into account the nature of the consumers who use our services, and we're oftentimes referred the people with the most difficult barriers to cross. So we are scored lower on the fidelity measure.

These are just a few examples of the kinds of things that we experience when using evidence-based practices. We truly believe that we should be focused on outcomes. We should be focused on consumer satisfaction, and if the evidence-based practices, again, do not provide outcomes as successful as the practices that we have used and proven effective, we shouldn't be required to use them.

This is one of the reasons why we are very interested in the concepts of practice-based evidence and also community-defined evidence. We believe it's important to look at what works from the ground up and to spend time researching what is effective about a given practice and not solely look at evidence-based practices as the only tool in the box.

DR. LARKE HUANG: Okay. Thank you, all.

You've heard several different perspectives here, and I applaud each one of you for being very committed to your particular perspective. Now we want to mix it up a little bit.

And so, I'd like Diane has really come with a very different perspective on the use of evidence-based practices in community settings and real-life practice settings. Jeanne has spoken to us about adaptations. Carolyn mentioned whose evidence and whose levels of evidence and what kinds of evidence might we need in terms of addressing disparities.

So I wonder if you can each comment a little bit on evidence. What's the significant evidence? What does evidence mean from your perspective? Diane mentioned also practice-based evidence, as opposed to evidence-based practice, if you could address that, each of you?

DR. CAROLYN CLANCY: Certainly, I'll be brave here. I mean, in my view, we put an awful lot of -- project a lot of meaning onto the word "evidence." Sometimes it almost sounds biblical or in terms of its importance. You can substitute another metaphor if that would be better for you.

In my view, it's all about reducing uncertainty. If I can do two things to help a patient, option A or option B, and I don't know which one is better, any information that helps me decrease that uncertainty about what's the right way to go.

Now for some interventions that are harmless and cheap, it probably doesn't matter quite as much as if you're talking about interventions that could actually make things worse or may involve some risk of harm and may also be expensive. So, to some extent, that is a very important part of the context.

What I take about practice-based evidence is two things. One is that it would be ideal, and we've been trying to do this a lot in our work in what we now call patient-centered outcomes research, and the Partners in Health study, I think, is exhibit A to be doing the studies in the relevant settings. Now this doesn't mean that we can address every single specific context factor, but I think ultimately it may help us reduce the uncertainty of trying to understand whether what's different is some aspect of cultural competence that is part of the individual's context or whether what's different is the specific context of the community in which these interventions are deployed and so forth.

So, for example, sometimes something works incredibly well in a rural area, and when transported directly to an urban area, not so much. Which has less to do with the people and much more to do with the context in which the practice is

situated.

The other term I take from practice-based evidence, and I don't know a normative definition, is from public health, which is the notion of positive deviance. If you don't know what to do, but in one part of the community they seem to be doing really, really well, it's kind of worthwhile to go find out what it is that they're doing.

Now in healthcare, that often turns out to be a matter of either intentional or inadvertent risk selection. So, for example, if you have a practice in a very affluent zip code, in general, you will attract a better off, better educated group of patients than if you are located in a different kind of zip code. But other times, we don't really know, but it's still worth trying to figure out.

And we do this a lot, for example, in healthcare-associated infections, right? Where for some types of infections, it's not clear what will work, and a lot of our hypotheses have just not panned out at all. People are trying really hard, and you know what, the infection rate just kind of stays the same or even goes up.

So it turns out for C. diff, wash your hands. It's a good idea for many, many reasons, but it probably has nothing to do with C. diff. I mean that kind of thing. What you want to find out is, is if there's a facility that's got a low rate, what's going on there? Is there something that they are doing that we could emulate?

So I take those two meanings away from practice-based evidence.

DR. JEANNE MIRANDA: Well, you know, I think I'm a little bit of a nerd, but I do believe in science. I think we have found several instances when things seem -- you know, knee surgery a while back. Patients love them. Doctors love them. Everybody thought they were really getting better, and the first randomized trials showed that they were totally useless. It was a lot of money, pain, and suffering, and they didn't make a bit of difference.

So I do -- I was laughing about the estrogen. But the same thing. I think all of us believed estrogen was really a great thing, and it turns out postmenopausal women, including me, who were taking it get breast cancers and not so much what you want.

So I think there's a huge role for science, and I really think there's also a lot of wisdom out there about treatments that we -- I would be very excited about seeing us then bring that into the lab and -- not into the lab, bring us out into the field and find does it work or not in randomized trials so we really know. It's very hard to know if you don't actually study it well.

So I do believe in studying, but I think there's a lot of wisdom, clinical wisdom

and lore out there that could really -- the field of mental health, to me, it's discouraging in terms of where we've gotten in, say, the last 15 years. We have medications that have different side effects, but they don't really seem to do any better than the old ones. And we now have tweaked CBT to work for a million things, and it does work. But we don't have any new or really exciting ideas.

And I think there probably are a lot of new and exciting things out in practice, but I'd like to see us actually do the science to find out if they really make a difference or not.

MS. DIANE NARASAKI: I was really struck by an article by Ken Martinez, who talked about different ways of knowing and epistemologies and the fact that science is obviously one important way and who would want to oppose an evidence-based practice that has been proven to work with a given population and is effective?

But that is not the only way, and it seems to me that to ignore outcomes that are successful outcomes because they haven't been the subjects of randomized clinical trials is dogmatic. What we're going for is successful outcomes. To me, if there are successful outcomes that have been used over time, that is a form of evidence.

And Ken Martinez points out in his article that in practice-based evidence or community-defined evidence, you really respect what communities and cultural groups have come to use over time, which have a track record of effectiveness and which the community believes is effective and which the outcomes suggest are effective. And one way of getting that evidence is to take that community-based evidence approach or community-defined evidence, which I believe he and his colleagues did in a national community-defined evidence project.

I don't think any of us in the room would say that we don't believe in science as a useful tool, but it is a tool. It is not a dogma, and I think we should look at all the tools in the box, and community-defined evidence or practice-based evidence are tools in the box. And I think they should be elevated to the same status as evidence-based practices.

I can foresee in my worst-case scenario all service providers being required to use evidence-based practices which have not been normed on their populations and which may not be culturally competent and whose outcomes may be less effective than the practices that have been used within the community over generations and have a track record of success.

DR. CAROLYN CLANCY: So I think one other important to mention that we didn't get into, but it's particularly helpful thinking about evidence is that a huge part of clinical care writ large across all domains relates to beliefs and

interactions and, frankly, to the placebo effect. I want you to do well, and you're so moved by my wanting you to do well.

And I've had patients come back to me repeatedly in the past mostly because I listened, and I think I was a sympathetic ear for them struggling through something that we didn't know what to do about, often a physical problem. You know we have. I'm just telling you we don't know very much.

But one big, big part of randomized trials as well is that we presume, and some studies actually test this up front, that you don't have strong beliefs about which intervention it is. And I think what makes it very, very hard for this field is that there is so much passion. You don't have another way to -- there's not a counterpart to sham knee surgery, right?

The study that Jeanne said, which, by the way, is not knee replacements. So those of you who weren't following it, it's kind of knee stuff where they stick in a needle and kind of clean things out. My dad had it done a couple of times. I talked him out of the third time and felt like a hero.

But the way they did this was patients were actually put to sleep and woke up with a bandage on their knee even if they didn't have the surgery to kind of minimize that belief factor. That's how they did it. And some studies have actually not allowed clinicians or patients to be in the intervention, the randomized part if they have beliefs about what works.

So I think that is another big, big feature of the kind of thorny nut of challenges that we're trying to work through here.

Agenda Item: Council Discussion

DR. LARKE HUANG: It's interesting because I think we often overlook at that piece. It's actually in the definition for evidence based. It is that patient values and belief, but we don't give as much weight or credit to that at times.

I want to open -- Pam, did you have any particular questions you wanted to address? Because I thought we might open it up. We probably have people who are in the audience or on some of the advisory councils who -- yes, I see hands already. Okay. So if you want to direct your question or if you want to direct it to a specific person or the whole panel, just indicate that.

MR. JOSEPH A. GARCIA: This is a perception. This is Joe Garcia from Ohkay Owingeh.

DR. LARKE HUANG: Joe. And please introduce yourselves.

MR. JOSEPH A. GARCIA: Yes, Joe Garcia from Ohkay Owingeh.

And I'll preempt this by giving you a scenario that happened in Ohkay Owingeh. It has to do with Head Start testing and how the Head Start students were performing. So we were informed by the Federal reviewers that our Head Start children were not up to par, and so I asked, "How do you know that?" They said, "Well, we gave them a test."

And I said, "Do you have a copy of what test you gave them?" And they said, "Well, we don't have one here, but we'll bring one tomorrow." So next day came, I said, "Let me see the test." One was a picture of a cruise ship. They said, "Your children did not know what this cruise ship was."

And then the next, "Were there any other pictures?" And they took out another one. They showed me a sailboat, picture of a sailboat, and I said, "Folks, this is northern New Mexico. The largest body of water we got is the Rio Grande River down there. You don't see no cruise ship. You don't see no sailboats down that road."

And so, part of the -- what is also involved here is that same aspect that unless you know the tradition, the culture, the language, and the scenario and the environment upon which that individual that is needing help comes from, then blind application sometimes could be a detriment. And my suggestion to this is that we've not talked about the phases that a person goes through when they're going through mental illness.

And so, it almost appears that in all the evidence that we've seen, the latter stages of an illness are at the times when we try to intervene and provide recovery. But that's way past the stages of if we had worked on it initially and recognized something earlier on, then the earlier phases might have been a good time to have intervened or to apply other techniques.

But if we have the evidence base, at what phase does this apply? And if you apply it too late, too early, or unless you apply right at an appropriate time phase, it may not be effective. And so, the biggest, I think, factor is the environment where the individual came from, and it plays a big, big role.

And so, that's why I had to tell the story about the Head Start because it's true those are tests that were scored in all over America by non-Indian students who didn't live in a remote area, and they did fine. But I suggested to the Head Start staff, let me devise a test for the non-Indian population and you take this test, take it to the city, see if they pass it.

But I think it proves the point. Thank you.

DR. LARKE HUANG: Does anybody want to comment? Jeanne, do you want to comment?

DR. JEANNE MIRANDA: You know, I totally agree with you about environment. And when we were doing the Partners in Care study, I was driving around Washington, D.C. listening to CBT tapes of therapists out there, and I became a menace to the traffic because I was so upset with the way therapists often dealt with patients. There's a lot of bad treatments going on out there, I'd have to say. And you know we try to supervise and hoping we made a difference.

But there's a certain -- you do need to understand the person in the context of their lives in order to do treatment. I just completely agree with you. And if you don't have that, it really doesn't matter what you do. They're not going to feel -- and to me, things like power differential, how that sits in the room with you all the time and how you need to be thoughtful about that.

So I think there are these ground rules that I don't know how to teach very well. So I certainly think the cultural competent classes where you get a lot of facts aren't a very good way to do it. But that kind of basic respect for and understanding of the person's life just has to be there before you do mental health treatment. I couldn't agree more.

I think that has to be there within an evidence-based care if you're going to do it. So the trials where it's done well, I think we do that well. And if you don't do that, you're not even going to get people to come to care. So I couldn't agree more.

MR. JOSEPH A. GARCIA: Thank you.

I wanted to add that the commonality between all of us is the physics. The laws of physics apply in every case, no matter where we are, who we are. If we get cut, we all bleed, and our blood is all red. And so, from the physics part, the science of physics, the science of biology and chemistry, those completely apply. And how they're impacting the situation at any one instant in time for any individual in time is the part that we should be clear on what part applies in this case.

Thank you.

DR. WILLIAM R. MCFARLANE: Bill McFarlane, Portland, Maine. Thirty years researcher on developing treatments, testing them, and implementing them.

I'm a little concerned we've set up a strawman kind of discrepancy here between Diane's position and Jeanne. I'd just like to share a little bit of experience about

working with families, which is one of the CMHS toolkits, family psychoeducation. So we're up to 40 controlled trials now worldwide. Probably the most cost-effective treatment for schizophrenia and probably the most effective evidence base we've ever had for any treatment of schizophrenia.

It's been tested, and it was developed in South Bronx of New York City of the multifamily group, and the only person not of color in that room was me. It's been tested across the State of New York, all across the State of Michigan, all across amongst Latinos in Los Angeles, a very large study in Tokyo, three studies in China, amongst Indo-Chinese and particularly Vietnamese, and Melbourne, et cetera, large studies in Denmark and in Norway, et cetera.

What binds all of those studies together is both the protocol for the treatment, but also in every instance, the leaders of the group were members of the culture of the folks who were receiving the services. And we relied heavily on that group, that whoever they were, whether they're Danes or Japanese in Tokyo, to micro adapt that protocol to the culture, based on what they knew inherently about their own culture.

And so, I think that before we throw evidence-based practices out because they haven't sort of been adapted well to communities, we probably ought to ask the members of those communities to try to adapt them and test them first. Because I share Jeanne's point of view about this is that if you adapt these treatments, they work remarkably well across cultures. And if you don't do it, you run into the kind of exact problems that Diane is running to, which is they don't fit. They don't work because they don't even get implemented.

And then I would also propose that the other way around really should be looked at, and that is what are those evidence or practice-based practices that need evidence? Because they may either influence the adaptation of existing practices or become new ones themselves.

But I'd hate to see this sort of because I know what happens when you say to the larger clinical culture in the United States, which is that is that practice-based evidence is good enough, is you have an immediate slide to the absolute bottom of practice, which is what almost all of these studies have used as the control groups. We don't do controlled trials anymore. We compare to standard treatment, and that's where the evidence is most consistently superior.

Long comment. I hope that's helpful.

DR. JEANNE MIRANDA: You know, I completely agree with you, and I really agree with Joseph that there is a bare bones of what is the treatment. And in CBT, we pretty much know it's helping people with the way they think about things, helping with the way they spend their time so they make sure they're

doing, and how they deal with people. And if you improve those, people get better who are depressed.

Always when I do a randomized trial, I do the pilot groups myself, and we did groups separately with African-American and then with Spanish-speaking women, and we did every element of the CBT. But if you would look at a tape, you would almost not believe how different they were based on who the patients were.

So many times, our group, we had immigrant Latina women. They were all immigrants. And they were very kind of nonassertive, and they would really always call us "Doctor" and want the doctor to tell them what to do. And we really worked with that sort of framework.

And our African-American groups, they always called me Jeanne. And they really wanted -- it was this great spirit of helping one another and a tremendous amount of support from the community. But we still did the CBT, just we did it differently based on who was in front of us.

And to me, that's good clinical skills. I don't know. If you're a good clinician, you just do that. And I've always said like the biggest cultural difference for me is between -- and you know, I worked at San Francisco General for many years with all cultures. My son, when he was 13, I couldn't -- a middle-aged woman and a 13-year-old boy don't have a single common goal. He's so different from me. I was like, "How could this be my kid?"

I mean, I don't need to get hit right before we talk, but he always had to whack me. Just so different. But so, like it's not like I couldn't breach that. So I just think of it as using good clinical skills, but not throwing out the kind of things we know make a difference.

You could be really culturally sensitive and warm and wonderful to someone who has a terrible depression, and they will feel better sitting in the room with you. But there's great evidence that they're going to come back the next week just as depressed. If you get them to think differently and act differently and interact differently, they're going to get better.

So I definitely believe in as a clinician, I think I change everything I do with each person. I try to use their language. I try to understand.

I always tell the story of one of my patients one time. It was so interesting. When I was at San Francisco General, I got transferred -- I was an intern -- up to the main campus, and I had gotten this patient at the General. So I took her up with me. And she didn't have transportation, and there was a doctors van that went back and forth and sent us back and forth. And so, I said could she ride on

that? She didn't have -- so they allowed her to.

She got to the first session, and she said, "Do you know what? Doctors get divorces, and their cars break down." And like her view, it was a very long couple of minutes, was her life was so tough, and everyone else was privileged and they had this great life. It was a huge impact.

So I think we can learn a lot from each other's cultures. And you can do that in a session, but you don't have to throw away the things that actually really make a difference.

MS. DIANE NARASAKI: You know, Bill, I don't think that, at least in my case, you're talking about one thing or the other thing. I'm talking about a range of tools. I don't reject and ACRS certainly doesn't reject evidence-based practices. But we also think that practice-based evidence is important.

And if we're going to go down the road of evidence, I think we have to look to what we're trying to achieve if this discussion in particular is about disparities. There's a disparity in research, to begin with. Who gets the research dollars? Who is designing the research? Who is a participant in the research?

My community doesn't have those dollars. We don't have those research. And yet for 40 years, ACRS has been helping individuals who are referred to us by the rest of the mental health system in our country and State because we have a track record of being able to work with our consumers, and our consumers indicate that they find these practices effective. So there's disparities when it comes to research at that end.

But then, secondly, I also think practice-based evidence and community-defined evidence are newer concepts. I don't know that much funding has gone into them either, and I still think about the fact that the rest of the county and State sends people to us that they have not been able to help.

Sometimes it's not even that they see, oh, this person is an immigrant or a refugee or is Asian American or Pacific Islander or ACRS has the language capacity. They have tried to help them themselves and failed and then send those individuals over to receive services to us. And in many cases, those individuals have prospered with the services they've received, which are more culturally competent.

And so, I can't dismiss the 4 years of experience that we've had at our organization using many practices which have not been scientifically investigated, but yet result in clients or consumers meeting the goals that they set out for recovery or improved GAF scores or other signs of improvement. I think it would be unscientific.

It would be dogmatic not to acknowledge that these things exist, that they work, and in some cases work better than the evidence-based practices which we are required to use, as I gave in the example. By the way, we have a variety of evidence-based practices that we use, almost all of which are adapted, only one of which requires strict fidelity and which is a complete misfit on some scores.

And my clinicians are just resigned to the fact that we are never going to score well on fidelity to this particular practice, even though we do better at placing people and having them retain their jobs than our compatriots who do maintain fidelity. When we brought up this fact to the generator of the evidence-based practice, the generator said, well, we don't have enough evidence from organizations like yours treating populations like yours to be able to say that what you're doing is effective and that an adaptation should be made, even though people were being employed at a higher rate and being retained at a higher rate.

So it's, to me, not a question of either/or. It's looking at all of the different tools that we might have to close disparities because I agree with Carolyn. The issue of disparities is urgent, and we can't wait until we have all the evidence-based practices in place to bring us to where we need to go, nor are we convinced that evidence-based practices are the only way to go.

We do believe in the importance of culture and the importance of practices that have been accepted by the community over time and proven to be effective.

DR. LORI SIMON: Well, I'd like to -- somebody else?

DR. LARKE HUANG: We had two hands in the middle and then the back.

DR. CAROLE WARSHAW: I'm Carole Warshaw from Chicago.

I'm wondering if you could talk a little more about the patient-centered outcome research because one of the things we were trying to think about is how do you develop evidence for models that are patient centered or survivor centered in the case of trauma research, when someone's lives are changing and things are complex and you're responding to things that are going on immediately?

How do you develop evidence or interventions that have some flexibility? Because most cognitive behavioral therapy interventions are manualized, and so they're protocol defined rather than patient centered. And how do you do that, and are there more complex methodologies that would allow us to look at multiple contextual factors that are emerging that don't require a huge N to be able to actually look at their effectiveness?

DR. CAROLYN CLANCY: So one thing, I would just say the Affordable Care Act

created the new Patient-Centered Outcomes Research Institute, and we're sort of their partner in terms of dissemination and building capacity for that research.

But in addition to a research institute with a lot of money, which if they're getting hit by sequester, it's a teeny, teeny bit because it's a different funding source. So they've got like \$3 billion over a decade. That's a lot of money. They haven't spent very much. So just if you needed any motivation to keep in touch with them.

They have a methodology committee that I don't think has gotten to that level of depth, but I think they would love the question as they begin to think about the next areas that they need to be thinking about methods for. So I do think that's an important thing.

The one comment -- I would make two comments here. One is almost a bit metaphysical. Defining an intervention is itself a little bit tricky. And yet when I think about this field, right, money and who's developing interventions has actually had a huge, huge influence on practice, right?

I mean, we came up with medications, and suddenly, that is driving a whole lot of what goes on in practice not because we've ever done the head-to-head trials in many cases, but because it's easier, feels cheaper, and it doesn't take so much time, and time costs money. But writ large in healthcare, I'm increasingly impressed over time, it's almost embarrassing to say after 10 years as Director, how hard it is to define interventions.

And the only reason isn't to pass a test, although I have to say the image of the cruise ship on the Rio Grande will stay with me. The reason to be able to define it is so that you can replicate it. So that if you're working with a group of patients and the outcomes are outstanding, others could learn from that, potentially adapt it, but actually trying to get to that core that Jeanne talked about. And yet even some of the most sophisticated researchers I find, particularly for interventions that involve teamwork and lots of communication and interaction, are challenged to communicate that very, very concretely. Okay, if we had another setting and they're starting from scratch, what do you do?

The other issue I think that we haven't talked about but is part of this whole mix is what do we study? So several years ago, we had all the ARRA money for CER, and it was just very exciting. People followed us around everywhere, and we had hearings to hear from a variety of folks, two in D.C., where lots of people have day jobs that include the requirement that you might drop everything you're doing and go testify at a moment's notice. And they're well equipped to do that, and that's its own kind of theater.

And one on the South Side of Chicago at the U of I. Very, very different kind of context. And there I heard about people's experiences with kinds of

interventions that, you know, they might work, but I could also tell attaching that particular intervention they were describing to a revenue stream would be really tricky. And I kept thinking, wow, it's now I know why we don't know very much about this particular kind of item.

Because if it's a drug, we've got a distribution network. For other kinds of approaches, it's much, much harder. So I'll leave it at that.

MS. CHRISTINE WENDEL: Hi. I'm Chris Wendel, and I'm from New Mexico, and I'm part of treatment.

I want to thank you. I really enjoyed this conversation. This is something I have personally struggled with. One of the things I love about being on this council or advisory councils is that we're all different kinds of people, and our backgrounds are so wonderfully diverse.

I am not a clinician, and I am not an academician, and I'm reasonably sure that I never, ever, ever in my life used the term "evidence-based practice" until about 4 years ago. And that said, I just want to say my background is in recovery from substance abuse, and when it comes to recovery from substance abuse, there has a pretty strong practice-based evidence. It's been around about 78 years. It is worldwide, and it has that pesky little thing about anonymity.

But, Diane, thank you. I do think it's a whole spectrum of options, and I'm going to counter maybe a little bit what Bill was saying that I want to make sure we don't lose the practice-based evidence, the common sense of looking around and seeing what's real and what works and what's helping people at a grassroots in their communities recover.

So, but mostly I want to thank you, Larke and Carolyn and Jeanne and Diane. Great job. I enjoyed the conversation.

Thank you.

DR. LARKE HUANG: Yes, Stephanie? Stephanie, say your name.

DR. STEPHANIE M. LE MELLE: Comments. One is -- I'm sorry. Stephanie Le Melle from New York.

You know, when we're talking about evidence, I think it's important for us to also -- it's sort of getting mixed in our conversation the difference between culture and ethnicity. Culture is learned experiences and values, and that's sort of the bulk of what we've been talking about. Whereas ethnicity is really much more genetically and biologically driven, and particularly when you're talking about substance abuse or if we're talking about nonbehavioral interventions like

medications, I think we really need to look at the disparities of the evidence that we use when we're looking at other types of interventions.

In particular, and I know some of the folks here have already heard me say this because I like to harp on this one, there's an entity called benign ethnic neutropenia, and it's common in people of Mediterranean and African-American descent -- and African descent. And what it means is that people of that ethnic, not cultural, but that ethnic background have low white blood cell counts as their normal baseline.

And I think because they have low white blood cell counts, they are not eligible for Clozaril, which is an antipsychotic medication that we have that in terms of evidence-based practices we know is the medication of choice for people who are resistant to all other medications. So we're discriminating against this whole population of people who have benign ethnic neutropenia simply because the baseline that we're using to determine eligibility for the medication is a baseline that was not based on minorities and not based in particular on people of African-American and Mediterranean descent.

So I raise that as a point that ethnicity and culture matter and that we have to look at both aspects. And when we're talking about evidence, the evidence as compared to what? What is the baseline that you're comparing to? And our standard is the majority population. And so, that means that the outcomes that we get based on that evidence may not fit all populations.

So we really need to think about it in both components.

MS. DIANE NARASAKI: Thank you very much, Stephanie.

I really agree with looking at the baseline, as you just mentioned.

DR. LARKE HUANG: Yes, next to Stephanie?

DR. JEAN CAMPBELL: Jean Campbell.

And like Bill McFarlane, I've been involved in directing the creation of an evidence-based practice for SAMHSA, and I speak from that experience, which was very enriching and empowering for the recipients of the services.

And I was thinking that most of what you said isn't really against science. It's just said in a way that sounds like it. If we just changed how we were speaking a little bit, it's more like how to improve science or the process of science to be more inclusionary, to be more grassroots, to look at things like community engagement and consumer participation in the process, doing the research, how to be in the research process, be more culturally competent.

Because if we don't have science, then what do we have? I mean, we can codify opinion without science, but it doesn't take us to the depths of understanding where we can build a field, an entire field because science is progressive. I mean, you can go from evidence-based practices to looking at the relationship of fidelity to outcomes, for example. And I was just thinking and when you look at that relationship, you could see what the disparities are in terms of the various practices, which can inform how you deliver a particular service.

In other words, you can make the process of adaptation scientific, and you can understand what affects what, you know? Those things are done because of the scientific method.

And also years ago, 1989, I headed up this project called the Well-Being Project, and we just did some descriptive statistics. It was the first consumer survivor research project. And we came out of that, and there was this common understanding that self-help works. The people who did self-help within the consumer movement knew it worked and believed in it, but nobody else believed them when they claimed it, and it was hard to get funding.

And it wasn't until we were able to do a randomized controlled trial with 1,827 participants in a program that we were able to find out that it did work and how did it work and for whom did it work. And that became a very powerful tool in the what is now a movement throughout the States to make programs better, to improve the quality of the programs.

Because most of the people said, okay, you can show in science it's an evidence-based practice, but it doesn't work in my program. But the emphasis at that point wasn't on a recovery-based system. And by taking the fidelity tool and making it a continuous quality improvement instrument rather than something that which is just administered as a monitoring system, like for State block grants, for example, we were able to change the consumer-operated programs in Missouri from mom and pop, recreation, and wash your clothes and take a shower places to really delivering recovery-based services based on the transformation of the science into the field.

So I think that that story shows what the possibility is for science, and there is a necessary tension. It's for us as providers and as scientists to work together to -- it's another one of those chasms like crossing the quality chasm. This science and evidence-based practices can help us cross that chasm.

DR. LARKE HUANG: Okay. I still see hands up. I'm really sorry. We're going to have to end. We're over our time. And I think I want to propose to Pam that this is just -- one more? Okay. Lori?

DR. LORI SIMON: Yes. I mean, I think a lot of what's being said here is that I think we need to do the studies, and it's -- we don't want to stop doing that. But I think the recognition is that with any study, you cannot control for every factor and every variable.

And I think with behavioral health, as hard as it is in any other discipline, it's harder for behavioral health because it's not only a particular illness and symptom. It's the social situation. It's the person's brain. It's the combination of diagnoses.

And so, there may be a time when we are so good and we have got every study and every factor controlled for that we will be able to solely do evidence based, but we're not there yet. And so, I think that the point that's been made is that the studies need to go on. It's important for clinicians to have access to that.

But ultimately, right now, it's the clinicians who actually are aware of more of those factors and variables than any study is. And so, that's why, ultimately, I think it's the clinician that needs to pull and decide what's going to work for a particular patient.

The other thing I'm concerned about, and I've seen this already with insurance companies with other things and with medication, is that we need to be careful that the insurance companies don't latch onto a particular study and go, okay, this is what's needed for this particular patient, and you must do this in order to have coverage. They do that with medications now, and I've seen them do that with other disciplines. So it's a concern.

DR. LARKE HUANG: I think we have -- do we have time for one more question? Is there a short, urgent question? Okay. Short, urgent.

MR. REX LEE JIM: It's not really a question. It's more of a comment. I'll make it short. Again, this is Rex Lee Jim, vice president of the Navajo Nation, but I'd like to introduce myself in a different way. I'm also what's called a Blessing Way singer, a traditional practitioner, a medicine man, if you will.

And there were times when people with mental problems or substance abuse, they came to my ceremonies. When they left, they stopped drinking. So there are alternative ways of dealing with this other than what we've called evidence based or scientific based, Western based. There are alternatives. There are ceremonies. There are different ways of treating these ailments, and they work.

And it's throughout indigenous America, indigenous world, and we need to realize that. And that's not evidence based, but it works, and that needs to be a part of this whole discussion.

And the other thing is when it comes to funding programs and different issues, they need to be involved, and they need to be a part of this funding cycle as well. The reality is that this evidence-based, scientific-based, Western-based notions of healing and doing things, they're biased in terms of getting the funding.

Thank you.

DR. LARKE HUANG: So I want to say that I was glad I wasn't given a charge to come to consensus on this panel.

[Laughter.]

DR. LARKE HUANG: But I think we've really started beginning an important dialogue and discussion. A couple of key take-aways. As we've heard from people in the audience, people on the panel, as documented in Carolyn's annual report on health disparities, they persist, and we are not making the degree of progress that we would like. So we need to figure out why.

Our toolbox, and to use Diane's term, maybe we need to expand our toolbox of what we think is going to be best for the people that we're interested in serving. Our science is really critical. The evidence, what do we mean by the evidence?

We hear adaptation, I think, through everybody. Maybe we need to think better about what is systematic adaptation so we can get a better sense of how we're using science or practice based or evidence based and the critical adaptations.

The other piece I heard throughout here was also engagement, that maybe the core of these practices going to work across populations, but the engagement strategies are really going to be quite variable. And there are some pieces, as Stephanie said, that there are just going to be real population differences in how people respond to different interventions, and we have to take that into consideration in guidelines.

So I think there were a lot of issues brought up. I hope that we will be able to make this periodically an ongoing discussion. Sorry to those we didn't get to you, but you can come besiege the panelists now.

Thank you very much to Carolyn, to Jeanne, and Diane for your courage in taking this issue on, and we are going to take a break now.

[Applause.]

MS. PAMELA S. HYDE: Not quite. A couple of things. I do want to make a comment or two. I was listening here, and I want to start with Rex Lee Jim, your comment. I do want to reiterate Steven Green was supposed to be on this

panel, and he is from the Gila River healthcare organization and I think would have added some of that perspective. So I'm sorry he wasn't able to be here.

But I do think it's interesting. I had a conversation once with a researcher from the Montana area, and she was a Native American woman researcher. And I said something to her about evidence. How do you know things work, or what standard do you use about that? And she said, she made some comment about, well, it's not the Western standards.

And I said, "Well, what do you mean about that?" And she said, "Well, we know it works in our community." And I said, "Well, how do you know it works?" And she said, "We ask the elders." And I said, "Well, how do they know it works?" And she said, "They just know."

And I thought, for me, that was -- and then we were able to talk about it a little bit more, about obviously what criteria they use as elders to know that that young person is doing better or whatever, and it's clearly something you could quantify. But the Western approach tends to be a quantitative. Let's quantify it. Let's put it in a 0 or 1, yes or no kind of construct.

And I think that is something we have to think about differently because even the concept of science. We have a tendency to talk about it as if it is -- the controlled clinical trial is science, and there's a whole lot of science that is beyond that. So I think that's an important comment that we heard from you.

And then I want to put on the table, nobody did, but for us to think about. We constantly say, well, we just need to know what works. Well, what works compared to what? It's what works compared to no care? What works compared to the care that the traditional population is using? What works compared to usual care?

So we might get a 50 percent gain in compared to usual care, but usual care is still doing pretty well. So we have those kind of issues, and we have what works for a population, which is almost never 100 percent, compared to what works for an individual, which may be very different than what the population response is. So all of these complexities are important, I think, as we even talk about this.

Now before I let you go on a break, I want to take -- because I think it's a perfect time -- one question. You know we get questions as we go from people listening in. A person wrote, "The overwhelming honest evidence shows that antipsychotic drugs are a harmful fraud for the majority of persons prescribed and is among the most costly of drugs." And a question is, "Does SAMHSA feel duty to reduce prescribing or to convince the U.S. that treatment medications are effective and expand prescribing?"

Well, the answer is yes and yes and no and no. The answer is there are definitely populations for which SAMHSA believes and works with people like the Administration on Children and Families in which young people are being overprescribed, we believe, antipsychotic medications who are in the child welfare system. We have some evidence of that in the sense of the data shows us that they are disproportionately prescribed these medications for perhaps not the appropriate reasons.

And we are working with that group to try to get other kinds of approaches in the process. There are other populations for which we know they do not get access to psychotropic medications, which there's some pretty good evidence that it would help the majority of them if they could get better access to that medication. So, in that sense, it's a yes and yes. We are both trying to decrease it in some places, increase it in others.

And it's no and no in the sense of I don't think any of us in SAMHSA believes that antipsychotic medications are the be all and end all for anything. It is one approach to treatment for psychotic illnesses.

There's also other places. For example, the issue of substance abuse has been raised a number of ways in which whether it's Blessing Way ceremonies or whether it's mutual aid that clearly helps in substance abuse, but so does medication-assisted treatment. And medication-assisted treatment is not well accepted yet.

So it's no and no in that sense. No, we are not trying to undo either one of these approaches. So, hopefully, that's helpful not only in the context of how we think of evidence and what needs to be available and SAMHSA's role in that, as well as an answer to this specific question.

All right. With that, we'll let you have a break. We're going to give you a 15-minute break, and we're right on time. So if you can be right on time at 2:45 p.m., we'll get started again. We're going to do an update on health reform, a minor issue in our world these days that you will probably have lots to say about.

So, thank you.

[Break.]

MS. PAMELA S. HYDE: This has been a rich day already, and we have another panel that we're going to both share with you and hear from you about. As you recall, over the last couple of years, we have been giving you updates every time you've been here with us about what's going on with health reform.

There's a whole lot about the Affordable Care Act that has already been

implemented that has a positive impact on the people in our field and the providers in our field. But there's a lot more coming, and this year, literally right now, we're in what we affectionately call the "countdown to coverage" because people are getting geared up on how to help people make selections about plans that they want to be involved in and get enrolled and eligible for that.

States are still making decisions about Medicaid expansions and about exchanges and such. There are RFAs coming out and all kinds of things, requests for applications for money that are coming out that we may want you to be aware of. But at any rate, beginning October 1st, 2014, people are actually going to be able to start enrolling in new coverage opportunities.

And as I said earlier today, there's 62 million people in America that are either going to get coverage for the first time and in that have behavioral health coverage or people who have coverage now, but may not be equivalent to -- or it may not have behavioral health in the package that they are going to be getting coverage for. So lots of opportunities.

Rather than us telling you a bunch of stuff this time, what we're going to do is have a panel of you all talking again. And to facilitate this panel is the person who heads our strategic initiative on health reform -- health finance and health reform, and that's Suzanne Fields. I want to turn it over to her. I think in your packet somewhere is her background. If you want to know more, you can always ask her later.

But she comes to us from Massachusetts. She's terrific, and she's been making a huge difference for us in this arena. So, Suzanne, turning it to you.

Agenda Item: Update: Health Reform – Outreach and Enrollment Strategies

MS. SUZANNE FIELDS: Well, thank you, Pam.

Good afternoon, everyone. I am Suzanne Fields, as Pam indicated, senior adviser on health financing here at SAMHSA.

And in terms of eligibility and enrollment, SAMHSA has identified this particular topic as an enormous opportunity for us to advance access for persons with mental health and substance use conditions, both in terms of physical healthcare and mental health and substance use treatment. So we're very glad to have an opportunity with a terrific panel of folks who are implementing in States access to insurance and working with States on these issues.

I'd like to begin by having each of the panelists just briefly introduce themselves.

DR. VICTOR A. CAPOCCIA: Well, I did earlier. I'm Victor Capoccia. You've heard me ask questions. I'm going to say no more.

[Laughter.]

MS. SUZANNE FIELDS: And that is why he's sitting next to me, actually.

MR. MICHAEL COUTY: Hi, I'm Michael Couty, and I'm from the State of Missouri, and I'm the juvenile court administrator.

MS. ELIZABETH A. PATTULLO: And I'm Betsy Pattullo. I am the founder and chairman of the board of Beacon Health Strategies, which is a managed behavioral health care company started in Massachusetts in 1996 and now doing work around the country.

MS. SUZANNE FIELDS: Thank you.

In terms of starting us off, we thought it would be very important to frame the issues that are of concern that could lead to policy operational issues to support persons with mental health and substance use conditions. First, we have what we mean by words such as eligibility, enrollment both for persons getting insurance for the first time, as well as issues around ensuring continuity of insurance status over somebody's lifetime.

And then we also recognize that there are a set of issues specific to the very nature of the conditions that many individuals are dealing with that can also create challenges both for access to insurance, but again for maintaining insurance coverage.

I'd like first to turn to Victor in terms of setting the stage for that broad context of both State issues and Federal issues related to enrollment for persons with mental health and substance use conditions.

DR. VICTOR A. CAPOCCIA: Okay. I'll start with I think just a couple of contextual facts. Pam has appropriately referenced a couple times the potential that we have with health reform in terms of 62 million people. The addiction world, which I know best, has 26 million Americans out there who would benefit from some kind of level of intervention, and we reach currently 1 in 10 of those people.

In effect, that says a lot of things, and we can list those. But one of the things it says is that we sort of have a system of care in one form or another, or in multiple forms, actually, that reach 2.3, 2.4 million people a year. So if we have

any, any at all expectation that we are going to move from 2.3 to anywhere down the road to penetrate the 23 million people with -- reported with diagnosis, it means we need to do something different because if we do the same thing, we will get what? The same result.

So we have to do something different. So there's huge opportunity, and there are a number of things that SAMHSA and others are doing, including from within the field, to expand and to approach this in a different way.

With the issue of coverage, we have the potential. We've woken up a field which I think cuts across behavioral health that has said we do not have sufficient resources, and all of a sudden, we have woken up and there is the potential for additional. Whether it's sufficient or not, I won't say because I don't know. But we certainly have additional resources in the form of insurance through exchanges, in the forms where Medicaid will expand, in the forms of where parity applies to existing plans. All three of those are drivers of additional resources.

For people to take advantage of that, it means they must become covered with insurance. For people that we serve to become covered by insurance, we know for a lot of reasons that it will take a fair investment for that to fully happen.

But we've done some work looking at this issue in Massachusetts where, just factually, 97 percent of the population in Massachusetts is insured. Only 3 percent remain. Most of those 3 percent, as you look at them on a large scale -- Carolyn Clancy said writ large -- if you look at them on that basis, are younger people, not surprisingly, who are more resistant to enrollment.

A huge effort was put, and we'll talk about that, in terms of the information outreach navigation to help people find their way through that system. But here's what's important to us. If you talk to your peers who are delivering care in Massachusetts and if you look at some basic sources of data, almost -- anywhere from 25 to 30 percent of the people who show up for treatment in both the mental health system and/or the addiction treatment system are uninsured.

So are they all of that 3 percent? Well, they're a significant portion. But I think we need to talk more as a panel, and I'll stop just in terms of setting the stage of why. What is that about?

So, essentially, there's an opportunity that's huge. It requires change. There's part of that change is getting the coverage, and a significant other part of getting the coverage is keeping it.

MS. SUZANNE FIELDS: Victor, you reference both the disproportionate impact on persons with mental health and substance use conditions as well as younger-aged persons in terms of insurance access. We've also recognized and

discussed that there are other populations that are also experiencing a disproportionate impact, those that may be involved in juvenile justice system, touched by the criminal justice system. As other examples, persons experiencing homelessness, challenges with stable housing.

Michael, I know that this is a particular area that you have been working on in your State. Could you frame a bit those particular issues?

MR. MICHAEL COUTY: Okay. Prior to my coming back to the juvenile justice system, I spent a little over 20-some odd years as State Director for Alcohol and Drug Use for Missouri. So I see it from two perspectives, but I'm getting a better perspective from the juvenile justice side of the house because I'm dealing with every entity now.

Where I was dealing, trying to get the alcohol and drug abuse services out into the community, now I'm looking at I've got to deal with children, the parents, the housing, and now I've got to deal with the child welfare system, trying to keep them focused on the outcome that we're trying to get.

What I have seen, especially in Missouri, we have done a very good job with the CHIP program. We've got most of our kids covered. I said kids covered. But our kids don't live by themselves. If they're with their parents and they have a substance abuse issue, we have taking -- Missouri took a stance about a year, year and a half ago, saying if, in fact, we have an individual over the age of 18 and they are using, they will not be eligible for Medicaid, but the kids will be eligible.

So if you have that issue going on and you have them coming to the attention of the court, you're looking at reunification, and now you have not the ability to access coverage. It becomes a problem.

And let's take it from another perspective. You get families coming in from issues of neglect and abuse issues or failure to -- educational neglect because kids are not going to school. Child welfare steps in. They then contact the court. Then we take a look at it.

One of the things that we try not to do is remove the kids from the family. If we have to, you look at kinship placement. But at the same time, you're looking at there are certain guidelines that you're asking the families to do when you're putting together a family support team and you're getting all the various members either from child welfare or from the court, from the education facility, from medical with the guardian ad litem for the child, the attorney for the parent. If you have two parents, both parents will have an attorney.

So you're trying to work out a plan in order to do reunification. But one of the

problems you have is that, as we go down this road and you're wanting to talk about health coverage, everyone is being tested, even at McDonald's, to see if, in fact, you're drug free in order for employment. If you're not drug free, you don't get -- you cannot be employed. So that may become another barrier for coverage and another barrier for you to even have reunification.

Those are some of the big issues that I'm struggling with. Yes, we have this reform coming down. But right now, I'm always seeing what are some of the barriers or issues that are facing the population that I'm dealing with, and we've got to be able to remove some of those roadblocks as we go down.

Another area that you talk about is -- you talk about homelessness, but a lot of our families have vouchers either at the local level or at the Federal level, and those vouchers do move from one locale to another locale. But one of the problems we have is that we're all in our little silos. As a housing authority, I just deal with the housing issue. I really don't think about that mental health or the substance abuse issues that may be coming along, or do I look at they do have an issue, CMS kids must attend school. But do we try to see if they attend school? No, we don't.

And so, if we were to even come together and try to work as a unit, I think we would have a lot more identification, early identification when it comes to education needs, where we talk about environmental issues that kids might have because they're failing in school. It's not because they don't have the ability. It may be because they've not been there on a consistent basis or those families move every quarter. And so, you have no consistency where you're able to develop an understanding of the subject.

So I consider that an environmental problem if they have not an educational problem. And so, these are some of the things as from the juvenile justice system we're looking at.

MS. SUZANNE FIELDS: One of -- the primary area that we've been talking about so far is the impact on a person who needs insurance and some of the particular challenges around that. We had also discussed that there is an impact on providers, as well as State insurers or State purchasers such as Medicaid authorities as well, when people are uninsured.

So we've spent time just highlighting some of the things that we do want to talk and hear from you about related to people and the particular challenges, but we also want to recognize the impact on providers and then the impact on State purchasers and the opportunities there for redirection of dollars and policy changes.

Betsy, could you frame a bit some of the issues related to both providers, or

since you are a CEO of a managed care behavioral health organization, also some of the impact from that perspective as well that could begin to frame some opportunities?

MS. ELIZABETH A. PATTULLO: Sure, Suzanne.

I hesitate to rely too much on Massachusetts, given the discussion that I've heard all day today, and it's been such a great education for me to hear from people from all around the country doing all kinds of work in different places. It's I want to talk to everybody before the afternoon is done.

But that said, we have gone down this road a little bit ahead of some other States in the country, and I guess my observation is that for the provider community, there is, as Victor pointed out, both an opportunity and also a potential burden. The opportunity, of course, is to have people who before were uninsured. And as we've done away with our free care pools and reimbursement to hospitals and community health centers and community mental health centers for free care reimbursement, it's been in the interests of the provider community to help with the enrollment of folks who come to them without insurance.

And they've actually been a key part of enrolling our newly insured populations at the point of service. We've relied heavily on hospital emergency rooms, on our community health centers, our community mental health centers, and in some cases have actively engaged, either through grants or reimbursement of one kind or another, outreach workers, whether we call them navigators, folks to assist in the enrollment process. And that certainly helped in reimbursement for the provider community for services that either may have been uncertain in the reimbursement or they may have given away in the past.

But it's an additional task. The payment for that work is not clear, and I think we end up looking at it in Massachusetts now as the front door has gotten opened pretty wide pretty quickly. And I think our experience was it was much more of a sprint in the first couple of years of this than a slow dance. I think people should be ready for pent-up need in terms of those who are understanding what the benefits of insurance coverage may be to try to elbow their way in quickly and for the provider community as well as the advocacy community to be very supportive of those efforts.

But I think that one of the huge problems that we experience is in the reassessment or reverification process that we now call churning, and that is a huge problem nationally of people going on and off coverage. When you may be eligible for your children, but particularly for either men who previously were not eligible, whether they're in families or attached somewhat distantly to families, not used to being able to access coverage. As people go in and out of the workforce, minor change in their income status can result in them being

disenrolled.

And I think that there is an opportunity at the State level and at the local level to kind of work this as an issue, both from the grassroots up where we know that the 3 percent in Massachusetts who have currently not participated tend to be young male Latinos, maybe new immigrants. Oftentimes language and cultural barriers will result in isolation. They tend more to be in rural areas in the State, but we know where they live. We can begin to send people out to engage those guys or those families or those individuals.

But come 6 months or a year later, when there's a redetermination, unless there is a plan to really attack the dogging of that process from the ground up, and I would argue from the policymaker down -- and I think there's a lot of work that has been done around the country, much of it through SAMHSA. Some of the work that Victor has done in Massachusetts in saying we've got to simplify these processes. We've got to get databases, which can talk to each other that can populate the applications so that we know that citizenship can be verified electronically rather than somebody going to city hall to get a birth certificate.

We still have a very long way to go with that, and I think there's a huge opportunity. And I think Massachusetts has not gone nearly as far as it should at this point, both with the State in thinking carefully about its processes, beginning with my mantra at Beacon in the early days was if we answer the phones and pay the claims, then we have the opportunity to actually do good clinical work.

In Massachusetts, our Mass Health, our Medicaid agency, still has trouble answering the phones. And if you can't be there at the front door, it's very, very hard to assure that people are going to get the support that they need to enter the system. So I think there's an opportunity for insurers, State policymakers, provider organizations to come together around the table and try and imagine how to make things work more efficiently for the user, the consumer on the ground.

MS. SUZANNE FIELDS: Victor, we had a conversation about that these types of challenges, which, Betsy, you just did a great job framing, also result in a financial impact and how those dollars are being invested in certain directions that could be redirected or redeployed in some instances.

DR. VICTOR A. CAPOCCIA: So I think this part of the discussion is really critical for those of you who are engaged in looking at what your States are doing and how they are designing and managing the enrollment process. And Betsy's point about the -- about the disenrollment due to the reverifications process just put a bunch of underlines under. Because here are some of the costs that it is beginning to assume.

For the State agency, and they seem to be willing to assume this cost, there is an administrative processes that goes into the several hundred dollars per person to manage this process. If you talk to the patients, which we did in a series of focus groups, both in mental health settings and in addiction treatment community-based settings, more than half of the patients who are being seen have experienced disenrollment in the prior year.

The disenrollment period goes anywhere from 6 months to a year. So there is an administrative cost to the State of the time reenrolling. Almost all, almost every single person is eligible through this period. They become reenrolled.

Through this period of time if the person is aware that they are in a gap, they're reluctant to continue their care. Their healthcare deteriorates. So personally, for the individual there is a cost of ill health. By the way, the State's cost now gets amplified. It's not the several hundred dollars for the administrative task. It's the cost of dealing with a more severe condition when they reengage in treatment, and this is across the board in terms of whole health.

The providers, not very happily, talk about being tired of subsidizing the State because, in effect, they are continuing to see people or they are seeing people for some period of time, and then they find that there's been a discontinuity of coverage. And so, they have to rely on free care.

Now this is where either State appropriation or block grant might be helpful for some to maintain a transition. But it's not probably the best use of that kind -- of that kind of resource. So the costs go to the patient in terms of health, to the State big time in terms of the administrative processes because they end up being reenrolled, and to the provider as the subsidizer of this whole process.

Oh, by the way, there's one additional cost. To the State and to philanthropy. Because the navigation and assistance to the process of reenrolling involves oftentimes the local legal service organizations or the local healthcare for all navigators, et cetera, to help a person get reenrolled for which they're eligible.

MR. MICHAEL COUTY: I guess I'm going to step out and may be inappropriately stepping out. But from a former State director, when you're talking about redirecting, I think it's very tough to redirect existing dollars when you already have them out there. I can't believe I'm saying that right now, being I'm not there.

But the block grant has gone a long ways and has really partnered with corrections because dollars have been set aside for drug court, for juvenile drug court, for adult drug court. You have mental health court now. So those dollars have been proportioned out. And when you talk about maybe redirecting, then you're going to have another gap there anyway. So you say the only way you

can get substance abuse help is go to prison if you're a male because you're not eligible for Medicaid.

I think we've done a real good job for women, pregnant women, and kids for Medicaid coverage. Excellent job in that area. Excellent job when it comes to kids. But I'm really seeing that disassociation when we're talking about males between the age of 17 and 21, especially when you're talking about mental health services. If you're not falling into the seriously mentally ill, you've got some coverage that's not there.

If you don't have insurance to cover you, as if you would have an EAP coverage where you get so many coverages for mental health issues, you're pretty limited in what you can get at that level. Because between 17 and 21, it's a tough age to be covered, especially for mental health services.

Substance abuse, on the other hand, there may be some dollars, may be some dollars available out there that are alternative dollars, either through what you have -- a lot of States because of county initiatives, they've gone for children's taxes. They've gone for mill tax dollars for the mentally ill and disabled population. And some of those dollars have been also used for substance abuse.

Some States have done a very good job in using it from a county perspective and then partnering with the State in order to fund services. I know Missouri was real good at that. With St. Louis and Kansas City, they had local taxes and we would then partner with our State dollars, and we would fund programming and shared programming so that not one entity was taking the complete cost. That was pretty wise in being able to share that along with United Way and whatever.

I think there's a lot of potential that's out there. But again, I am seeing, just on a cautious side, we have an area out there that I think that we're setting ourselves up that we're going to have a number of people, regardless of having access, having denied access because of their substance use or because of their criminal record, not being eligible because it's been identified in that way.

And I think that's something we're going to have to work on either from a I don't know if it would come from a Federal perspective or working with the State saying that we need to -- there needs to be some exceptions within those areas, and you cannot deny because of ABC for those services. And that would encourage some legislatures to relook at some of the laws that they've passed, but I think there needs to be an encouragement along that way.

MS. SUZANNE FIELDS: I want to be mindful of time and that we very much want to get to dialogue with everyone here with us today. But Michael, you just began to frame something that we had discussed, which is what's working in

States?

We're very fortunate that each of you has a multi-State perspective and in some instances an international perspective given your work related to these issues. Could each of you highlight some of what you know from your experiences and what you've seen that is working that we can begin to take back in conversations with others?

MS. ELIZABETH A. PATTULLO: Well, my recommendation for the future is universal and permanent eligibility. Pam, if you could just work that out with the Congress?

[Applause.]

MS. ELIZABETH A. PATTULLO: I think a lot of this would go away. And Michael, it's a little ironic that you get thrown off of Medicaid for the purpose of accessing substance abuse services if you have a substance abuse problem. So I'd be glad to come to Missouri and talk to a couple people, if that would be of any use. Maybe we could get a few other people from this room together and go out and talk to your legislature?

I think based on the experience that we've had in a number of States, but primarily I would say in Massachusetts and New York, I think we have found that there is a high level of motivation in the consumer community, in the provider community, in the advocacy community, amongst all stakeholders really, to encourage enrollment in the first instance.

I do think that where we've seen some success is as Mass Health, the Medicaid agency, has gotten together with our exchange for subsidized insurance coverage as well as the larger insurers and some of the managed care organizations and tried to put together packages of enrollment forms, enrollment processes, to try to make it more accessible. But you really do need somebody who's an expert. And I think most of the success has come in our hospitals, in some of the larger organizations where they have devoted some resources and really developed expertise because it's complicated.

And then you sort of have to take the individual advocate and have them bring information back to a central repository because it has to be chased. It really has to be dogged. And the more of that we can automate, the better.

We've had some success with that. We've engaged some of our cap organizations. I went to the lunchtime discussion about faith-based organizations. I think we need to think broadly about where are our folks, and where are there people who have an interest in encouraging enrollment and try and help build some capacity in those areas.

But we've also seen that in Massachusetts we've had something where we've been able to designate an authorized representative. Sometimes it's a consumer who asks a family member to be their representative. It might be a case manager from the Department of Mental Health. It might be a Beacon case manager or someone from a family stabilization team or an outreach program at a community mental health center who can be the person who is designated to gather information on behalf of the member.

Those things have been helpful. But I do think as we go forward to this fall and the implementation of the Federal act, I think there is an opportunity to further integrate what we do at the exchange, what we do at Mass Health, what we do with our -- all of our eligibility. And what I would say about the criminal justice side, in Massachusetts, it's still a mess. It's so fragmented. At the country level, with people who are in county houses of correction, State as well as adult and juvenile corrections, there are particular challenges in that area that I think need to be addressed.

DR. VICTOR A. CAPOCCIA: Betsy's first suggestion absolutely is the key. But we're not there. So an interim policy that I would suggest that you strongly look at within your States -- it's doable, it makes sense -- is that of targeted presumptive eligibility. There are categories of people who are eligible for subsidized and/or public insurance who have chronic existing conditions that are going to limit income eligibility. And let's just grant them presumptive eligibility rather than throwing them off when they happen to hit a match that is done weekly relative to the IRS and I think daily relative to the State Department of Revenue.

And so, I mean, there are 34,000 people in Massachusetts a month that get disenrolled of all categories. We're a population of 6 million people. So you can extrapolate. Why are we doing that?

Well, the CMS rules require that at either 6 month or annually. However, and it's done for good reasons relative to assuring security and integrity to these programs. But there are other methods for segments of the population that you know are going to remain eligible, like sampling, that are more efficient and probably will yield better results relative to program integrity.

The second policy that I would suggest you look at relative to your State, Betsy referenced, let me underscore, it needs to be automated and prepopulated. The system, paper-based systems provide you with opportunities for errors that are going to be picked up, and they're going to be the basis for disenrollment.

If you look at Massachusetts has the application form, the booklet is 34 pages. The application form is 13 pages of paper-based information. By the way, that's

just what you fill out. You have to then supply additional documents for birth certificate, et cetera, et cetera.

So think about the opportunity for error when every single transaction represents an opportunity for an error. An opportunity for an error represents an opportunity for disenrollment. So the more you have this automated and prepopulated from databases that the State has access to, the more you will reduce the points of entry of data and, therefore, reduce the opportunities for error.

The third has to do with interesting discussion relative to several States have what Michael referenced in terms of conviction for felony, et cetera, being ineligible for Medicaid. Question went into my head just as you're talking about that. Given that this is, for those that take advantage of the expanded program, 90 percent, 100 percent funded for 10 years federally, is there any, in effect, implicit right to service associated with that Federal dollar?

That may be a question that some legal entity needs to address. But those are two particular policy realms, presumptive eligibility and the automated systems, that I would suggest you look at within your States.

MS. SUZANNE FIELDS: Michael, anything to add before we turn to the group?

MS. PAMELA S. HYDE: Suzanne, could I ask them a question? So you guys are talking about eligibility systems in some ways as they are now and the barriers and the difficulties. Let me suppose or propose a scenario and see what you think.

So let's presume there is a single eligibility form that would get you into any type of available insurance. Let's assume it's automated, and let's assume that it connects to Federal IRS for purposes of income verification. Let's assume no asset tests are allowed, and let's assume that if you can't find all those pieces of paper what the person says and reports goes.

And let's assume that the assumption is you don't get kicked off unless you're proven to get kicked off, as opposed to the other way around. So let's assume all those things. Would that make it easier?

DR. VICTOR A. CAPOCCIA: Are you living in Cuba?

MS. PAMELA S. HYDE: No, I'm living in the Affordable Care Act, October 1st, 2014.

MS. ELIZABETH A. PATTULLO: That would make it would be dramatically easier.

MS. PAMELA S. HYDE: Well, now --

MS. ELIZABETH A. PATTULLO: And I think that is the challenge is getting from here to there.

MS. PAMELA S. HYDE: Right. And I am not -- I'm not ridiculous enough to think there will be no other problems. But I think one of the things that we have going on in our field that we don't realize is there is a lot of change coming to our assumptions about the way we get people onto eligibility now.

And as Cindy Mann often says to me, "Pam, it's not your grandmother's Medicaid system" once we get to January 1st of 2014, beginning October 1st for people to be able to start to sign up. So things like being able to say you can't be eligible if you don't -- if you have a conviction for drug abuse, I think for the benchmark plans that's not the case. The only eligibility standard is income.

And the place where it's going to be difficult is if your income changes, you might go into the voucher program as opposed to into the free program, if you will. So that might be a problem. But my point is just in asking, would those things make a difference? And then what could you surmise the new problems might?

Because those are, in fact, the changes that are coming, and I can't even imagine it sometimes. And I had responsibility at one point for getting people eligible all over a State. So I can appreciate the old way that it was a problem.

So would any of those things help, and what do you think we should watch for as those new things online?

DR. VICTOR A. CAPOCCIA: Personally, I think they'd help immensely, and my ignorance is that I was not aware of the requirement that those be universally applied in all the States. I thought that those -- I thought each State was designing its own -- its own enrollment system and form. And so, if it is as you say, I mean, it absolutely would make a huge difference.

MS. PAMELA S. HYDE: Each State has got to design its own system. So who actually manages this at the State? But that happens now. The thing that's different is a universal -- this is required by law now -- a universal, single application. It is -- the example or the draft is online now at healthcare.gov. You can go on and look at it now and see whether or not you think it's going to be a big pain in the bazoo.

For the old Medicaid, so the place where you get Medicaid because you're in a disability status or something, that will still be what it is. For the new benchmark plans, though, for the single men who haven't had a child in the family, who hasn't been eligible for Medicaid in the past, those benchmark plans are those

new plans which will come through the Medicaid expansions will use this new eligibility form.

And I think the place where it's a problem is where the States have chosen or are trying to choose not to do the expansion. Then it gets a little squirrelier. But nevertheless, and none of us know precisely how all that's going to happen. Suzanne, you may have more information than I do.

But the point I was trying to make here before you turn it to the group is I have found that all of us, including me, and I was responsible for getting people on Medicaid for a very long time. So I tend to go back there in terms of the old barriers. I can't even really fathom what the new system's problems are going to be like.

But it is going to be different, and I suspect we'll solve some problems, create others. So that's what I'm trying to have you react to or reflect on.

MS. SUZANNE FIELDS: Please, let's turn to the audience.

MS. PAMELA S. HYDE: Can you say your name, please? I'm sorry. Thank you.

MR. JOHN PAUL MOLLOY: Paul Molloy, the Center for Substance Abuse Treatment.

When I got onto Medicaid in 1975, the only thing that was needed, and it was in Montgomery County, Maryland, was my Social Security number. And I remember that specifically because I was fighting with my wife at the time who didn't want to see me and had a protective order against me. I said I don't want to go over there and get my birth certificate or any other records. They said all we want is your Social Security number.

And they didn't check the Social Security number and verify that I was who I said I was, and I got my plastic Medicaid card, which got my teeth fixed.

MS. PAMELA S. HYDE: Yes, again, and I don't want to be the one talking here. But since I struggled with this as an administrator, in New Mexico, where I was trying to do all this eligibility, we couldn't get the New Mexico Tax and Rev Department to share records with us.

And of course, at the time, Federal Government wasn't even an issue. But it wasn't because they were being mean. It was because the law didn't allow them to. So it took all this hoopla to get that done.

As I understand it, this new form is going to take a lot of information from IRS

only for purposes of verifying income, and for those who don't file with IRS, then self-report is going to be the first start. And then Social Security is also supposed to be connected federally. So if that really happens, does that change the ballgame in a way that is something we can't even really fathom now?

MS. SUZANNE FIELDS: Benjamin?

DR. BENJAMIN SPRINGGATE: Thank you. I appreciate all the insights that you all -- thanks, Ben Springgate from New Orleans.

I appreciate all the insights that you all have shared from your experiences and what you're projecting and also this information that Pam has just shared that relieves a lot of the anxiety that was building up in my corner of the room as we were talking about this.

One of the questions that I'm thinking about, however, is as you pointed to some of the challenges with disenrollment and churn, but another area of challenge that you all haven't touched on yet is, okay, we suddenly are able to see 60-some odd million people become eligible for treatments, whereas such a very small proportion were able to get coverage for these treatments in the past or 20-some odd million, depending on which denominator we're using, but we still have the same workforce practicing and the same settings in large part. And the ability to shift practice patterns to new models of delivery that will be cost effective will be challenging, I think.

And so, I'm wondering if you all have any insights that you can share, either from what you've observed in Massachusetts or for what you're projecting based on your national work with Beacon or otherwise. How are we going to try to -- I know this is a big deal in the physical health community as well. How are we going to try to transition to deal with some of the workforce challenges, and what are the strategies potentially to try to address expanding cost-effective care or value-based delivery systems that can really target getting the best bang for the buck?

MS. ELIZABETH A. PATTULLO: Yes, I think we've got a huge challenge in that coming down the road, and that's before we get to dual-eligible populations coming into a managed care setting, which with everything that at least we've put forward in our proposals around the country require much more intensive approach. And a huge question for us is, okay, who's going to do this work?

And as I look around this room, I mean, I don't want to be critical or anything, but we need more young people in this field because we need that next generation going to study social work or going to do direct care, and we've got to figure out how to incent people to join us in this enterprise. Because I think our challenge is going to be the fire hose problem.

There is going to be a spigot that gets turned on that is a marvelous thing and I believe over time will be the best thing that's happened in this country in a very, very long time for many, many people. But I think that transition is going to be very challenging.

And I think one of the hopes that I have is that there will be a movement in the provider community, and I think this is pretty broadly embraced anyway, is there is infinite need and there are finite resources. And that's sort of the nature of the work under the best of circumstances and the worst of circumstances. But we have to take sort of a population approach.

If we have 50 social workers in a clinic and we're seeing 2,000 people now, how can we figure out how to see 5,000 people responsibly? And I think there are ways to do it. I mean, the good news about our field is that it is still in many ways a bit of a cottage industry. The practice variations are great, and the opportunities, because we're so fragmented in some ways, for doing our work better and more efficiently I think are great.

But I think one of the fun things about this group is you get such a wide range of people who are doing work under different circumstances. I think we need a lot more of that kind of cross-fertilization. And it can't be dependent upon SAMHSA holding a meeting. We've got to figure out how to connect with people in a more efficient way.

But I think that's the huge challenge in some ways for all of us.

MS. SUZANNE FIELDS: Cassandra?

MS. CASSANDRA PRICE: Hi. Cassandra Price, National Advisory Council.

Coming from a State who has a little bit of a disadvantage of currently not expanding Medicaid, one of the challenges that I see is we kind of keep talking about the cost shift, and maybe because I'm not living it and breathing it is my anxiety level is high. And I'll go back to what Michael had talked about, about redirecting funds and closing gaps and those kind of things.

Even if Georgia does expand at some point, the benchmark, which I think will be where Georgia lands, won't cover a lot of services that are non-Medicaid billable. So when you talk about cost shift and being able to have a system that has a full continuum of care, you still have a lot of services and supports that will never be potentially Medicaid eligible. So kind of keeping that in mind because that cost shift and that big blinking dollar sometimes doesn't account for that when you're looking at the State and local level of the way money gets reapportioned.

So that's one of my anxieties and fears. Again, not living it and breathing it, sometimes it's hard to know and to position.

The other thing that I have a real critical concern about is when we talk about workforce and we talk about the ability to serve the new individuals who may need services and who have coverage, I worry about the almighty dollar driving down the quality of care, of having a lot of practitioners -- or put in air quotes practitioners -- jumping on the bandwagon and that workforce expanding but not really staying to the quality of care that we expect for people.

And we see that sometimes when we open up a provider network very, very wide and we're not real careful about how it gets positioned. And so, that's just kind of some concerns about that, of how you balance improving and expanding your workforce, but ensuring that that quality is there and that people are getting the services that they need.

MR. MICHAEL COUTY: I think that is something that we took a look at several years ago is for the workforce and wanting to make sure we had qualified individuals, either through license or through certification and making sure that you had that provider community there. But I don't think you're ever going to have enough, as we were talking about, in order to cover it.

I think this redirecting what we do. Not everyone needs to go into a bed in order to get substance abuse treatment, and that's what we've tried over the years to explain. Do day treatment, intensive outpatient services in order to reach that population, and it's just shifting. Sometimes it's a lot easier because I got cap that in order to keep things going, and I think that's going to be the mindset that we're going to have to do in order to increase the availability of services.

MS. PAMELA S. HYDE: Can I comment on Cassandra here that you are right, and you've touched on something I don't hear too many people talk about. It's not just the workforce. It's the competition. I mean, right now, all of us who are working in the behavioral health system, especially those who are doing direct services, are largely doing it way paid less than you could get anywhere else, and you're doing bake sales to pay for the people who don't have insurance.

Well, there's competition coming. Now there's going to be a whole bunch of people who have coverage, and they're not going to be going after the people who don't have coverage. They're going to be going after the people who are already enrolled. So they're going to be sort of sucking off those -- I mean to think of it in an economic way, those people who have a funding stream. And then they're going to be coming to those providers to hire away the people who can bill directly and on their own, leaving the bake sales for not only -- and I wouldn't say necessarily less qualified, but certainly differently credentialed providers.

So it's not just a matter of numbers of providers. It is. But it's where they're going to get pulled off, too. And it's the competition, I think, for people who haven't even concerned themselves with this population or a lot of the population because they didn't have coverage.

Well, now they're going to have some coverage or they're going to have some ability to do it. And if our system doesn't figure out how to get people signed up, you can bet that those we used to call them Medicaid mills. I don't know if that's very appropriate or nice, but those people who know how to get people enrolled and billed.

I mean, you've seen the ads. "I can get you durable medical equipment, or I can get you diabetes supplies" or whatever. "You don't have to do anything. I'll sign you up. I'll do everything." That's going to happen in our field if we're not careful, if we're not thinking about what this enrollment and eligibility process means for our system.

MS. SUZANNE FIELDS: Marleen?

DR. MARLEEN WONG: Earlier, we were talking about Now is the Time, and how there was support for perhaps tuition reimbursement for people coming into the field who would provide services, mental health services. I wonder if there's a parallel discussion going on about this need, what I think is like surge capacity.

Is there going to be some support or encouragement or incentive for young people to take on these kinds of careers in order to serve this greater multimillions of people?

MS. PAMELA S. HYDE: Well, again, we talked about it a little bit earlier, the workforce capacity issue that we're -- there's new money in the budget for that. And I think it's not just that we want to grow 5,000 more mental health professionals, mental health associated professionals. That's a drop in the bucket in a way.

But what we're trying to do with those dollars is use them to bring in a group of peer professionals and paraprofessionals and minority professionals that in some ways are seeding the process. It's certainly not going to fix it all. But we're trying to do that in a way that looks at the clinical level.

So that's why we're focusing on the master's level. That's why we're focusing on peers and paraprofessionals and minority professionals and all different kinds to kind of seed the field. Because we know the more of them that are there, the more that get attracted there.

So there's a lot of conversation going on about that, and there's some money being put toward it. The Federal Government is never going to do it all, however. It's going to have to be some -- the whole system is going to have to look at what's incentives to do there. How do we go get the high schooler who's trying to think about which direction they want to go in career? How do we make it exciting for them, et cetera?

And frankly, by being a peer, they might decide that's a place to go have a career as well.

DR. MARLEEN WONG: You know, in Los Angeles, we have all of the magnet schools for performing arts and law, et cetera, et cetera. Well, we just opened the first social work school. So I'm hoping that social work -- Social Work High School.

So we're hoping that social workers, they are in the mix. I think they get sort of mixed in generically with counselors, but I think it's the largest provider group of mental health services in the country, and I'm hoping they're right in there with the others, the psychologists and the nurses.

MS. SUZANNE FIELDS: Jacome, since you're way in the back, you've had both arms up. So we'll get to you next.

MR. MARCO E. JACOME: Thank you. Marco Jacome from Chicago.

I have the issue, the same thing as I want to say 60 more million people are going to enroll. Capacity is going to be issue. I would like to hear comments of Massachusetts experience.

But my real question will be what is going to be covered? I think that's important, especially in the behavioral health arena. Paraprofessionals are going to be covered? Are there going to be only master's level who can deliver services, credentialed people. That's one of my questions.

And Pamela, a question for you. What's going to happen from the Federal perspective people who are not going to qualify for the coverage? Is there going to be a support in terms of the Federal block money to continue to States to operate or give services to people who don't qualify for Medicaid?

MS. PAMELA S. HYDE: There are -- especially on the substance abuse side, there are a number of services that are being provided today to people who are not covered. And to the extent that those people get covered for even a portion of their services, we are trying to work with the States, and I think a lot of the States are trying to kind of think about how to redirect those existing dollars to areas where either people who don't have coverage or services that aren't going

to get covered.

Because you're right. Not every single service, Cassandra said that, are not going to be covered by these benchmark plans or by the exchange plans, qualified health plans. Every one of them are going to have to have substance abuse, and every one of them are going to have to have mental health.

But each State is going to drive that in the same way your State drives it now. So there are, I'm guessing here, but I'm guessing that most of them are going to have the sort of basic physician visit and the basic medication visit. The issue about medication-assisted treatment is still a big "if." But I imagine most of them are going to have basic counseling, you know, some of those kinds of things.

The things that I think are going to be more difficult and will vary State by State are things like intensive outpatient. Some States explicitly include that. Others not so much. And others are silent on it. So there's a range from advocacy to yes to no. A lot of them don't cover residential treatment, and as Michael said, we just are going to have to keep understanding that putting someone in a bed is not going to be the only way to serve people. We've got to have other ways to serve people.

And then whether or not a peer is covered or whether or not a paraprofessional is covered is also a State by State decision on some levels. So Georgia has been cutting the edge on that for a long time. There are other States who just don't get it yet. So it's both an advocacy opportunity as well as an opportunity for coverage.

So block grants should play a role there. Other State and Federal dollars that have been there should -- I mean, State and county dollars have been there should play a role, but that is going to take the shifting. And as Michael said, that's not always as easy as it sounds.

MS. SUZANNE FIELDS: I did want to add one additional piece. Given the emphasis on the use of qualified health plans in the marketplaces and the growing use of managed care within Medicaid, I also do want to highlight the opportunity to talk directly with the managed care organizations. They also have enormous purview, and Betsy can talk about this, within a contract they have from the State purchaser to also be establishing criteria and qualifications for providers.

And we've got terrific examples from across the country from the managed behavioral health organizations where they have been establishing provider qualifications for persons with lived experience related to peer recovery, support coaches, et cetera. So I wanted to make sure that I also highlighted that example as well.

Chris, I know you've also had two hands up.

MR. CHRISTOPHER R. WILKINS: Just one. Thanks, Suzanne. And thanks for this -- I'm sorry. Chris Wilkins from Loyola Recovery Foundation.

And thanks for setting such a great stage for this dialogue.

I just need to beg your indulgence while I, as the leader of sort of a small behavioral health provider organization, unload my anxiety closet in front of all of you. Just if I start crying, just give me a tissue, right?

So the irresistible force, this really beautiful moment of 63 million souls having access to care meets the immovable object next year of a full risk-bearing model and the limitation of the available dollars in some managed care settings around the country, where at least -- and Victor, I'm thinking as a New Yorker now in terms of the full risk-bearing model.

So here are the flashpoints, and then I just want to maybe make a comment and ask a question. We're asking traditional providers who have traditional board of directors and not a lot of internal resiliency or infrastructure to do very, very fine and complete and complex analysis of a risk environment and to employ transformational models. Both as a matter of management and a matter of corporate governance, that's a very difficult thing.

I'll offer my humble opinion that yesterday's rates, today's rates, and I'm going to bet something I really like, I don't know, my Mickey Mantle autograph maybe, that tomorrow -- that tomorrow's rates are not going to account for, because they've never accounted for, the costs of risk management, compliance, and quality improvement that an outcome-driven environment demands.

I have to tell you. I'm already, as an employer of 90 people, getting calls from those damned insurance brokers who sell my workforce health insurance, that I'm going to be looking at another 20 percent increase next year, and that would be the 20th year that there's been an increase on our own health premiums, and I didn't use nice words when I got that call.

And I thought how can you guys be doing this to me? This isn't supposed to be happening. But that's going to be another very, very real cost that we're going to face as employers.

One thing I love about our field, both mental health and substance abuse, is that we would rip the world off its axis to protect our employees and make sure they've got the best possible pay and benefits. And an unintended consequence for certain types of employers in our space at a certain size is that we're going to

be looking at some premium increases.

I think that I worry about the leadership workforce, very trusted and valued colleagues of mine who are over 50 who are fleeing the space, looking for sinecures and safe harbors where they can not have the sort of challenge and responsibility that this environment is demanding. I hear a lot of talk about people retiring and going into consulting these days because they just don't want to nerve up after 20 or 25 years of doing this and have to dig the trenches and fight the battle.

And apropos of Betsy's comment, I don't see a long line of younger folks that we've done a good job cultivating and bringing into our space. We've got to attend to that as quickly as possible.

I think that beyond all of that, you sort of begin to suspect that in this new environment, either big, monolithic organizations are going to appear that may not be as sensitive to this as they should, to patient-centered care. Or in the alternative, or maybe and, smaller, nontraditional models are going to appear that are unregulated, unlicensed, and working on the fringes in a way where we can't account for what's happening to people.

There's benefits and detriments in both ends of that, but they are still things that could happen. What I worry most about is that we haven't articulated the viable market model for the people who want to do the transformation and stay in the middle to meet the demand.

And then, last but not least, this great unknown to me -- and it will probably be unknown to me at the moment that I'm not doing this anymore -- is what is consumer choice when the new people appear? And God willing, when we start to capture some of those folks that we've never seen before, some of that 12 to 14 million that we've been talking about for the last few years, what are they going to want in terms of their care experience? What are they going to ask us for? What are their families going to ask us for?

What are they going to want to demand in terms of that care experience that they're rightly entitled to that we've never dreamed of giving them? All of that is tough, but I'll close by saying, please, any insights, any models, any thoughts, any policies. We've got to stretch the collaboration net wide. We've got to work together, and we've got to find the answers.

I was reading a combat memoir by Jim McDonough, the former drug czar of Florida, last night on the plane, where he described trying to defend a town for a year from the Vietcong where he was grossly outmatched and overrun. And one of the core conclusions of the book is American ingenuity overcame that battlefield, and he won.

We can win this. Not going to be easy. It's not going to be quick, but we can win it. And we've just got to work together.

MS. SUZANNE FIELDS: Any remarks?

DR. VICTOR A. CAPOCCIA: I think you've been eloquent in terms of the challenges that are being faced by the provider community, and they're going to vary because as you've put it in context in terms of risk environment is different from a contract environment is different from an individual service reimbursement environment.

I think you've also put your finger on it in terms of the collective wisdom of working together in creating networks both for the delivery of service, but also for the influence of policy and also for the sharing of knowledge. So it's that communication and association that you've identified that I think is going to see your way through.

In terms of if I were going to bet on organizations that are not only going to continue mission but are going to do well in terms of the environment as it continues to change because, I mean, this is a major change in terms of environment. But the reality is if you've been doing this for the last 20 years, you've done a lot of changes over that period of time, and this may be different in terms of scale or nature, but it's also a change. You know how to manage change.

So if I were going to bet on organizations, I just will reference two. One about 15 years ago created -- this is an addiction treatment organization that had a detox and outpatient program, and they were losing money on the detox, et cetera. And about 15 years ago said we're dealing with a lot of patients with HIV, with hepatitis, with other conditions. They're not really being seen. They created their own federally qualified health center in the organization.

Fast forward over the course of 15 years, this organization continued to see needs in their community. They responded to those needs. The consequence to their seeing needs and responding is that they grew. They are just opening their second qualified community health center.

The issue of integration between primary care and the specialty service is not totally dealt with to their satisfaction because they know that they need associations partly for the risk issue and partly for the flow of dollars with larger in-patient units, and they are having those conversations. Not to be gobbled up, not to be assumed, but to have a contractual relationship with.

So here's an organization that serves an urban deteriorating core area with two

community health centers, their in-patient unit, a little bit of residential care. The residential care was a moms and children program, lots of outpatient program in multiple forms, lots of medication-assisted treatment, relationships with in-patient units, dealing with emergency departments. I mean, that's a model. That organization, I am confident, is going to not just survive this change. That organization will do well in terms of serving its community.

And so, we could pull out the elements. It's a longer discussion. But there are elements in that little story that are quite generalizable.

MR. MICHAEL COUTY: And just to follow along with you, Victor, I think this is something that SAMHSA has worked on for over the years, talking about being diversified, trying to be transparent, meeting the needs of the clients where they're at. I think in a lot of States, our providers are going to be there. They're going to be there. They're there today. They're going to be there tomorrow because they have transformed from one system to another system.

I think States have -- for Missouri, Missouri did not have a managed care system for its Medicaid, but it had its managed system for its general population of covered services, which they turned around and employed the provider community to provide the substance abuse services for the general population that were paid for.

So this would be a little different situation for Missouri when it comes for this coverage for the uninsured. That's going to be a little bit different situation, but I think that we've been -- we've tried it. We've been there, and I think that is going to eventually be more promising for the population that we're serving that we've not been able to provide services to.

MS. SUZANNE FIELDS: We are near the end of time. Pam, did you have any final remarks, comments to either Chris or to anything else we've heard today?

MS. PAMELA S. HYDE: The only thing I would say is, Chris, I'm glad you were willing to share your anxiety because, frankly, it is a little less anxiety to me to know that some of you are thinking about this. I mean, I've been concerned for a while that our system wasn't even starting to think about it. So I think in that way, I feel very good about it.

I think what both Victor and Michael said, and I'm sure Betsy would add to that from a managed care perspective if we had time to do that, is there is going to be major shifts. And frankly, some people won't make it. Some of the providers will morph. They will either morph out of existence and somebody else will pick up that business, or they will do the kinds of collaborations that Victor is talking about and it sounds like you're thinking about, et cetera.

I know Yolanda has done a lot of work over the years in her program of sort of taking them in a different direction than maybe a substance abuse provider might have normally thought about, and I think that's going to stand her in good stead, frankly, as this comes along.

I think there are -- if you go back and look at the DRG experience where, basically, a hospital that was living by itself with just beds found it couldn't survive. And a lot of those went out of existence. They either literally closed their doors, or they became hospital systems.

And you know, there's pros and cons to those hospital systems. But I think there is going to be a whole lot more diversification in order for us to survive as a system and as a set of providers. But frankly, in some ways, I think that's good for our clients because as they come through the door, you can address their substance abuse issues, you can address their physical health conditions, their mental health conditions, and hopefully, some of their human service conditions because we know how much they go together.

So I think that is going to be the wave of the future, and it is going to change the provider mix. And I don't know whether it's good or bad, but I think it's good that some of you are anxious out there. So, yes.

Thanks to this panel. This is terrific. And thanks to Suzanne. She didn't say much, but she's leading a lot of this effort. So --

[Applause.]

Agenda Item: Open Discussion

MS. PAMELA S. HYDE: All right. Before you start leaving here, because one of your jobs as advisers is to listen to the public. So we're going to do that in a few minutes. But this is the time in the afternoon where we're going to open the floor for any comments, any topics, any things that you have on your minds. And one of the things I always like to ask you about because the National Advisory Committee meets tomorrow, and they sort of advise us a little bit on what next.

So having heard this set of conversations, we usually try to bring to you at these meetings a combination of what we need from you, and these rich, rich conversations do generate ideas for us. So I appreciate that. I just can't underscore enough how important that is to us is hearing you talk and hearing you ask the questions and making sure we're asking the right questions and thinking through things in the right way on behalf of not only you all, but on behalf of the system as a whole is important.

But part of it is what do you want to hear about, talk about, advise us about? What have you heard about? Are there things you would like the National Advisory Committee tomorrow to reflect on about next steps for this group?

There's two big topics on tomorrow's conversation, which you're welcome, if you're still around, to come and listen to. One is the workforce report and what that means and what we're going to do about it.

The other is the National Behavioral Health Quality Framework, which I know we've talked to you about two or three times or at least the national council two or three times. It is in yet another stage and soon ready to go out to public comment again. So we're interested in your advice on that as well.

So, open floor. Any topic, anything you'd like to hear about, say about. And for those of you listening by phone, we are going to go into public comment here shortly. So be ready.

So back in the back? Mary?

MS. MARY ANN TAUFA'ASAU TULAFONO: Pam, thank you very much.

From my perspective -- Mary Tulafono, American Samoa.

And sitting here listening to the panel that just addressed the insurance and the Affordable Care Act. Ironically, from my perspective and the work that I do on the initiative, that I, quite frankly, am not fully aware of what would be going on and how the coverage would affect the territories. I do know that Governors are -- they have that on the radar.

But one particular concern that was brought to light was that the issue regarding, that you did clarify, that it is not basically -- will not be based on your criminal background, for lack of a better way of putting it. But the focus would be on your income earned. My point is that for me the issues that have been addressed from the workforce in yesterday's CSAP meeting very well, and I'm happy. I'm going to go home, and I have a lot more that I would like to take up with our people back in the territory.

And the panel discussions here this afternoon, the whole day, you know, kudos to you. Very, very well informed, and thank you very much for all the information.

MS. PAMELA S. HYDE. Thanks. That's really great input. I mean, we do suck you up a lot when you're here. We know we send you home tired or, as they say, ride 'em hard, put 'em up wet. We do that to you a lot.

But we are trying to give you and understand what we need to do out there for

people as well. We can't do everything, but to the extent that we're getting you the right information or stimulating you in the right way, that's good input for us.

Yes?

MS. MARY ANN TAUFA'ASAU TULAFONO: If I could just, please, one more? There was a presentation earlier, and it had to do with national involvement. And I'm sitting here and in my position -- every February there is the National Governors Association conference where the Governors come together and the first ladies here in Washington, D.C. And when you sit here and you listen to all these concerns about mental health and substance abuse, for me, as one of my initiatives that I took on was the underage drinking initiative, and I think and I know that it's come along very well within the territory.

Perhaps if I may suggest for those of you that you have some -- you have people in government and we are told that in your position as the first lady, the Governor's wife, you do have a platform. And perhaps that if you are in the position, do you have the ear of these people? What's wrong with whispering in their ear and saying to them, "I need help. Would you help me to bring my initiative to the forefront or draw more support?" in what your particular interest is or your focus is.

All I'm saying is that there is another avenue out there within your respective States that perhaps may be willing to come forward and help because I believe it was last year or the year before, and I'm at a loss of facts right now. But Pam, there are I believe it was about 11 to 12 first ladies that came into the NGA, and it was primarily to when we talked about taking up initiatives, it was take your time, take the initiatives and be focused on what you would be interested in.

At the same time, too, there are so many issues that are going on within the territories and the States, and if these groups come to you and they want you to help out, then it behooves you to do that. And all I'm saying is that for all of us sitting in this room, if I may suggest that there is another avenue. There is interest there as well.

MS. PAMELA S. HYDE: Great. Thank you for that.

Other comments? Yes, Leighton?

DR. LEIGHTON Y. HUEY: Based on the civil discourse discussion earlier today, civil discourse does not just involve geographic communities, but also involves organizations and from that concept. And one of the areas that occurred to me was that as healthcare is expanding and as it becomes more inclusive to meet the demands that are going to be imposed on it very shortly, that inter-professional education is going to become even more important not just for the

established workforce, but for people in training and feeding people in training.

So, for example, SAMHSA could do a lot of work with entities such as the AAMC, the accrediting bodies for medical schools, the ACGME, the LCME for undergraduate medical education in order to establish that kind of Now is the Time type of dialogue for those individuals who are in the training pipeline. And so, I'm focused more on not so much the people who are already committed to going into mental and behavioral health, but for people who are not in mental and behavioral health in order to have the kind of outcome that I think that we all hope for as healthcare becomes more inclusive because it needs to.

MS. PAMELA S. HYDE: Yes, thanks, Leighton.

I won't spend too much time on it because I, frankly, don't have it all in my head. But there is some work going on about engaging private sector partners like some of the ones you talked about in this process of doing the national dialogue.

So there's two other parts of the process we didn't talk about today. There's a whole electronic media process that's going to emerge, and then there's a whole what we call public-private stakeholder commitments or partnerships that are going to emerge not exactly and completely like what you said, but some of what you said is part of what is in that space.

So I think there's not nearly enough of that, and I know it's something that's been on your mind and on the minds of those who've been working in the workforce field for some time. So, thank you. It may be worth a conversation tomorrow at the national council a little bit about what to do about that.

Thanks.

All right. Back there?

MR. EMMITT W. HAYES JR.: Emmitt Hayes, Austin, Texas.

Pam, in hearing the panel discussion and having some concern about the previous panel discussion, some concern about practice-based evidence and then even some discussions about common sense. You know, you get to this place of understanding common sense ain't so common.

So where we get to is really what might be available for us to get at some of these issues for practice-based evidence. And I've become aware that the Department of Labor and I believe the Department of Justice, who began to look at social impact bonds. And bringing that up yesterday, it was apparent that there was not much information available with regard to social impact bonds.

Now Goldman Sachs has taken on the challenge, I believe, in New York with Mayor Bloomberg and beginning to look at some opportunities to fund good outcome. So, in essence, we're talking about success-based income. Now we're also talking about corporate population and the corporates being able to invest and see that they can get at a profit.

Being that this is a capitalist country, it seems to me that when corporate America begins to invest in social outcome, then we're probably on the right path. And I would really like to recommend that when you've got \$3 trillion sitting around waiting to do something with in a country that is as rich as ours, when you're recognizing that we have the opportunity to do some things differently, that seems to me a great opportunity to explore.

And I really would like to encourage more exploration into social impact bonds. And perhaps a relationship that will allow some of these outcome, these evidence-based practice outcomes which, again, the profits would be resulted in terms of outcome. And if these things are really working, then I think we have an opportunity see where we might be able to make some headway.

While the Government can't fund all of them, you have corporate America, private foundations who can contribute or invest in the upfront cost. And then, of course, be reimbursed for those upfront costs. And the other side of that which I think is great, if there are no good outcomes, there is no reimbursement necessary. At least that's the way it's proposed. That's the way it's working.

And I believe in the UK, they have more evidence on that and have done a little bit more in terms of social impact bonds, and I really would appreciate some exploration of that part.

MS. PAMELA S. HYDE: Okay. Thank you for that suggestion. It's a great one. Not one, I have to admit, that's been on our radar, but we'll think about that and think about the way to do that.

Yes?

DR. WILLIAM R. MCFARLANE: Hi. Bill McFarlane.

In terms of workforce, I'm sure this won't be one of your high sympathy groups, but psychiatrists are actually kind of disappearing. Some would be overjoyed about that. But I think one of the issues that has to be a part of the workforce discussion is, is if the current trends continue, as physicians become generally inadequate in numbers to match the population needs, it will be inevitable that psychiatrists are part of that group.

Now, so I don't want to push this as one of the highest priorities for SAMHSA,

but I think it's out there lurking. One of the most common complaints in most areas of the country now amongst pediatricians and primary practice folks is I want to refer to a psychiatrist, and there's none really available. That's right now. That's before that 62 million joins the rolls.

MS. PAMELA S. HYDE: Yes, and certainly we -- there is nothing about SAMHSA not liking psychiatrists. I mean, we need psychiatrists. We like them. Some of my best friends are psychiatrists.

[Laughter.]

MS. PAMELA S. HYDE: Uh-oh. No, it's true. And it's actually why we've spent 2 years looking for someone who would come and work for us in that role.

Now, again, as I said, we sometimes rely on Wes a little bit for that, but he's got six other jobs he's supposed to be doing. So it took us a long time, frankly, to find someone who had the background, the qualifications, and was willing to come work for the Federal Government, with all the constraints in pay, outside activities, and everything else you can't do when you work for the Federal Government.

So we had several people that we talked with, and when we got to that part, they weren't willing to do it. So we found someone who was -- had lots of outside activities. I think you're going to really enjoy her.

She has been literally willing to make that sacrifice, to give all that up in order to come and be part of this enterprise right at the moment while so much is changing. And I think part of her motivation is because she's able to both learn, but also be part of an incredible time in history to be part of that. So I think having her onboard will give us an opportunity to really look at and expand our information and relationships and issues about psychiatry in particular.

Certainly with adult -- I mean with child psychiatry, our CMHS has had a long history with the academy and does work with them. We have an intern who comes and spends time here from the academy. So we have lots of those kind of relationships that we probably haven't highlighted because we haven't had sort of the person in place to do that.

So hang on. By the next time you get here, she'll be onboard, and we'll make sure you guys introduce, all of you who are psychiatrists and want to do that, maybe we'll do a pullout on psychiatry next time?

By the way, while we're talking next time, we have a tentative date for next time, which is August 14th to 16th. So put that on your calendar. I know August is always difficult, but September is even worse because people go back to school

and because people have lots of conferences then and stuff. So we've done relatively well at having August meetings. So August 14 to 16 is the tentative next date. We'll confirm that for you when we get a little closer.

Okay. I'm going to take a couple over here, and we've got time for a couple more. Yes, Lori?

DR. LORI SIMON: Just to add on to what Bill just said, I actually am a psychiatrist.

MS. PAMELA S. HYDE: Fantastic. See, we've got lots of you. Stephanie is a psychiatrist, lots of you.

DR. LORI SIMON: So just to add to that maybe for future dialogue and things. I know part of the issues about the dwindling of psychiatry has to do with a few things, and a lot of it is related to managed care. And I know Elizabeth is in the room, and so I'm sure you're the exception. So --

But it's been on several fronts. I mean, first of all, psychiatrists used to do both therapy and medication. And over the years, that has dwindled. I mean, I do both, and I think having treatment together, as opposed to split treatment, is always optimal.

But part of that was because managed care didn't want to pay for psychiatrists doing therapy. So there's been a disincentive, and there's been more of a push for other people besides psychiatrists. So then they started getting relegated more to medication.

The other issue, and I don't know whether it's strictly an outlier. I'm in the New York metropolitan area. There are very, very few psychiatrists who are in managed care as in-network providers because of just -- I'm not going to go into all, just a lot of problems.

And so, now when you talk about all these 60-something million people coming into the system, okay, a lot of those people are probably going to be looking for in-network providers. And as far as psychiatrists go, and also I know social workers, too, they're just not going to be there.

So I think, going forward, there's an awful lot of issues around managed care that we need to do better because it's really becoming a problem. And in fact, with Medicare, I'm not in network with anybody, but I do take Medicare. I have to tell you it is very hard to find a psychiatrist, at least in the New York metropolitan area, who takes Medicare for the similar reasons.

MS. PAMELA S. HYDE: Yes, I actually think this is not just a psychiatry issue

and this is not just a managed care issue and it's not just an any one thing issue. I think it's a significant issue. I can tell you that my own personal physicians and dentists and everything else, most of them don't take any insurance anymore. They will maybe file it for me, but they won't take it.

And there's lots of issues about that, I know. So I think it's a broader issue than that. But I think all of you are raising an issue around part of it's a workforce issue, part of it's a payment issue, and part of it is specific to psychiatry. So I think it's something we can think about, and I really do think it would be great to have maybe a session on that or a breakout for lunch or something when Ellie is here because I think she's going to want to learn from you all as well.

So, all right. I saw Steph, since you're a psychiatrist, Stephanie, we'll take you again. Three in a row, see?

DR. STEPHANIE M. LE MELLE: And I'm Pam's friend. So I can confirm that she does have friends that are psychiatrists.

MS. PAMELA S. HYDE: There you go.

DR. STEPHANIE M. LE MELLE: But I think, to Lori and Bill's comments, that you're absolutely -- I mean, you've sort of covered exactly what I was going to say. The only thing that I'll add to it is I think that psychiatrists in particular, because we are trained as physicians, as doctors first and psychiatrists second, have a unique training that is going to be really essential as these new funding streams and healthcare reform come into play. Because we can't separate mental health and behavioral health from medical health.

And the idea that people will go to a primary care doctor and then have consultants who are bringing all of these other specialties to them, that the role of the psychiatrist, particularly for people with severe mental illness, where they may be seeing the psychiatrist more often than they're seeing a primary care doctor, that our role as boundary spanners and as systems thinkers, systems managers, that we are the ones that are going to have to understand the medical aspects, the mental health aspects, and the social aspects of people's lives and bring it all together.

So, and of course, you know, part of the reason I think that a lot of young people aren't going into psychiatry is that nobody wants to be just a medication manager. That's not why any of us went into medicine. We went into medicine, and particularly psychiatry, to develop a relationship with people and try to treat the whole person. And that's how we're trained, and our training needs to be improved.

But I think that we really need to think about how we present ourselves, and this

is for the psychiatrists in the room, that we can't depend just on SAMHSA and other organizations to promote our issues. I think that we have to step up to the plate, and we have to not take positions where we're just relegated to medication management, that we really have to say, well, I'm skilled in all of these other areas, and to be efficient about my use, you really should have me doing more than just managing medication. So we have to do some of this ourselves as well.

MS. PAMELA S. HYDE: Yes, I think these are all good points. It's been a while, but there was certainly times in my career when a lot of psychiatrists worked for the organizations that I was running, and I sometimes found the psychiatrists weren't willing to be those boundary spanners. They were uncomfortable being in the sort of physical health, whole person arena.

At the same time, we now have primary care physicians who are uncomfortable being in the even screening and treating relatively minor mental health issues that they probably could deal with, either with some consultation or with additional training or whatever, and I think it's going to be some of both.

And then, as things like accountable care organizations and other kinds of models of mixing practices so that practices are happening. It's not just the traditional interdisciplinary stuff, but really groups of practices coming together to treat and be responsible for the whole person, I think some of that's going to change at least the opportunities. And it may go back to Chris's anxiety. There's got to be -- there may be some real opportunities in that, in thinking about how your provider would change with that kind of an approach.

So I think there's a lot of those things that we can think about more. This issue of models, I'm always struck, like the conversation we just had? I'm always struck by how some of the most experienced and knowledgeable people in our field don't know what's coming. And as I said for myself, sometimes I don't even get it, and I sit in all the meetings with all the regs and everything else. And somebody has to say to me, "Well, it's not the way you think it is. Not the way -- you know, it's going to be different."

So I think there are some profound changes both in practice and in payments and structures coming.

All right. Back over here. Rosalind?

MS. ROSALIND WISEMAN: I'm Rosalind Wiseman.

I've been thinking about the comment I think a couple of people made about young people getting into the field, and so I've had two realizations and a question to ask. One is I think the domestic violence advocacy people have

been really, really good at having people stop thinking "Why doesn't she leave?" And I don't get -- I don't get that from teenagers or young emerging adults. I don't get that a lot in my work anymore than I used to get all the time.

And I was thinking about that for rehab and for people who go in for services, that that -- that there is still very much that feeling of "Why is that person going back? They've gone three times. This is ridiculous." And I feel like there was a connection in our ability to give outreach about that, that message because I think that the domestic violence community did a good job of that.

The second thing is, is that in my experience teaching teachers, one of the biggest problems that we have in schools is of getting help for kids is that teachers don't trust oftentimes the counselors or people who are in the mental health field in the school because, and this is my question, there seems -- is there a program of twofold of SAMHSA helping -- and there's under the bullying prevention programs now, there's lots of opportunities funding wise. I'm getting asked to teach a lot in teaching colleges to potential -- to up and coming teachers.

The area of frustration for teachers is they have a problem with a child. They refer them to the counselor. The counselor says, thank you so much for telling me, and now I will not tell you anything ever again about that child because I have to respect confidentiality.

And I work a lot with teachers and counselors about how to get to a place where counselors can say here are the things I can't tell you, but here are one or two things that might help you in the classroom. Because the teacher stops talking to the counselor right after that. They say, "Why would I ever talk to that person again?"

And so, there seems to be a place where young people and young teachers can learn how to have better relationships and vice versa with the mental health professionals in the school. And so, I was hoping that or can you tell me a little bit about are there efforts to be able to have these two cohorts work together? Because I see that as being such a moment of lost opportunity oftentimes where not just for that child, but for the teacher's future experience or seeing the mental health professional as a resource.

MS. PAMELA S. HYDE: Paolo, if you're back there? I see Paolo and Fran, and I don't see Wes. Deepa, can you come up and represent Wes? I want to use this opportunity to have center directors come back up, or Deepa, can you find Wes?

MS. DEEPA AVULA: Yes.

MS. PAMELA S. HYDE: She would much rather find him than be him. I know. They left me here.

So I'm asking Paolo to come up here because I know we do a lot of work with schools, and Marleen, you may have a comment about this as well. There certainly are models out there where behavioral health people and teachers and others in school settings and parents and others, we fund some programs that bring communities together in that way, but I don't want to be the only one answering some of this because I think there's other models besides just what I might have in my head.

So did you hear this question? All right. The question is in a school system, if a teacher refers someone to a counselor and they go to the counselor, and then the counselor says, "Well, now I can't tell you anything about the kid," do we have models that are working to try to help in the school the counselors and the teachers help each other in addressing the kid's, the young person's problems?

MS. ROSALIND WISEMAN: And what do you think is the best, what do you think is the best strategy for that? Because I see that as being one of the largest impediments to the adults working together in a school is this lack -- is this conversation, or lack thereof.

MS. PAMELA S. HYDE: And Marleen, I'm going to give you a chance to speak here, too, in a minute. But Paolo, do you want to comment about that?

MR. PAOLO DEL VECCHIO: I have to say that we hear this is not just in schools either, but issues around sharing of information among family members and others, as well as sometimes raised as a concern. I think our Safe Schools/Healthy Students program has looked at ways of -- and the systems of care approach as well -- building coordinated team concepts that can share information regularly with the children and families' consent as the key aspect of what we're doing.

I'd be happy to go back and pull some of that out for you.

MS. ROSALIND WISEMAN: And I guess my part B question of that is my -- the feedback I'm getting from teachers oftentimes is if they have a concern about a child, young children in a school, that they are being told by their administrators that they can't say to the parents -- of course, the teacher can't diagnose the child, and they should not do that.

But that they feel that they are silenced to say to the parents even, "There are some concerns that I have. Maybe you'd like to talk to your pediatrician about X, Y, and Z." And that that seems to be something that teachers are more and more talking to me about as sort of -- as mental health issues and people -- this

is now me extrapolating -- are becoming more anxious about the entire concept. Does that make sense?

MS. PAMELA S. HYDE: I actually got asked a question like that when I was testifying before Congress recently, which a congressman asked me in a way that it was pretty clear he thought it was concerning that we should be having teachers trained to recognize the signs and symptoms of mental illness because they might then diagnose them or they might label a child that has "normal" growing up issues with mental health issues.

And obviously, I think there's a balance here. I mean, we don't want to label a young person with a problem that he or she doesn't have. On the other hand, if the teacher is unable to get through to the child or unable to manage the behavior in the classroom, there's got to be something.

We have something called the Good Behavior Game, which I know is a prevention tool that helps teachers know how to work with behavior in the classroom. So there are some models out there, but they're probably not as widespread as they need to be.

Marleen, do you want to comment here our resident school expert here?

DR. MARLEEN WONG: I actually do. I was Director of Mental Health for L.A. Unified School District, the second-largest school district in the United States. And I can say that it depends on the leader of the school. It's just like a family.

There are some people that are very close to this. I've heard people say, of course, "Everything I can do for a child early I want to do that. This is a whole child." And I've heard some principals say, "I don't want to know about it because if I know about it, then I have to do something about it."

I think there are special education concerns. Some school districts are very reluctant to identify children, more and more children for special education. If a teacher says your child really needs this, it becomes a whole special ed issue.

The other thing is it depends upon the bargaining unit that the teacher and the mental health professional are in or not in. So many school districts outside of Los Angeles have no mental health service. So there isn't really a mental health professional in the school. It's somebody from the community who comes in, and they have "therapeutic relationship." So they can't really say anything much about the student, and they might not be trained in mental health consultation where they could talk about in general students who have a certain kind of, you know, and it could be all these kinds of things and really discuss and educate the teacher. They may or may not be trained.

So I think there are a number of factors that go into this, which doesn't make your job any easier, but it's good that you're there because you can share more from a general point of view what they might be concerned about.

MS. PAMELA S. HYDE: I think some of the programs that the President has proposed, which is really a school-community-State education authority partnership that we're proposing will provide some more opportunities for that.

Harriet, you're our resident retired school person. Do you want to comment on this?

MS. HARRIET C. FORMAN: This is Harriet Forman.

I guess it all depends on whether there are developmental issues. There should be all kinds of ways of talking about -- talking with parents about what's going on with their kids. If it's just kind of developmental issues, I think that teachers and parents should be able to talk freely about what's happening with their childrens - - their childrens? Yes, I'm a real good educator.

If there are behavioral issues, certainly they ought to be talking about what are alternative approaches that they've done with the kids, you know? If there are behavioral issues, they need to talk about various approaches that they've done, and they ought to be able to talk freely with the parents. I don't quite understand what are they being not able to discuss with the parents?

MS. ROSALIND WISEMAN: I think that Marleen's comments really rang true to me about not wanting to do the IEP, the special education, the fear. There's just a lot of fear and anxiety about not wanting to label or doing something that would be perceived as irresponsible. And so, to that point, you don't even say anything. Everything that she said really, really rang true to me.

MS. PAMELA S. HYDE: Okay. Bill?

DR. WILLIAM R. MCFARLANE: I just wanted to add to this conversation a kind of mechanism for dealing with this issue for younger adolescents and adults who are at risk for possible psychotic disorder. This was a very tricky issue in doing this across all the schools in the 10 cities we've been working in.

We came to a kind of strategy of having the teacher talk this over with an in-school professional, if there is any such, and it can often be to the guidance counselor, who would then make the contact with the parent with a clear understanding that this is a very delicate conversation. On the other hand, it kind of takes the teacher out of that role of being the arbiter of this child's risk.

And that worked very well. Most schools adopted that approach and then used

that mechanism, and over time, actually some of the teachers got comfortable with actually and the schools got comfortable with a direct contact with the parent.

MS. PAMELA S. HYDE: Fran, do you get the same thing about substance abuse issues in schools? Does this come up in some of the prevention programs, do you know?

MS. FRANCES M. HARDING: It comes up a little bit. Mostly it's around bad behavior and exposure to bullying and normal parental breakups, boy and girl stuff. So it's more behavioral kind of reaction to something.

The closest that I've seen a really good model is after 9/11 in New York State, we had -- New York State has a very elaborate student assistance program which deals with everything. And they quickly assembled teachers and whatever parents were left and community members together, and they made these school-community partnerships, which SAMHSA actually funded, and made sure that there was all of the professionals in the particular community that were a member of the team. Because it became a healing team, part of using the word "community" again, of bringing in both community and school and family, just as Paolo was describing.

There wasn't a name for it, other than just community assemblage and responding to crisis. So that's really all. We rely mostly on our school counselors and social workers in the schools.

MS. PAMELA S. HYDE: Okay. We're going to take a couple more comments. Then it's going to be time to get to public comments. So, Michael, over here?

MR. MICHAEL COUTY: Michael Couty from Missouri.

We have addressed that in two different areas with the schools, and we -- as the court, we're brought in because of behavioral issues. And as a result, we bring together, we use the model in child welfare family support teams. So you have the court. You've got the school. You've got maybe an outside mental health professional. You've got the parent and anyone else associated with the behaviors of the child.

And then we have the consent that is signed by the parent, and so we're able to share the behavioral issues and suggestions and what could work within the school and things of that nature. Then we have with the school contacting the court, we call it the resource council, time consuming, where the school refers information to the court wanting to get information.

And we do a court order at that point where we come together, and we have a

school personnel along with social work, child welfare, and the court system identifying issues that may be shared with that child and the professionals within the community on how to best address those issues with that particular kid. But it's time consuming.

MS. PAMELA S. HYDE: So I think the theme you're hearing about from all of this is when it's just left to the teacher and the counselor, it may not get as far. When it's really systems that have created opportunities and ways for this communication to happen with sort of pre-agreements about that and stuff, it seems like it's more successful.

All right. Let's see. Bob, I think you had your hand up next.

DR. ROBERT M. FRIEDMAN: Thank you, Pam.

Bob Friedman, Center for Mental Health Services.

I wanted to mention, first of all, that in our CMHS meeting yesterday, we had, I thought, a truly outstanding presentation of the work that's going on here at SAMHSA around trauma. It's very exciting. It sounds like it's getting a great response. The organizing framework is wonderful to see the partnerships within SAMHSA, the partnerships outside of SAMHSA.

It's -- I see it having major impact that's only going to grow, and I just wanted to comment and commend SAMHSA for all the good work it's doing around trauma. It's very much appreciated.

Also thinking to the future, the whole area of prevention is one that I would like to see us spend some more time talking about. The schools are certainly related to that and the discussion about schools, and I think there are within SAMHSA and within the Department of Education some good models certainly here for schools, and I certainly hope that Congress will act on Project AWARE. But I have skepticism about what Congress is going to do with regard to it for sure.

We had a good discussion, I thought, on evidence-based practice. I would like to see that complemented as we are talking about major system change with some discussion of models and approaches for promoting organizational and system accountability. It's great to focus and we have to focus on what needs to happen at the individual level, but we also have to equip our organizations and our systems with the capability of continuously monitoring how well are they doing at this time of transformational change.

How well are they doing at achieving their goals and serving the population according to the values and principles that they have, according to best practices, and getting the outcomes they want? And where they are not getting

the outcomes, what can they be doing to enhance those outcomes?

So I would want to put that. And always an issue for me is how can SAMHSA continually with tighter resources enhance its impact? I hear lots of focus, for example, on training, some by choice and some almost by default because some other options have been taken off the table.

The research on training is not always that encouraging about its impact unless it meets certain conditions. Technical assistance perhaps a little more favorable. But as SAMHSA, by choice and because of resource reasons and other constraints, moves toward relying more on the training and technical assistance, social marketing, and other kinds of approaches, I think it would be useful to spend some more time looking at the experience and knowledge about the fusion of innovation. I know that's a key part of the theory of change.

How well are we doing? What can we learn from our successes? And given the new context, given the different context now than even several years ago when the theory of change was proposed, what are the implications of that for how we go ahead and enhance the impact?

MS. PAMELA S. HYDE: So let me take that up to you to ask a question maybe back to you, Bob, but maybe it's a broader question. And we've got just about 3 minutes before we're going to go to public comment.

At the moment, there's nobody on the line for public comment. But we said we'd do it at 4:45 p.m. So we have to wait until then to see if there's anybody asking.

But one of the things that you raise for us, I mentioned it in passing earlier today, is that SAMHSA hasn't been reauthorized in a very long time. There's a political reason for that, which we could go into and talk about. But setting that aside, there was a time when we tried to reauthorize SAMHSA kind of in its current existence with a tweak or two. But there is in some ways, it's almost kind of good in a way that that didn't happen because there is so much has changed in the last 4 or 5 years.

The issue that sometimes comes to us and at some point we're going to have to cross the path of what should SAMHSA look like in the future? This is part of what the executive team has been thinking about. What should we look like in 2016? And if we were going to reauthorize ourselves next year, what should SAMHSA look like in Congress' eyes? And would that be a conversation that you think would be of use?

I know I've had some -- well, that one hit a nerve.

DR. ROBERT M. FRIEDMAN: I think that would be a great conversation.

MS. PAMELA S. HYDE: We might have some conversation about that next time because part of what you're telling us, and it's what we asked, but part of what you're getting at is we have less and less money in some ways. And it's more and more constrained in some ways. So where should SAMHSA be putting its effort for the future for the field?

DR. ROBERT M. FRIEDMAN: I think that would be a great conversation. The only thing I'll throw out very quickly is I would encourage becoming more of a learning community. I would encourage looking at internal feedback mechanisms, feedback from the field, lessons learned, and how SAMHSA can apply some of the resources in a more productive way.

That's not to be critical of what it's doing now, but I think given the contextual changes, given the new knowledge that's developing, new technologies that are out there, how can we make sure that we capture the best knowledge of what's working for us and gather the best feedback from multiple stakeholders and be able to apply that and move forward?

MS. PAMELA S. HYDE: Okay. Great. Thank you.

Pat? I'm going to go all the way in the back and come forward here.

MR. PATRICK A. RISSER: Thank you.

I'm old enough to remember a time when our goal was to get people healthy enough to put ourselves out of business, and I'm concerned about the almost explosive epidemic growth of the behavioral health system and the needs of people. And then we're coming out with a new DSM guidebook in June that will be even more encompassing.

So for a long time now, I've made it a personal goal to oppose any new programs that create new entrance doors into the system, whether it be screening or whatever, unless they also contain within them a very clear exit door out, where you've graduated. You've recovered. You get to move on and have a life.

And I would just urge you, as you move forward at SAMHSA, that you please try to rein in this out-of-control growth and try to create more of those exit doors, those paths to recovery. Look at the outcomes and make sure that we're clearly doing what we can to help people get through whatever is going on in their life and come out the other end so that we're not becoming Hotel California, where everybody gets in and nobody ever gets to check out.

MS. PAMELA S. HYDE: I'm smiling, Pat, because years ago when we created some of the first case management programs, a couple of us, some of whom

you will know, sat around and said, you know, some day, this system is going to be somebody's nightmare. Because back then we were talking about case management for life. Remember, that was the goal? Case management for life.

And then, of course, years went by, and that wasn't financially feasible, nor was it appropriate, and we got to the point of how did you graduate people or how did people graduate from one intensity of coverage to more of a support-type approach? So that concept happened, but I don't know that we ever got to graduating out of the system in quite the way that you're talking about it.

I'm also amused because there's a lot of conversation right now about things like in-patient and outpatient treatment and stuff. And I saw Wilma here a little bit earlier today. I don't know if she's in the room at the moment. But back in Ohio, years and years and years ago, we actually created what I think was one of the first State statutes that said if you're going to be on a commitment to an outpatient setting, then there has to be -- part of the treatment plan has to be how to get you off of that.

And I don't know, Stephanie, what New York does about that now, but that was back in the '80s that we said if you're going to put somebody on that, you got to have it literally in the treatment plan about how you're going to get them off. So just this idea of can we move people through and not into to stay.

MR. PATRICK A. RISSER: I had a friend at our peer recovery center come in in tears. She said, "My therapist says I don't have to go see her anymore," and she was crying and upset. And instead, I turned her tears to a smile when I said, "Congratulations. Way to go. You graduated."

And when she thought about it, she realized, "Yes, I have." And somehow we need -- people become almost brainwashed into this helpless, hopeless, dependent place. We really need to work on helping people to recover and be proud and able to move on.

MS. PAMELA S. HYDE: Yes, thanks, Pat. That's a great place to move to.

Let's see if -- do we have anybody ready to ask for questions? Okay. In that case, I have Leighton and Joe, and Stephanie, do you have your hand up? Okay. So we're going to take those three, and then we're going to end for the day. So --

DR. LEIGHTON Y. HUEY: So maybe these comments might have something to do with 2016, Pam. The discussion on evidence-based practice focused primarily on the intricacies and the sensitivities needed to introduce EBP into communities and to differing populations.

But if you back up for a moment, to what extent does the workforce even apply or know about evidence-based practice, which is a more fundamental issue? So does evidence-based practice drive change? I don't think so. It's based upon altruism and the sense of professionalism and this is a good thing. But to what extent does our workforce actually apply evidence-based practice?

Now Carolyn Clancy assures me that it's no better in physical healthcare either, although I had presumed that that was always the case. But apparently not. So if we are experts in behavior change, we should be able to figure out how to change the behavior of our workforce.

If you kind of link evidence-based practice with quality improvement, performance, linking with incentives and disincentives, we do pay-for-performance to reward people for the jobs that they already should be doing. So that's pretty perverse, in my perspective.

What are the disincentives that would shake people to actually adopt and utilize evidence-based practices? Seems to me that's a pretty fundamental issue that the field needs to get to.

MS. PAMELA S. HYDE: Good point. Okay. Joe?

MR. JOSEPH A. GARCIA: Thank you.

A couple things I wanted to mention. First thing is that I wanted to commend SAMHSA, your leadership and your team, for doing all of these sessions that we've had, and I think they are very productive. And so, please don't be -- if someone tells you that they aren't productive, then they'd kind of be lying to you. Because they are.

MS. PAMELA S. HYDE: Thank you.

MR. JOSEPH A. GARCIA: I wanted to throw an engineering perspective. I think you remember my background is electrical engineering. So from an engineering perspective, my job as an engineer is to create something that does not exist for the well-being of humanity. And it seems to me that too many times, we get caught up in trying to tweak the system, and your comments about change and about tweaking and about reauthorization kind of is a parity to what I wanted to say.

That is that the things that we may need in the care for our people may not exist in the way we want them to exist. And so, changing the system, changing policy, changing protocol, and changing all these other things may not be the answer. The answer is what you said many times over just in this few statements about creating.

We created this. We created that. And so, please let all of us not get caught up in the thing about we just want to change here and there, and maybe that's not all we need to do. It's about -- if we're talking about change, let's talk about real change. Real change comes as an effort of creating something new, something unique, something innovative that doesn't exist.

So, therefore, by doing that we've addressed some of the current needs, and we blend into the needs not only for today, but for the future. And I'll give you an example. The cell phone right here, smartphone, I'm kind of sad because it's smarter than I am. But there was a need for something useful, something different. It didn't exist.

If we thought about tweaking a few things to create this kind of a phone, we'd be dead in the water, and we wouldn't have what we've got. And so, if you think about technology, that's what technology is all about, creating something that doesn't exist but for the betterment of humanity.

And I'm proud to say that President Obama, right before he became President, asked little old Joe from Ohkay Owingeh in Albuquerque, New Mexico, he said, "Well, Governor Garcia, do you have any advice for me?" And all I could think of was a statement about change. And I said -- and I called him Mr. President before he was President. I said, "You'll feel good when you become President."

I said, "Mr. President, change would be easy if it weren't for all the people. Because it's a system that change -- you can change mechanics. You can change. But as long as people are involved, it's going to be hard to change." And so, he called me up one day, and he said that statement is very, very true. And you know he's fighting that in Congress right now.

Thank you.

MS. PAMELA S. HYDE: Yes, we do. That may be the wisest advice we've had all day. So thanks, Joe.

Stephanie, you get the last word, and we're going to -- after Stephanie talks, we're going to ask you to think about if you could wipe the slate clean, how would you create a SAMHSA that is the smartphone, the smart SAMHSA of tomorrow?

DR. STEPHANIE M. LE MELLE: Actually, I guess my comment perfectly dovetails with this idea of technology. And I'm stepping outside of my comfort zone now because every time we have a change in technology, there's a good and a bad that comes with it.

But one of the things that I was thinking about in terms of how do we understand

where we should be in the future and how SAMHSA might see itself in the future is the use of predictive technologies. There is this huge field now of using computerized systems to do predictive technologies.

And even though again, as a clinician, I have issues with making generalizations about data, when we're talking about individual people, I think using that technology to sort of look at the trajectories. We have tons of data. We have Medicaid data. We have OMH data. We have data up the wazoo that we're not really using efficiently.

And using these new technologies, we might actually be able to see patterns that will help us to sort of look at things differently. What is this? Oh, what was the bet?

DR. PETER J. DELANY: Not sure yet, but she got it.

[Laughter.]

DR. STEPHANIE M. LE MELLE: I hope it wasn't related to what I'm saying.

MS. PAMELA S. HYDE: No, I'm sorry. Pete is our Center for Behavioral Health Statistics and Quality lead, and we frequently have been talking about data. And he's just been scrambling to try to figure out how we're doing data in the future with the help of all these people up here.

So we've been having sort of this very conversation about it's we've got to get beyond just SAMHSA's data. We've got to get to how we can use all the data to look at where we're at, where we're going, how we're using it, and consolidating some of that data so it's more useful. So that's why I was laughing with him. Our good advice is telling us that we should be doing what we've been talking about.

DR. STEPHANIE M. LE MELLE: Yes, and the insurance companies and the managed care programs are using this. And they're using it, and we're not. So I think it's something we really have to get up to speed with.

And even though, again, it's outside of my comfort zone, but I think it's something we have to pay attention to.

Agenda Item: Closing Remarks

MS. PAMELA S. HYDE: All right. Well, well said. And Betsy, several things have been said today, and you're a new member. So you can be thinking about what you can add to this conversation because people have a sense that you

can help a lot, I think. Or at least be a part of the process.

Thank you again to everybody. All of your comments, it always stimulates so much. We have long lists when we're done with you to see what we need to do next. And we'll have the conversation with the NAC tomorrow. Make sure that you come if you want to.

You are welcome to stay for 5:30 p.m. if you're interested in hearing about the 2014 budget. We'll be doing it with stakeholders from all over the country at 5:30 p.m. today in this room.

So thanks a lot. Good travels if you're going back. We'll see the National Advisory Council people tomorrow.

Thanks.

[Whereupon, at 4:55 p.m., the meeting was adjourned.]