

**Substance Abuse and Mental Health Services
Administration (SAMHSA)**

Joint Meeting of

SAMHSA's National Advisory Council

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1 For the Joint Meeting, if the ACWS and NAC members would please
2 leave your meeting binders at your seat when we adjourn, the ACWS members, our
3 contractor will be sending you all your materials in the mail, so you will not have to take
4 them on your trip home. The NAC members, our contractor will be making updates to
5 your binders for tomorrow's meeting, so please leave those at your seat when we adjourn.

6 Finally, as a courtesy to those around you, please silence your cell phones
7 and other electronic devices. With that, I will officially this meeting to order and turn it
8 over to Pamela Hyde, administrator.

9

10 ***Agenda Item: Administrator's Remarks***

11 MS. HYDE: Good morning, everybody. I want to welcome Geretta.
12 There are acronyms for these things, but she is the new helper for the committee,
13 committee case manager. She's terrific. She's been on with us for a few months, but this
14 is our first time to actually go through this together, so if we miss any steps, which I
15 doubt we will, but if we do, give us a break as we get everything figured out here.

16 Welcome to everybody. We have a good agenda for today. We are really
17 committed to trying to have each part of our agenda have some time for discussion,
18 because as I have said to all of you either individually or in collective groups or
19 whatever, your advice is important to us, your time that you give to us is really critical to
20 us, and the goal here is not for us to talk at you, but rather to have you give us some
21 advice. The discussion among you and the discussion with us, is what's so critically
22 important.

23 We're always trying to balance the fact that you all ask us for information,
24 so we're trying to sort of balance getting you information about the topics. If you'll

1 recall, last time we met one of the things that kept coming up -- and we decided we
2 would do a consistent and concerted effort to discuss -- was issues of kids, young people,
3 and schools, and how we're relating to them and what we can do as SAMHSA about
4 them and as the behavioral health field, about them. We're going to have some good
5 conversation about that today.

6 We are pleased and assume he's still coming, the Acting Assistant
7 Secretary for some of these big problems that we care about -- I don't like these
8 acronyms -- from education is coming to join us this afternoon, so that'll be great. A lot
9 of you should have already participated in some discussion about these issues in your
10 individual advisory council groups, so hopefully you're ready to have those
11 conversations.

12 We also have other great things coming up this afternoon. There's an
13 interesting panel we're going to try to do on SAMHSA issues. We're going to try to do
14 that a little differently, almost an Oprah Winfrey style. We'll see if that works, give you
15 an opportunity to hear from different folks.

16 Then we're going to do later in the afternoon, some updates for you on
17 health reform. I know, as I've said in some of the meetings I was with you yesterday, it's
18 a hugely historic time. Yesterday we talked in the Supreme Court about jurisdiction, and
19 can the court even decide the issues in front of them. Today they're talking about the
20 personal responsibility issues and other things that people are arguing about out there.

21 Everybody seems to agree, however, that no matter what happens with
22 elections, with courts, with everything else, the fact is the health system in America is
23 irrevocably changed, and that's a good thing. It is on a different trajectory, and that's a

1 good thing. The issue is how behavioral health is a part of that, so we'll have a little bit
2 of conversation about that in the afternoon as well.

3 I want to start by just telling you a few updates. One thing I want you to
4 know is we did quite a bit of work in the last meeting about a couple times we've talked
5 about workforce issues. You know, I think, because we've told you that SAMHSA is
6 both limited in resources and authority about how much we can do about workforce. We
7 certainly have a role in practice improvement. In that sense, we do a fair amount of
8 interface with the behavioral health workforce on providing information, training,
9 technical assistance, et cetera.

10 But there are other things that are not in our authority, and those tend to be
11 in HRSA's authority, but they also are limited. There are also things that they cannot do
12 about workforce. But they continue to be incredible partners.

13 Mary Wickfield and I, have agreed to do some follow-up listening
14 sessions with stakeholders about workforce to see if we can pinpoint a little more clearly
15 where the gaps are and what, if anything, we can do about that or what, if anything, we
16 can let Congress know is the problem about that. It's hard to at this point in time, to
17 suggest anything new to Congress because they're in a cutting mode, not in a new-thing
18 mode. But nevertheless, I wanted to let you know because it was an interest of this group
19 that are continuing to talk about that and continuing to see what we can do.

20 The second thing I want to tell you is this is LGBT Health Awareness
21 Week. If you all haven't seen that, there are all kinds of announcements and stuff going
22 out about that. HRSA is doing a conference call with a whole national coalition on
23 LGBT health. The National Institutes of Health are doing a lecture series on LGBT
24 health data. SAMHSA is having an event here on April 2nd. The Administration on

1 Aging is doing health disparities in LGBT older adults. There's a lot going on this week
2 and next to celebrate LGBT Health Awareness Week. There's also a news release, a
3 statement by Secretary Sebelius. Hopefully you have that at your seats to look at.

4 We do lots of celebration of lots of different kinds of populations'
5 disparity issues, not celebration of the disparity issues, but highlighting disparity issues,
6 and celebrations of efforts that are going on around different populations. This one is
7 LGBT Health Week, and I wanted you to be aware of that. If you want any information
8 about any of those events, let me know at the break and I'll get that for you.

9 I also want to say happy birthday to SAMHSA. SAMHSA is 20 years old
10 this year. Birthday, anniversary, I'm not sure which it is. I think it's a birthday, but we
11 tend to call it an anniversary. You will hear more about that in a little bit. We are doing
12 a ton of stuff inside SAMHSA every month, all kinds of fun activities so our staff can
13 relish in the fact that we are a 20-year-old agency now.

14 It's also giving us an opportunity to think about what has changed in 20
15 years, what's different than 20 years ago. I know that there are some people in the room
16 who are historians. If any of you have great materials, if you have quotations, if you have
17 stories or anything from 20 years ago, we'd love to know about that. So let us know at
18 the break if you have something and we'll figure out the right people to get to you to hear
19 about it.

20 We're going to have some poster contests and other kinds of things to kind
21 of highlight this, and then on October 4th we are going to have a big event here to
22 celebrate our birth, which was October 1st of 1992. I don't know about some of you, but
23 I remember that day. I remember the arguments about whether creating SAMHSA was a
24 good thing or not. I remember ADMHA. I remember some of the work that they did.

1 Some of you are young enough that you're sort of looking at me like, yes,
2 it's today, not 20 years ago. We have a whole range of people's awareness about those
3 issues. But nevertheless, we're using it as an opportunity, and you'll hear more about it
4 in a little bit, to talk about behavioral health and its importance and what's happened in
5 the last 20 years.

6 I also want to highlight some personnel changes. Last time we met, last
7 August, Mirtha Beadle, our Deputy for Administrator for Operations, had just joined us,
8 or actually I think you hadn't even really joined us at that point. She's been here an
9 entire five or six months. It probably feels like five or six years at this point. We've got
10 a lot on her plate, but anyway, if you haven't had a chance to meet her, please do.

11 I also want to acknowledge that John O'Brien, who was our health reform
12 lead, has left us, but started this week, I believe, at CMS. That's the agency that does
13 Medicaid and Medicare within HHS. So he's over in a sister agency, or a brother agency,
14 as the case may be. We expect that partnership with John to continue. We were sad to
15 lose him and the leadership that he's provided for SAMHSA on health reform, but
16 frankly, we feel like infiltrating other agencies is a good thing, so we are glad to see that
17 he will be over there. He'll be continuing to work with Barb Edwards and the folks who
18 are doing the disability work over there.

19 I also want to acknowledge Geretta and thank her for her work. She's
20 jumped right in and has gotten us quite organized and is helping us get these committees
21 and councils working and continuing to work well.

22 I hate to say this, but I haven't been here all that long, two and a half years
23 or so, and you're now the third person I have worked with, Geretta, so hopefully that's

1 not me. Hopefully it's just the normal retirements and details and such. We hope Geretta
2 will be around for a long time. Welcome, Geretta.

3 There's also another person I wanted to introduce you to. She is not here,
4 unfortunately. I got an email from her this morning. She's ill today, so I apologize, but
5 for somebody who may still be around tomorrow, if you get a chance to meet her, her
6 name is Miriam Delphin-Rittmon. She is the new second political appointee at
7 SAMHSA. There are only two of us, and that position has been open for quite some
8 time, so she has joined us as a political about two or three months ago.

9 Anyway, Miriam is taking on lots of things. She is from Yale and from
10 the state of Connecticut. She has done work in disparities and lots of other things. She's
11 a psychologist by training, as I recall, and is doing a lot of work for us on different things,
12 but one of the things she's focusing on, which you'll hear a little bit more about later
13 today as part of the health reform discussion, is service definitions work.

14 That is work that we're doing with other agencies to try to see if we can
15 come up with some common definitions of terms across multiple agencies, and also
16 looking at the evidence base associated with each of those or some of those services.
17 This sort of follows from the work that John and other people did with The Good Modern
18 paper on services. We're starting now trying to work on defining and doing evidence
19 base. She's doing a lot of good work on that, so at some point you may want to meet her
20 and say hello, and if you have input to that, we'd love to have you talk with her about
21 that.

22 I also want to acknowledge that Kana has been playing many roles.
23 Again, over the course of the two and a half years I've been here, I think she's had four
24 or five different hats, but right now she's got two of them, the OP Director. The Office

1 of Policy Planning and Innovation role she's still playing, and also the Principal Deputy
2 Administrator.

3 I'm pleased to say, but probably she's even more pleased to say, that we
4 have hired and named a new OPPI director, Joan Erney. Please get a chance to know her.
5 She's from Pennsylvania, worked at the state level, currently working in nonprofit, and
6 has lots of experience in both substance abuse, mental health, Medicaid, and a number of
7 other things. She will be the new OPPI director.

8 I don't think we have a formal start date yet, but sometime in May she will
9 be with us, I believe, and will be in and out. She's here to listen and hear what you all
10 have to say today, so we're really pleased that Joan is here and onboard. We're looking
11 forward to Kana getting more rest and being able to get more fully into the principal
12 deputy role. Some of those things will change over the next few weeks and months as
13 well.

14 The other thing I wanted to highlight is that we still have on the record and
15 on the books a new executive exchange. We've done several of these. We started in the
16 first full year that I was here, 2010, with Kathryn Power and Fran Harding switching, so
17 our CSAP and CHMS division, our center directors changed for six months, and I think
18 we learned a lot from that process. We've done several other executive exchanges since
19 then and have one still going on.

20 Then starting next week we're going to have another executive exchange
21 in which Pete Delany, who is the head of our Center for Behavioral Health Statistics and
22 Quality, will become the center director for CSAT, the Substance Abuse and Treatment
23 program, and Wes, who is the center director for CSAT, will become center director of

1 CBHSQ. That will be a six-month exchange. They are both, I think, looking forward to
2 it, or at least they're claiming that they are, whether they really are or not.

3 These things are both incredible challenges and also incredible
4 opportunities. There are some agencies within the federal government who do rotations
5 much more regularly than SAMHSA does, and I think what we found or discovered or
6 decided we wanted to try is to get some of our leaders within SAMHSA to learn a little
7 bit more about each other's areas so our collaborations would be better. I think that has
8 been successful in doing that.

9 But it is a challenge, and it means that it gets a little confusing for us
10 because we say things like call Pete, no I mean call Wes, no I guess she should still call
11 Pete. So we'll probably be doing that for the next six months, and about the time we get
12 that figured out, it'll be time for them to go back. They take with them their executive
13 assistant and their special assistant, so it's really a team switching for six months.

14 Each of these individuals has background or interest or capacities in the
15 areas they're going to as well as the areas that they're currently responsible for, so they
16 will bring something new. Part of what we're interested in doing in these processes is not
17 only them and their teams learning something from the other centers, but the other
18 centers learning different leadership styles and maybe having a fresh eye take a look at
19 things that we could do better. I want to thank Pete and Wes for being willing to do that.

20 Then we're really going to confuse the field and ourselves by having Pete
21 and Wes maintain their role in their strategic initiative leads. So Wes will continue as the
22 Health Information Technology Strategic Initiative lead, which already has some quality
23 and measurement parts to it. And just to make things really confusing, we're going to
24 have Pete maintain his role as the Data Quality and Outcomes Strategic Initiative lead.

1 You may say how can you do Data Quality and Outcomes Strategic
2 Initiative lead, but not be running the Center on Behavioral Statistics and Quality.
3 Believe it or not, there actually are different things in those two areas, but it will clearly
4 require that Pete and Wes and all the rest of us think even more about how these things
5 are related. But there are clearly high-level policy issues and issues interacting with other
6 agencies of other things in the Data Quality and Outcomes Strategic Initiative that we
7 didn't want to disrupt Pete's role, what we call downtown and other places, for that.

8 If you get confused on who is responsible for what, it's okay. We, as
9 leaders, feel like we are all quite capable of answering questions, directing traffic, and
10 getting you the answers that you need. Please let us know if we're confusing you.

11 There are currently 14 people viewing us on the web and about 4 on the
12 phone, two of whom are members. One is Bobbie Benavente. Bobbie, it must be one or
13 two in the morning out there.

14 MS. BENAVENTE: No, not quite, 11 p.m.

15 MS. HYDE: That's not too bad. It'll be this afternoon that you'll be
16 asleep probably. Kana and I are particularly sensitive to that, having just come back from
17 two weeks in the Pacific jurisdictions, at least the five that are out that direction, and so
18 we are very sensitive to what it means to be in the middle of the night trying to participate
19 in work efforts. Welcome, Bobbie.

20 The other person is Starleen Scott Robbins who is on the phone. Both of
21 them are from the Advisory Council on Women's Services, so welcome. There will
22 probably likely be more people over the course of the day. We sometimes get many
23 people listening, so we'll see what happens over the course of the day, and we'll let you
24 know as people continue to join.

1 I believe those are the things I want to start with. I want to try to
2 hopefully get us almost caught up maybe a little bit more. Let's see if I've missed
3 anything here.

4 Regional administrators. Most of you know, I think, that we are very
5 proud of having added 10 regional administrators, so each of the regional offices that
6 HHS has now has one person -- only one, but they are high-powered -- representing
7 SAMHSA out there. We have a great group of 10 folks, some of whom are ex state
8 commissioners, providers, people in recovery, people who are preventionists, people who
9 are experts in emergency preparedness and response, people who have experience with
10 Indian Health Service, and just a variety of skills and experiences in those 10 people.

11 They are a terrific group. Ann Herron is sort of the lead and director of
12 that group. Is Ann in the room? Ann gets a ton of credit for both helping to identify
13 these 10 people and also helping to sort of bring them along. If you have not had a
14 chance to say hello or welcome the regional administrator in your area, I really encourage
15 you to do so.

16 They're a great group of people, and they are bringing us lots of
17 information from the field. They are connecting a lot to the states and providers and
18 communities out there. They're also connecting a lot to the other agencies. We do a lot
19 of work here with CMS and with ASF and with HRSA and all those other folks. They
20 are doing that at the regional level. We're getting tons of great feedback for them.

21 You all may know because you may have seen the email, but Paolo del
22 Vecchio is Acting Center Director for the Center for Mental Health Services. He's doing
23 a terrific job there. Kathryn Power is Regional Administrator in Region 1, so she is out
24 there, I think, enjoying being closer to home. She actually gets to go home very night

1 now instead of having to commute for so much. We're pleased to have her out there
2 providing some leadership not only to the region, but to other folks.

3 The other person who's out there that some of you may remember is
4 Dennis Romero, who is our Regional Administrator in Region 1. He was leading our,
5 what we call, TLOA effort, our Tribal Law and Order Act effort, which SAMHSA is
6 responsible for coordinating across not only our agency, but across HIS and DOI, which
7 is where the Bureau of Indian Affairs sits and the Department of Justice and a number of
8 other agencies.

9 We are looking for the Office of Indian Alcohol and Substance Abuse
10 director. We haven't found that person yet, but Dennis has gone to Region 2. He also is
11 kind of home. He came from New York, so he's out there doing a great job for us in the
12 region as well. The regional administrators are listed under Tab 6, so if you don't know
13 them or don't know who your person is, you can take a look there and see them.

14 Kana and I a year ago met with some folks when they were here for some
15 prevention efforts from the Pacific jurisdictions, and they invited us, and we committed
16 to going to see them. We went, finally, a couple of weeks ago and spent two weeks out
17 in the Pacific jurisdictions. Believe me, it is one thing to see on paper what it's like to
18 visit there or what the challenges or what the time zones are or anything else. It is
19 another thing to go experience it, and that's certainly what we wanted to do.

20 We went to all five of the jurisdictions that were out there a little closer
21 together. We haven't made it yet to American Samoa, but we will eventually do that as
22 well. As you know, we have a council member from American Samoa, so welcome. We
23 met with her this morning. We wanted to just tell you a little about that experience. It

1 was a terrific experience both in terms of the people, the culture, understanding the
2 issues.

3 Three of the jurisdictions of the six jurisdictions out that way are
4 territories and the other three are freely associated states. All of them get our block grant
5 dollars, and the territories also have access to other dollars, so they are doing great work
6 on prevention, all of them are, in various and sundry ways. At some point we could, I
7 suppose, do a slide show for people if they wanted to see the great work that people are
8 doing.

9 I think, if anything, I came away from is not only the wonderful island
10 culture. Each one of the jurisdictions is completely different, even though they share a
11 lot in common. But also, they really embrace substance abuse and mental health together
12 in ways that we still struggle with in the 50 states, and they embrace behavioral health as
13 part of health, in fact, if not as part of health, even more fundamental to health than we do
14 in the 50 states. There's much we can learn from them, and it was a very profound
15 experience for us. We'll let Kana add some stuff about that, and then I'll come back to
16 another personnel comment.

17 MS. ENOMOTO: The Minister of Health in Palau had the concept of a
18 social ecological concept of where he says if you heal the soul, the body will follow. So
19 he has spiritual, familial, social, mental, behavioral health really very core to the
20 individual, and then physical health comes beyond that and community health follows
21 close from that. That's the framework for the Health Department, and behavioral health
22 fitting and being part of that, if he says he's trying to get health to become part of the
23 Behavioral Health Department.

1 Minister Kuartei is leading an effort through the Pacific Islanders Health
2 Officers Association, and then now bubbling up to WHO on non-communicable disease
3 being a health crisis. In the Pacific the rates of diabetes, heart disease, and obesity are
4 astronomical and really killing far more people than infectious disease now.

5 But he's also open to the conversation that Pam's going to go to the WHO
6 to talk about, behavioral health being part of that NCD cluster, that mental illnesses and
7 substance use disorders are costing our people, our communities, our country more
8 money, more lives than we really realize, and then we're allocating resources to address.

9 I think the visit to the Pacific was very eye opening. We appreciate that
10 Bobbie's on the phone. We learned from freely associated states that 800 calls are not
11 free; they're international calls. Webcasts are really not feasible because you don't have
12 the bandwidth and you're running around with a wireless card trying to get Internet.
13 People sort of log on to their email at night, download it overnight because it's dial-up,
14 and then they deal with it the next day.

15 Technology, human resources, very few folks with master's and doctorate-
16 level degrees, but at the same time you have truly visionary leaders, very competent staff,
17 very sophisticated people who are making fantastic use of the technical assistance
18 resources, the publications, the grants, the staff at SAMHSA.

19 I felt very proud coming away that SAMHSA does have an important
20 footprint in the Pacific, that the people there care very much about their communities.
21 They're very aware of the behavioral health issues and are doing fantastic work. I think
22 with our Master Trainer Development Program that we're launching, we can scaffold
23 upon all the good work that's already been done.

1 MS. HYDE: One of the reasons that we were out there, or probably the
2 reason we were out there, at this time was to launch something called the Master Trainer
3 Development Program. We actually missed the ending because the plane screwed up and
4 we got stuck. That happened to us several times, so we also got an appreciation for the
5 travel challenges out there.

6 But nevertheless, the opening was individuals from the Pacific region that
7 we had an opportunity to help bring together to be trained not only in a topic area that
8 they had selected to delve more deeply into and become more expert at, but also to be
9 trained to be trainers, so to be trained in adult learning theory and other kinds of things.

10 The idea was this was a program that Winnie Mitchell from our staff and
11 the Pacific Behavioral Health Collaborating Council Committee had worked on for quite
12 some time to try to build capacity there from the Pacific. So rather than us always
13 sending experts out there, for them to use their own knowledge of their culture and their
14 resources, to be resources for the Pacific.

15 It was a very successful kickoff. It's a yearlong program. They'll be
16 doing some site visits and some mentoring and some other kinds of efforts. Then I think
17 there are 16 of them that went through the program this time and maybe one other that's
18 going to eventually join them. That's a fairly amazing amount of resource capacity to
19 infuse into the area, so we're really pleased about that.

20 Katie is the President of PBHCC. Katie is back there if anyone wants to
21 know more about the Master Trainer Program. Bobbie was talking about it yesterday in
22 the Women's Services Committee, and I think everybody wanted it. It's a great idea.
23 They deserve a lot of credit for coming up with the idea. We were happy to be able to
24 help pull it off, some logistics help.

1 Kana mentioned the WHO. Let me just say a word about it. SAMHSA
2 doesn't normally do a lot of international work. We have a little bit of work that Wes has
3 consistently done around some drug trafficking issues and drug treatment issues and other
4 things with ONDCP and others in Vietnam and Russia and a couple of other places, Iraq
5 and others. We've done some work in Afghanistan, Iraq, and other places as a result of
6 some of the efforts in that region over the last several years.

7 But generally speaking, our authority is domestic, so we don't do a lot of
8 international work. Three of the jurisdictions that we work with out in the Pacific are, in
9 fact, countries; they're not territories, so it is international. We saw the ambassador and
10 actually had an international engagement with them.

11 The WHO, which I've been invited by the HHS Office of Global Affairs --
12 has asked me to go, because if you've followed this at all, the World Health Organization
13 has really been doing significant work on the role of behavioral health as a non-
14 communicable disease. So I feel very honored and flattered and a little bit humbled at
15 being asked to come out.

16 I'm going to have an opportunity to make a speech or be a part of some of
17 the dialogues about behavioral health in that way. That's going to happen in May, and so
18 maybe next time we meet I can tell you how that went. Any of you who are following
19 that effort, if you've got any guidelines or thoughts for me, I would love to hear your
20 advice about that, as well.

21 I do want to just acknowledge Winnie Mitchell, who's our international
22 officer who does a lot of this work in helping us and has done a terrific job. She
23 accompanied us on the trip to the Pacific jurisdictions and was really part of the
24 leadership in pulling off the Master Trainer Development Program out in the Pacific.

1 One other personnel issue I forgot to mention. Mark Weber, who has been
2 our longtime Office of Communications Director, is now Deputy Assistant Secretary for
3 Public Affairs at the HHS. So he's also gone downtown, we call it. You can either call it
4 downtown or kicked upstairs, one or the other.

5 But we're really pleased because the Assistant Secretary for Public Affairs
6 has also seen a significant amount of turnover downtown, in part, because this is one of
7 the positions along with CMS that the Senate has refused to confirm. So a person or two
8 has been there acting, and then another person acting, and then now there's another
9 person acting. There have been some changes in that arena. They do a terrific job, but
10 they haven't had a lot of public behavioral health background, and so Mark is now down
11 there with years of experience in behavioral health helping them. We're really pleased
12 about that, even though sad to lose him.

13 Nancy Ayers is acting in our Office of Communications, and you're going
14 to hear from her a little bit later about our 20th anniversary efforts. You'll hear from her
15 in just a little bit. If we think of more personnel changes, we'll let you know.

16 I can tell you that every organization I've ever been in in government has
17 always had people coming and going. Good people leave and good people come, and it's
18 part of the nature of the beast, but we've had a lot in the last few months, almost to the
19 point that I've been saying that Kana and I are sort of utility infielders. We just kind of
20 fill in wherever the holes are, in trying to provide the leadership.

21 I'm actually really quite pleased and just always want to take an
22 opportunity to thank Kana for her work. She has been an incredibly important stabilizing
23 force and also an incredible advisor to me, and now principal deputy. So I thank her for
24 her work. With that, I'm going to turn it over to Nancy. Nancy, do you want to talk

1 about our 20th anniversary efforts?

2

3 ***Agenda Item: SAMHSA's 20th Anniversary***

4 MS. AYERS: Good morning. As Pam indicated, across the agency we're
5 very excited about our 20th anniversary. This is a significant milestone and a prime
6 opportunity to engage and excite stakeholders, grantees, the media, the public, and the
7 behavioral health community.

8 As such, we have prepared a promotional plan that celebrates the
9 milestones and accomplishments of the past 20 years. The following plan taps into
10 SAMHSA's main communication channels such as our newsletters, social media, the
11 website, and focuses on making an initial splash with key audiences in the coming
12 months followed by a steady stream of promotion throughout the year.

13 Our efforts are already underway. We've developed a suite of materials that
14 commemorate the 20th anniversary such as a logo and a letterhead, an outdoor banner, a
15 document that provides an in-depth look at historical milestones.

16 We've developed some web materials such as a twibbon, which is an image that will be
17 placed on SAMHSA's Twitter page that includes the 20th anniversary mark. Many of
18 these materials have already been developed or are in process and will be used as part of
19 our outreach activities throughout the year.

20 Many of SAMHSA's partners and stakeholders have indicated that they would like to
21 help celebrate SAMHSA's 20th anniversary, which is critical for helping us reach beyond
22 our existing audiences. As such, we will develop a packet of materials that stakeholders
23 can use to help promote and celebrate SAMHSA and the behavioral health field advances
24 such as articles for their newsletters, resources to post on the websites, and sample posts

1 for social media platforms. All these materials will be drafted and designed as templates
2 that stakeholders can adapt and personalize appropriately.

3 An important part of this effort is having SAMHSA spokespeople, those
4 who are at events, conferences, and meetings across the country, talk to audiences about
5 the anniversary. To support this, we're developing key messages that our spokespeople
6 can use and adapt to help shine a light on how far we've come and where we're looking
7 to go in the future. We'll also be using SAMHSA's newsletters, SAMHSA News and
8 Headlines, to promote the anniversary.

9 SAMHSA's social media platforms such as Facebook, Twitter, and
10 SAMHSA's blog give us a chance to create a steady beat of excitement about the 20th
11 anniversary, but also encourage engagement across our online network and help us reach
12 a broader audience. For example, we will provide stakeholders with suggested social
13 media messages as part of the promotional packet so that our partners can celebrate this
14 milestone within their own networks. This helps us reach audiences we may not
15 otherwise have access to.

16 Also, many of our social media messages will link to SAMHSA resources
17 such as the SAMHSA News anniversary articles and the stakeholder feedback forum
18 that's currently on our website, and SAMHSA blog will promote our anniversary in a
19 series of posts, including interviews with staff who have worked for SAMHSA for the
20 past 20 years as well as guest posts from individuals who have been directly impacted by
21 our work.

22 We will also launch a media campaign called 20 Is A Magic Number in
23 which we'll do a series of monthly press releases timed for the 20th of each month. The
24 releases will emphasize SAMHSA's impact on communities and highlight a different

1 facet of the services that SAMHSA provides. The hook for each release will focus on a
2 behavioral health issue and the number 20. It could be a statistic, an observance data, or
3 some other fact. We will be involving the entire agency in this effort to ensure that we're
4 representing the full range of programs and activities that SAMHSA offers.

5 Additionally, we will host a tele-briefing or in-person briefing for trade
6 press to hear from the administrator on the major advancements in the behavioral health
7 field over the past 20 years and SAMHSA's strategy for moving forward.

8 As you can see, we feel that this is a comprehensive plan that uses existing
9 agency channels, resources, and networks in a thoughtful and coordinated manner.
10 Please let me know if you have any questions about our anniversary plans and, of course,
11 welcome any suggestions or additional activities that you wish to suggest. Thank you.

12 MS. HYDE: Thanks Nancy. The slides that Nancy was using are in your materials, so
13 just help you kind of get a flavor of what's coming. Does anybody have any questions or
14 comments about the 20th anniversary stuff at the moment?

15 If you all can think of ways that we can use the 20th anniversary as a hook to do anything,
16 let us know, let Nancy know. We are going to try to do more media efforts and histories
17 and other kinds of things and get materials out, so if you have thoughts about that or,
18 again, if you have old materials you'd like to share, we'd love to have it.

19 We're going to move into the budget discussion. I do just want to remind
20 you as I hand this over to Kana that we really do want to try to have as many
21 opportunities as possible for conversation, so we will try to get to that part as soon as we
22 can. I don't want you to think we're going to sit and try to talk at you all day. We're just
23 trying to get you some information to get us started. Again, Kana, I'll turn it over to you.

24

1 ***Agenda Item: Update: SAMHSA's Budget and Operations***

2 MS. ENOMOTO: Good morning. I do have a bunch of numbers to talk
3 through with you, so feel free to jump in and ask questions as we go along. I think we
4 can do it expediently enough, otherwise it will get confusing to do it all at the end.

5 We were pleased that the president presented his budget for fiscal year
6 2013 with a total budget request for SAMHSA at \$3.4 billion. It represents a four percent
7 decrease, or about \$142 million less across all sources, from fiscal year 2012, but
8 continues to support our efforts to increase access, improve quality of behavioral health
9 services nationwide through fiscally responsible approaches.

10 It also maintains a continuing commitment to SAMHSA's roles in
11 surveillance and quality, public awareness and support, regulatory oversight, practice
12 improvement, and providing a voice for behavioral health issues through leadership
13 across all aspects of Health and Human Services.

14 In the 2013 process there were clearly tight and challenging economic
15 times that we had to deal with. Within that we continue to highlight a commitment to
16 states, territories, and tribes to reduce the impact of substance abuse and mental illness in
17 all of America's communities.

18 This slide with the blue, the rust, and the chartreuse gives you a sense of
19 the tallest bar is the fiscal year 2011 actual, so that's a \$3.599 high watermark we see in
20 the distribution. The green is the ACA Prevention Fund. The rust is PHS Evaluation
21 Funds, and the blue is our budget authority.

22 As we see, the funds are shifting in their balance. There's an increase in
23 2013's budget. We have proposed \$105 million from the Prevention Fund. That's the
24 green. I guess it's really the balance. You see there's increasing green, there's increasing

1 red, and there's less blue. Within changing numbers, we're also changing the distribution
2 of the sources of funds.

3 But in that we are still continuing to prioritize our strategic initiatives.
4 The Strategic Initiative for Prevention and Trauma and Justice maintain their top roles,
5 and in 2013 the budget includes \$500 million.

6 In 2012, the Congress passed the Consolidated Appropriations Act, and in
7 that gave SAMHSA four appropriations. So where we had been with the single
8 appropriation for SAMHSA, SAMHSA, HRSA, and CDC had their budgets divided into
9 multiple appropriations, which, for us, came in the categories of mental health, substance
10 abuse prevention, substance abuse treatment, and health surveillance and public program
11 support.

12 The mental health, prevention, and treatment lines are not one-to-one
13 correlations with the centers, because many of the activities, including staff surveillance,
14 program performance, data collection, public awareness and support, that's all in the
15 fourth appropriation, and those activities, of course, spread across the other four centers,
16 so CMHS, CSAT, CSAP, and CBHSQ.

17 For example, in the 2012 budget there is a line for military family's policy
18 academies. That's an activity that spans prevention, treatment, and mental health, so
19 since they couldn't put it into one center, they put it into the fourth appropriation.

20 In our 2013 budget you'll see later, we have the tribal prevention grants,
21 which span prevention and mental health, and so that's also in the health surveillance and
22 program support lines. When you look at the numbers for the mental health
23 appropriations, substance abuse prevention, substance abuse treatment appropriation, you
24 have to then do a little bit of a math calculation to figure out what the total budget is

1 supporting those things because you have to incorporate some part of the fourth
2 appropriation in that.

3 That being said, we do have \$500 million for focused prevention efforts,
4 which includes substance abuse prevention and mental health promotion grants for states,
5 territories, and tribes with the goal of bringing evidence-based prevention and promotion
6 strategies to scale nationwide. We also have two new programs, which are adult trauma
7 screening and disaster distress line, which we can talk about a little bit later.

8 For substance abuse prevention we have \$404 million for the substance
9 abuse state prevention grants, which is combining substance abuse prevention streams,
10 multiple funding streams, primarily the SPF and the current substance abuse prevention
11 and treatment block grant, set aside.

12 Again, the goal for that is to increase accountability and to expand the use
13 of the strategic prevention framework across the statewide substance abuse prevention
14 efforts and to increase focus on high-need communities. We would maintain a strategic
15 prevention framework state incentive grant funding for those grantees that already have
16 them.

17 For the mental health state prevention grant we have \$55 million. This
18 creates a new formula-based grant to states and territories which would expand our
19 Project LAUNCH approach, which focuses on early childhood, but then we're still sort of
20 in discussions about exactly what that would look like, but may focus on early childhood
21 and give states and territories the option of expanding the age range to go up and to
22 include school-aged youth. It would also maintain a funding for current Project
23 LAUNCH grants, which is our prevention and promotion program on the mental health
24 side, which works across systems for children 0-8.

1 The tribal prevention grants, this is one that's in the health surveillance
2 and program support line. It's \$40 million, which is coming out of the Prevention and
3 Public Health Fund, the ACA funding. This would provide sustained, predictable levels
4 of funding for tribes to do culturally appropriate suicide prevention and substance abuse
5 prevention programming and encourage them to use data to drive their prevention efforts.

6 This has been something that was developed in consultation with tribes. I
7 think the staff had conversations about how we might generate a formula for this
8 program. It was in our '12 budget, I think, at \$50 million and is in the budget this year at
9 \$40 million. Were this to come to pass, I think we need a little bit of additional
10 consultation in how those funds would be allocated.

11 But the point, I think, is after many years of consultation with the tribes,
12 hearing about how suicide is a very important issue there, mental health promotion,
13 therefore then substance abuse prevention across the board, but that it's the challenge for
14 tribes of getting discretionary grants, and then those funds going away. So you get a
15 suicide prevention grant, but then it goes away. You get a CSAP grant, and then it goes
16 away.

17 They need to be able to have a more stable infrastructure because
18 prevention is -- that's fluoride in the water; it's not handing people out a tube of
19 toothpaste. You've got to keep doing it and you've got to do it everywhere and you've
20 got to do it over and over again.

21 For our trauma and justice portfolio, criminal justice programs are still a
22 healthy portion of our discretionary portfolio at \$69.4 million with the emphasis on
23 diverting individuals with mental illness and/or addiction from the criminal justice
24 system with a continuing emphasis on adult drug treatment courts.

1 We will be continuing grants that we are starting in 2012 looking at teen
2 courts within the criminal justice portfolio and continued emphasis on offender reentry
3 programs as well as what's not listed there, but the partnership with the Bureau of Justice
4 Affairs on a couple of our programs.

5 We maintain the increased level of funding that we received in 2012 for
6 the National Child Traumatic Stress Network. That will continue with three categories,
7 categories one, two, and three, which is the national coordinating center, our
8 dissemination and training centers, and then the community-level provider work.

9 There will be a stronger focus on trauma, which has really started already,
10 but it will continue in 2013 looking at issues of trauma-specific and trauma-informed care
11 within our pregnant and post-partum women program as well as within CMHI systems of
12 care.

13 One of our new initiatives which, as we've gone around and talked to
14 people, has gotten, I think, fairly good responses is, in part, a response to the IOM's 2011
15 report that it issued, recommendations on preventive clinical services for women and
16 girls. The IOM made recommendations which included universal screening for
17 interpersonal violence with women and girls, and HHS adopted those recommendations
18 as guidelines for preventive services for women.

19 Included in that recommendation was current and past abuse, where we
20 recognized that we have a little bit of a knowledge gap around how to screen for past
21 trauma in a non-behavioral-health-specific setting. Often the women that we see where
22 we screen for trauma that are already in mental health treatment settings are in a drug
23 treatment setting, homeless, criminal justice.

1 How to screen appropriately and to conduct supportive and culturally
2 appropriate brief interventions is something that there's a well developed knowledge base
3 around domestic violence and less so around other forms of interpersonal violence,
4 trauma, and abuse. So we are proposing a small research demonstration or services
5 research program which would allow sort of an active community partnership to identify
6 good models of doing this in a supportive, safe, and effective way.

7 Another new line that we are proposing is the National Distress Health
8 Line, which is a continuation of a pilot that started with the support of BP funding
9 following the oil spill. We've piloted this distress line so that communities in need at the
10 flip of a switch -- and really not of a switch, but as a disaster occurs -- and there is
11 probably a disaster of some form, whether it's presidential, gubernatorial, or non-declared
12 and human-made, a school shooting or other, those are happening almost every day of the
13 year. People are in some state of recovering or responding to a disaster somewhere in the
14 country every day of the year.

15 When that's happening, people experience psychological stress and often
16 need somewhere to call. This national distress line would provide a number that's
17 connected with an existing network of crisis centers across the country which are helping
18 us with our Suicide Prevention Lifeline, but they would be able to help people in
19 emotional crisis in a time of disaster.

20

21 The line would be live all year long, but would be advertised or promoted
22 in areas of a disaster when it was happening. We've looked at models of having a line,
23 turning it off, turning it on, turning it off, and that ends up being much more expensive

1 than keeping it on all year-round. We're in a pilot now. We'll be getting data from that.
2 We're proposing to maintain it with appropriated funds from 2013 and beyond.

3 The 2013 budget reflects our commitment to working with states and
4 affording flexibility and involving healthcare, health reform environment, while
5 increasing our commitment to communities for prevention and services. For example,
6 with our state prevention grants, we are asking states to use their discretion to identify
7 high-need communities in a consistent data-driven way, but then we're also making a
8 commitment to keeping a certain amount of that money going to the communities, similar
9 to where we are with the Strategic Prevention Framework.

10 Another major thrust of what we're doing, which is a departure from what
11 SAMHSA has done historically, is trying to move the ball down the field, so to speak.
12 Where we have in the past sort of come up with a program and gotten support for that,
13 and then done it the same way over and over again for 20 or 25 years, even though the
14 science has evolved, even though the state of the field has evolved, what we're trying to
15 do now is say when you first have an innovation and you need people to try it out, test it,
16 it really needs to be a resource-intensive investment because it's something that people
17 will have to radically change their systems and their practices.

18 Over time, when you've done something in every single state or you've
19 done it already in 100 communities, you have a good sense that it works and people want
20 to do it, so they need a different set of tools, a different investment. The grant then needs
21 to change and evolve, so it's less of that intensive investment and looks more towards
22 dissemination into fusion. It's the same topic, but you have to move it towards this
23 evolution of eventually getting to widespread dissemination.

1 But if you keep doing an intensive investment in one community at a time,
2 I was talking about it's like shining a flashlight. Some of our discretionary programs are
3 such an intensive investment of resources in a few communities, like shining one
4 flashlight brightly on one community, and then after three or four or five years, you shut
5 off the flashlight and you put the flashlight on somewhere else.

6 Then you do that again, and you do that for many years, but you never
7 figure out how to turn on the light for the whole state. That's what we really need to
8 figure out how to do and use our tools, whether it's the block grants, the technical
9 systems, our leadership, the discretionary grants. We need to use our tools to figure out
10 how to turn on the light for the practices that we know work for the communities we're
11 trying to serve.

12 The budget authority is reduced for a number of our discretionary
13 programs, in which we've had major investments. PBHCI, Primary and Behavioral
14 Health Care Integration, is a program that's focused on bringing primary care services
15 into settings where we've been treating people with serious mental illness.

16 While the budget number drops fairly significantly, because we were
17 anticipating a drop in funding, we have provided multiyear funding for grants in 2011,
18 and therefore will have sort of the same number of grantees because many of them are
19 operating on prior-year funds. The moral of that story is if you see some drops, before
20 you get alarmed, come back to us because in many cases because we anticipated
21 reductions in funding, we planned for that, and so we will maintain activity without
22 needing to terminate grants.

23 Children's mental health services, also sees a reduction because we have
24 done planning grants, we've done state one-year planning grants in 2011, and we're

1 doing implementation grants in 2012. There's going to be a reduction, but it's largely
2 coming from recycled funding or grants that are coming to a natural end.

3 The request of \$105 million from the Affordable Care Act Prevention
4 Fund is an increase of \$17 million over 2012. What we're seeing is the PBHCI program
5 is moving entirely into the Prevention Fund. The Sober Truth on Preventing Under Age
6 Drinking, or the STOP Act grants are also moving entirely into the Prevention Fund.
7 SBIRT will be funded \$30 million out of the Prevention Fund, and \$40 million for the
8 Behavioral Health Tribal Prevention Grant.

9 That is the budget. Just a final word on that is we have had the
10 opportunity to talk to both the Senate and House appropriations staff to talk about our
11 budget for 2013. We look forward to continuing conversations with them. They've been
12 interesting and rich dialogues so far, so we look forward to continuing that. As any of
13 you have comments or questions, I'm happy to take those.

14 MS. HYDE: Let me just say a 30,000-foot comment or two, and then ask
15 you if you have questions. The split of our budget is about 70 or 71 percent substance
16 abuse and about 29-30 percent mental health. That is true for the proposed fiscal year '13
17 budget and has been true for several years. We do try to keep it in generally that area.
18 Frankly, there are a number of programs where we braid money across different areas
19 because there's both substance abuse and mental health efforts going on in a particular
20 program.

21 But nevertheless, it's important to a lot of people and certainly the way
22 some of the states' programs -- about half of them are still separated. It's important that
23 the dollars stay pretty clear between substance abuse and mental health, at least at this
24 point in time. This budget maintains that. That's one thing I wanted you to know. There

1 actually is a little tiny mistake in one part of the budget. Some of the money got counted
2 in the mental health side, should have gotten counted in the substance abuse side. We'll
3 fix all that. But nevertheless, it's about 70-30, give or take.

4 Our budget is also about three-quarters block grant. Our discretionary
5 grant programs and our surveillance efforts and our public awareness and everything else
6 is only about a quarter of our budget. Those other roles are really important, but what we
7 do with block grant is also critically important because of the budget that we have.

8 Our budget's also only about \$3.4 billion, which is a drop in the bucket in
9 the nation's behavioral health system. In fact, the states have now lost more money just
10 on the mental health side than we had in our entire budget. NASMHPD analyzes and
11 asks the states to give them information. They are now up to about \$4-point-something
12 billion in lost revenue to the states on mental health, and the substance abuse side is not
13 quite that high, but it is significant.

14 We continue to think about the other roles that we have in making sure
15 that we work with CMS, which is an increasing part of the budget for behavioral health in
16 general and working on health reform, which has to do with private-sector payments. All
17 of those things are really just as important to us as the dollars that we have to operate or
18 give out as grants. It's critical to the field.

19 The other thing I would say about high-level is if you are the least bit
20 confused sitting here at this moment about which year are we in and which year are we
21 talking about, join the club. We are actually in fiscal year '12 getting grants and
22 contracts out the door and doing fiscal year '12 activities. The budget that Kana just
23 talked about is the president's proposed '13 budget. Believe it or not, we are already
24 thinking about development or formulation, as we call it, of the fiscal year '14 budget.

1 The President's budget went out about early February, mid February. Just
2 last week or so the House passed a budget. If I could show you a graph, the president's
3 budget might be here, the sequestration budget, that is all that stuff that happened last
4 year that would go into effect in the lame-duck Congress in January of next year -- so
5 whatever that lame-duck Congress is, they'll have to live with it or deal with it -- it would
6 be here. The House just passed a budget resolution that would be here. You can't see my
7 hand anymore because, for those of you who can't see at all because you're on the phone,
8 it went down.

9 My point in saying that is in '11 we lost about 1.5 percent, in '12 we lost
10 about a percent. This budget, the president's budget, proposes about a 4 percent
11 reduction. That sequestration could be many more percentage points beyond that
12 reduction, and the House budget would be even lower than that.

13 I think everybody's best guess is, frankly, that in terms of budget levels,
14 neither the president's nor the House budget is what we're going to end up with. We
15 don't know what we're going to end up with, but we can probably rest assured that it's
16 going to be less than it is today. We can probably rest assured that '14 is going to be
17 directing us to reduce funding even more.

18 I say that in order to say to you as we go through the rest of the
19 conversation today, we'd really like your thinking about what SAMHSA can do absent
20 money, because we often think about what grants we can give out or what new programs
21 can we fund. That's just not very realistic right now. What we're doing is asking
22 ourselves what can we cut or what do we need to preserve in difficult budget times, but
23 there's lots of other stuff we can do.

1 For example, the service definition work that I just told you about is a
2 profoundly important set of work to do. The block grant application, which we'll talk
3 about later today a little bit, is profoundly important work that we're doing. The CSAP
4 work on the prevention paper that the CSAP Committee is looking at and will be out for
5 public comment soon is profoundly important work for the field.

6 There are things like that that we are trying to think about how we can do
7 differently that we need to talk about. We'd like your input about that. Actually, one of
8 the things I meant to say about that 70-30 split -- and Kana mentioned it, but I want to
9 underline it -- is with the way the budget's been restructured, it is sometimes hard for us
10 to track the money. So truly when you see a line item that you have some interest in,
11 please talk to us about it before you sort of try to figure out what happened to it, because
12 it may have gone in other places.

13 The one place we formidably switched some money from one place to the
14 other was in the HIV/AIDS area. We have about this much -- and I'm putting my fingers
15 really close together, for those of you who can't see me. We have very little money in
16 the mental health HIV/AIDS money. We have quite a bit more in CSAT and somewhere
17 in the middle in CSAP in prevention.

18 What we're trying to do is equalize that out a little bit so that we can
19 continue to be good partners with CDC and others who are doing HIV/AIDS work.
20 There is a little bit of the treatment dollars that we moved from HIV/AIDS in treatment to
21 HIV/AIDS in mental health just to even that out a little bit. But otherwise, the budget as
22 a whole stays about the 70-30 to 71-29.

23 Those are my high-level comments. Anything else, Kana, that you
24 thought of that you want to say before we open the floor here?

1 MS. ENOMOTO: I'm just going to make a clarifying note that when we
2 spend the money, it's very easy for us to track it. Daryl and her folks in the Office of
3 Financial Resources are assiduous about being able to track where the money is, where
4 it's coming from, where it's going to. It's just conceptually a little bit difficult for us in
5 the 2013 and the abstract written document, but execution, our folks are doing an
6 amazing job of keeping everything straight.

7 MS. HYDE: See how they keep me straight here. Questions?

8 MR. RISSER: I am Pat Risser with the Center for Mental Health Services
9 National Advisory Council. I wondered if you could just speak briefly to your
10 collaboration with other agencies. I notice we're funding things like mental health
11 courts, and yet the savings would seem to accrue to the criminal justice system. Maybe
12 they ought to be footing part of the bill for some of these efforts. Likewise, we've got a
13 number of efforts that I didn't hear mentioned targeted toward veterans, and maybe the
14 VA could be picking up some of the expense of some of the efforts that we're making.

15 MS. HYDE: We do a lot of work with justice, and when we fund things
16 together, which is not always -- sometimes we fund things, sometimes they fund them
17 separately, but when we do it together, they fund the court part and we fund the services
18 part. We did that with drug courts. We do a lot of collaboration where other agencies.
19 For example, the Administration on Children and Families are funding some new trauma
20 grants, and we're funding the TA portion.

21 It's hard just looking at one budget to see what's going on there. The
22 Department of Justice actually funds a lot of services for mental health and substance
23 abuse for both juveniles and adults. There is stuff all over. We try to keep this straight in
24 terms of where it is that we all play, but there is collaboration in that regard.

1 With regard to veteran services, the money that Congress gave us for '12
2 was really for a very specific that they don't do, which is it's about policy academy. We
3 do the policy academy work, convening people, providing TA, getting them together to
4 help plan and figure out what to do, the National Guard Bureaus and Reserve and such.

5 They were very clear they didn't want us to do service delivery with those
6 dollars because that is, in fact, the VA and DOD's responsibility. I think they make fairly
7 clean distinctions about these dollars. DOD actually paid for the policy academies in '11.
8 We had done some in earlier years. They actually gave us some money to do them in
9 '11, and then Congress gave us some money to do them in '12.

10 MR. ALAWNEH: Good morning, everybody, and happy birthday,
11 SAMHSA. I don't know if this a good time, but this is an opportunity to really thank you
12 for all the good work you are doing to improve the public health for the population here
13 in the United States. I don't know if I can say this, but I thought -- is the public health
14 system fund distribution is like my hair. It's good production, but unfair distribution.
15 Maybe there is something that can help in some way with fair distribution.

16 For example, the funds are distributed based on competition, so I noticed
17 some states get funded, some states don't get funded. This -- leads to health disparity. I
18 want to give you an example. I'm here just to raise the voice of Arab Americans, which
19 we know that we area absolutely an underserved population, especially when it comes to
20 women and children.

21 We live in the state of Michigan, specifically in Dearborn and Detroit area.
22 If the state of Michigan doesn't get money, we're not going to get anything. I want you
23 to know that people are coming to Deer Point from not only United States; they come

1 also from Europe. I am suggesting sometimes SAMHSA needs to look at funding
2 communities that really have a need for services.

3 I'll keep talking about this, and I know you are open for any suggestions.
4 Maybe something can help. I'm here just to let the voice of underserved communities
5 and minority communities. Again, thank you so much. I hope not to miss you guys to
6 come again here.

7 MS. ENOMOTO: I think your point is well taken, and that is why as we
8 are working with states, we're trying to encourage the prioritization of high-need
9 communities. High need gets defined differently in different places, but I think the points
10 that you're raising -- and we're not working entirely with states. We do have a
11 significant portion of our discretionary grants that continue to go to communities, but
12 striking that balance, I agree, is difficult.

13 MR. FRIEDMAN: Bob Friedman, Center for Mental Health Services
14 Advisory Council. I appreciate the efforts to try to do more with less. I appreciate the
15 efforts to move away from such a reliance on time-limited grants. Your flashlight
16 metaphor certainly strikes home. I know that your theory of change that you all
17 developed over the last couple of years puts a major focus on widespread adoption of
18 innovative approaches.

19 It seems to me that a potential area of doing more with less is to really
20 look at cross-program areas to see what has been successful and what we have learned
21 about how to promote that widespread adoption. One of our major challenges, I think, in
22 our field is that most of what we do in the short-term isn't sustained in the long-term, and
23 if it's sustained, it's sustained maybe in a narrow geographic area and it's not expanded.
24 Of course, the states are across broader jurisdictions.

1 But you all, it seems to me, have a wealth of information across children
2 and adults, across program areas, of different efforts and what's worked and what hasn't
3 worked to kind of systematically look at and see what lessons can be learned and shared
4 with the field and translated into less intensive or less expensive programs to really help
5 move you along that theory of change to that widespread innovation.

6 I'm interested in how there are analyses going on. Are there lessons? Are
7 there documents? Are there lessons being learned? Does it make sense to look to see
8 what we can learn from the experience of all these years of what works in being sustained
9 and being expanded?

10 MS. HYDE: There are a couple of grant programs that we've tried to use
11 to do that because we knew they were going to get reduced. In our Children's Mental
12 Health: Systems of Care program last year we did planning grants to try to take systems
13 of care to scale, and then we did that similarly in the SPIF funded some states to do
14 planning on how to take that evidence-based approach to scale.

15 We already have some either flexibility or, in this case, we have one-year
16 money, so we're trying to use it to foster something that states don't often have the ability
17 to do, which is just to step back and do the planning on how to get it to scale. Sometimes
18 part of that planning is figuring out how they're going to do the financing of it. We did
19 do those things, and then in a couple cases from that, we're doing implementation then of
20 that taking to scale. That's one thing we're trying to do.

21 Then what I mentioned earlier, the work we're doing on assessment of the
22 evidence base for services, we're going to try to make that available to the field to say
23 here's what the evidence says in different areas about a particular kind of service, some
24 of which we've funded and some of which we don't fund. We're trying in different ways

1 to make that information available to the field, and then also to seed taking things to
2 scale, but if you have other ideas about how to do that with declining resources, we'd
3 love to hear that.

4 MS. ENOMOTO: I think your point about looking across programs and
5 kind of harvesting lessons learned is a good one, and in some of our programs where
6 we're seeing some rejection in scope we our doing exactly that, looking back across a
7 cohort of grantees saying who did succeed, who did sustain, and what did they do in
8 terms of trying to harvest that knowledge?

9 Across our portfolio, not just in discretionary grant programming, but also
10 in our communications, our campaigns, in our technical assistance, we're realizing as we
11 are having restricted funding, we really need to be very cautious and careful, judicious, in
12 our investments, so we are increasing our look at maybe we need to look back at TA and
13 say what TA works best for whom when? What kind of campaigns or public awareness
14 efforts work for which topics? What's needed? What's the priority?

15 We haven't been quite as scientific, I think, as we could have been over
16 time. It's often a little more idiosyncratic. I feel like we need a national campaign on X,
17 or I feel like we should have a TA center that looks like that because that's what people
18 are telling us.

19 But maybe we need to be a little bit more fearfully driven and go back and
20 say which TA efforts have been most effective or produced the greatest gains, and which
21 public awareness efforts have produced the actual behavioral change or attitudinal change
22 or knowledge change that we've been looking for. It's also then similarly in
23 programmatic ways we need to do the same thing.

1 MS. NARASAKI: I am Diane Narasaki from the Center for Mental
2 Health Services. Thank you very much for this really informative report. There was a
3 portion that addressed evidence-based practices and looking at how they might be taking
4 scale. I just wanted to say that we in our community, Asian Pacific American
5 community, are often concerned evidence-based practices are required, but oftentimes are
6 not norm to our population. While we support the use of evidence-based practices, we
7 think there needs to be room for cultural adaptation or more studies being done on our
8 population and other racial, ethnic, and LGBT minorities.

9 In our state, for instance, legislation was recently passed which would
10 require the use of evidence-based practices in children's mental health. Again, we
11 support the use of evidence-based practices, but if they're not norm to our population,
12 they may not, in fact, be effective.

13 I want to look at how evidence-based practices might be culturally adapted
14 or there might be more information about how they need to be culturally adapted or norm
15 to our populations, because I don't think we can close the gaps in ethnic and racial
16 disparities unless there is that attention to how that plays out with our populations. It
17 would be great to hear more guidance from SAMHSA on that point, because I think it's a
18 real danger to communities for whom they're not a good fit.

19 MS. HYDE: All I can say is we agree, absolutely. Again, at some other
20 point maybe we can get you and Miriam together to have a little conversation as they do
21 the evidence-based practice assessment. She has a background in disparities work, so I
22 think she'll be very sensitive to that issue as well.

23 MS. ENOMOTO: I think it's also interesting, Diane, you're sitting with
24 Jeanne, who's done incredible work on looking at using evidence-based practices with

1 minority communities. There's obviously a good dialogue to be had at some point about
2 not throwing the baby out with the bathwater and being able to build on considerable
3 science that's been conducted for the benefit of all populations. I know you're also
4 involved with the NNED, the National Network to Eliminate Disparities, which is doing
5 good work around practice-based evidence and looking at adaptations.

6 But pretty much throughout our portfolio SAMHSA remains fairly
7 flexible in understanding the fact that different communities, defined however you want,
8 may have different needs and different resources available to implement things. I think
9 we try to use good judgment in that, but still not wanting to throw away years of research
10 that has been done to produce good results for people.

11 MS. HYDE: I didn't do introductions because we were running late, but
12 you're also sitting by Steve Green who's from Gila River who runs the, I would imagine
13 at this point, premier Native American program.

14 MR. GREEN: Thank you for those kind words. I would like to make a
15 comment on Diane's comments too. I think when we take a look at culturally appropriate
16 and culturally sensitive services, in the future SAMHSA's going to be recommending
17 some of the best practices for the Tribal Law and Order Act, and we certainly would be
18 looking forward to and be very supportive culturally of meaningful best practices.

19 MR. JOSEPH: My name is Badger Andy Joseph, Jr. I represent the at-
20 large position on SAMHSA Tribal Technical Advisory Committee. My comments are
21 going to be about our YRTCs. I know in California there's going to be two new ones
22 coming online. In the Portland area we have a YRTC called the Healing Lodge of Seven
23 Nations.

1 I mentioned this during the consultation a couple weeks ago in the Hubert
2 Humphrey Building about the need to do an administrative fix to allow for the facility to
3 build as an inpatient/outpatient facility. What holds it back from doing that is it has more
4 than 16 beds. I believe at the high level, Pam Dashika(?) worked with CMS and with
5 IHS to fix it so that we would be able to build the inpatient rate.

6 As tribes that do 638 -- that's self-governance -- each tribe is entitled to do
7 its own youth treatment or whatever they want to do in treatment. They might be held to
8 the 16 beds. They might not even get 16 beds in each tribe. You're talking about seven
9 tribes that have pulled together their resources to, I guess, make a better program.

10 The Healing Lodge of Seven Nations, I believe, is a role model for youth
11 treatment in a nation. The success rate is really high. If we are able to that
12 inpatient/outpatient rate, it would be able to hold its own really well.

13 Just being at one of the recent meetings, we were told there is, I guess, this
14 new thing that's going to hit in Indian country. I'm worried about it, actually, nationally.
15 When you get into some of the smaller communities in Indian country, you're having
16 babies that are fetal alcohol syndrome babies, mothers that are using drugs while they're
17 carrying or maybe even when they conceived.

18 These babies are growing up to be young adults now, and some of them
19 are in grade school and are hard to handle or hard to control because they don't have that
20 part of the brain developed that they can be, I guess, safe to be around. You've got a lot
21 of our children that grandparents have to take care of, and you might have this kid that
22 turned out to be 6-foot-5, 250 pounds, and he can snap a little grandmother's bone
23 without even realizing it, or another kid in his class.

1 My worry is there's no place for some of these children. I've worked with
2 the administration in trying to help place some of these children, but in Indian country I
3 think we're going to need to look at the future facilities to take in some of these youth.
4 They've never abused a drug themselves, but they're impaired by what their parents did.
5 To me, I'm really worried. They are a threat to themselves and to the local public. I
6 know it's probably going to take SAMHSA and maybe some other programs to work
7 together to try to prepare for these types of children. Anyway, that's all I have to say for
8 now. Thank you.

9 MS. HYDE: I just want to say I'm aware of some of the concerns, and
10 particularly the individual you were trying to find some resources for. I was glad to see
11 that our new regional administrator was able to help a little. But the issue you raise is a
12 really complicated interplay of CMS rules and IHS and stuff, and I'm happy to talk to
13 you offline. Maybe there's something we can do to engage them to have the conversation
14 about what you're talking about. That is a hugely complicated issue, and we'll see if we
15 can work with you on that issue.

16 MR. JOSEPH: We did talk to some of our Senate and Congress about if it
17 kicks back to Congress, to do some -- what they recommended to ask was to ask
18 administratively if it could be fixed that way before they have to make a law.

19 MS. HYDE: Yes. Making a law is pretty hard right now. I'd be happy to
20 talk to you offline about that, Andy. We'll see what we can do.

21 We've got another presentation from Mirtha to do, so I want to do that and
22 get you to a break. Steve, last comment here.

1 MR. GREEN: Just to my tribal colleague, Andy, we've gone down the
2 same road, and we're having some success, so if I could join in that conversation, I'd
3 certainly like to do that.

4 MS. HYDE: That'd be great. You might have suggestions that I don't
5 have as well. Thanks, Steve.

6 MS. BEADLE: Good morning. I just want to be able to add to the
7 comments that Kana provided earlier. As Pam said, many things cross multiple federal
8 years. Kana talked about the budget that was introduced. I want to talk about the here
9 and the now.

10 We also talked earlier about the funding that will support some of the
11 programs that SAMHSA provides supports for our country, but we also need to talk a
12 little bit about the internal operations and actions that we're taking to assure that we are
13 efficient, as well, internally as folks are trying to be across the country.

14 A couple of specific things, and then we can move forward. The first slide
15 is around in-sourcing. For those of you who are not familiar with the term, in-sourcing
16 essentially is taking a look at those activities that are funded through contracts and
17 assessing whether there is a way of bringing some of those functions, in this case
18 government-supported staff, in-house to carry out those responsibilities.

19 What we know is that in many ways, contracts ultimately do cost more. In
20 the cases where we have contracts that, for one reason or another, might have been
21 carrying out what is inherently governmental work, we're bringing back those functions
22 in-house.

23 Last year we undertook a very broad review of a number of contracts to
24 assess those contracts, and found that there were places where we could in-source staff.

1 In-sourcing is not a process where you can just bring everybody in-house at one time; it
2 really is a phased approach as we assessed our needs, as we assessed those government
3 functions, we started to bring folks in-house.

4 Several examples of things that we're doing; We're looking at how we
5 can support block grant compliance reviews, helping the Grant Review Administration,
6 data review and analysis. The list goes on and on. What we have found is there are
7 several positions that were supported vis-à-vis contracts that we could bring in-house.
8 Some of those positions that we've done by contracts are very targeted, very expert-level
9 functions, but we found that we can do those in-house with more graded personnel and
10 could be as effective, but do them in-house and cost us less.

11 We've centralized a lot of common functions, as I mentioned earlier. A
12 couple of other examples are the financial reviews that we do, emergency disaster
13 management. We're trying to bring those functions not only in-house, but bring them
14 together through different teams that allow us to really balance out and redistribute the
15 work in a way that is much more effective for us.

16 In the longer run, what does in-sourcing obviously do? It's saved us a
17 tremendous amount of funds, allowed us to re-channel some of our programmatic efforts,
18 and it's also expanded the competencies that we needed to have in SAMHSA staff as we
19 support many of the programs that you all need.

20 In terms of being efficient, last year the president signed an executive
21 order to promote efficient spending. In addition to that executive order, there are other
22 executive orders and other policies that really require us to take a look at how we are
23 operating and assessing how we can do a better job in supporting those kinds of activities.

1 This last January SAMHSA established new policies for appropriated
2 dollars specifically that conference and meeting space, look at publications, look at food
3 and other extraneous promotional items. We have to provide an update to the department
4 on our review so that they're aware of what we are doing. I'm proud to report that we are
5 on track, and we are looking at being much more efficient in our spending. I want to give
6 you a little slide here on the kinds of things that are impacted by this efficiency
7 movement in internal government spending.

8 For example, for conferences, meetings, trainings, and other kinds of
9 events, we now have to make sure that we can hold these events in a federal facility when
10 it's possible. It doesn't mean that we can't use non-federal facilities, but we're trying to
11 assure that we're using the space that we have to host and manage the meetings and
12 conferences that we need to support. If we cannot do it in-house, we have to provide
13 justification. This is what all SAMHSA staff have to be able to do.

14 As you'll see, food is becoming less and less in federal meetings, but
15 basically what we have to do now is assure that we do not have food, we do not have
16 beverages, we do not have broader support of these kinds of things at our meetings and
17 conferences.

18 Promotional items are things that can be viewed as gifts. You give them
19 away. They could be pens. They could be bags. They can be other giveaway items. We
20 can no longer do promotional items that are extraneous. However, those promotional
21 items that are educational nature, that support some of the work that we're trying to
22 convey and communication, those items are still allowed.

23 We're also moving to a more web-based process for publications. This is
24 a new time and a new era, and so in addition to saving the cost of publishing hard copies,

1 we're also making sure that we're using new technology to be able to communicate and
2 share information that's coming out of the agency.

3 Space planning. You ask yourself the question why are we talking about
4 space planning in the context of being more efficient? Obviously states, cities, private
5 organizations are really looking at how much they are spending on space. We're looking
6 at that as well.

7 Last December the secretary made a determination that HRSA in addition
8 to SAMHSA, IHS, and AHRQ would be co-located in the same building. This new
9 building, for those of you who are familiar with the Parklawn Building, is being
10 completely renovated. The only thing that will remain will be the steel and the concrete,
11 but a newly refurbished building. Why is that important?

12 When we share services, we bring them together, that helps to reduce the
13 individual costs to each of the agencies. More open-space layout. We're going to have
14 smaller office space. We're going to develop opportunities for staff to do their work
15 differently that is much more efficient and effective.

16 But the benefit here from an efficiency perspective is by co-locating these
17 four departments, we're going to save \$250 million in 15 years. That is efficient and that
18 is effective. It also allows these agencies -- SAMHSA, IHS, HRSA, and others -- to
19 really work together differently. There was a conversation earlier about CMS and IHS
20 and different ways that we can work together. Co-location allows us to really work
21 together and to bring together our work.

22 I just want to show you this efficient and effective building that will be our
23 new home. We anticipate that the building will be renovated and we will be moving
24 there and you will be working with us there in four or five years. As we go through this

1 process, we will keep you aware and informed. We have worked very closely with
2 SAMHSA staff to ensure that none of the services that are being supported are going to
3 be impacted during this time. We will make sure that you have updates as we go
4 through.

5 I do want to mention that we have not, as I understand it, in the past shared
6 a lot of the internal operations work. There's been some sharing, but we're going to try
7 to assure that you have that at every meeting that you have in the future.

8 We're developing these dashboards that help us take a better look at how
9 we are managing and leading specific activities. We'll bring some of these dashboards
10 that are relevant to your work to the meetings so that you are aware of how we are
11 functioning and to share our internal efforts to be much more efficient and effective and
12 supporting our projects. Thank you.

13 MS. HYDE: Thank you, Mirtha. Let me just say one or two words about
14 this. That means if you think we are bad hostesses and hosts, it's because we're required
15 to be. We're not allowed to provide food and water and good things and takeaway things
16 anymore. Underscore that.

17 It also has something to do with where we meet. You remember the
18 conversation we had about should we meet outside of DC so we could be other places. It
19 costs us a whole lot more to do that. It doesn't cost us anything to have you in this
20 building, and it costs us about the same amount to travel you here as it does to travel you
21 to anyplace else in the country.

22 But if we go to someplace else in the country, we have to travel all of us,
23 too, and that costs more money. It would then be another meeting cost. So we're

1 probably going to have to stay here for a while, bring you all to DC, until the budgets
2 loosen up a little bit, which we hope they will at some point.

3 I also wanted to just acknowledge that Hortensia is on the phone, who is
4 another one of our council members. Hello, Hortensia. There may be others on the
5 phone joining us as well. Does anybody have any quick comments about this?

6 MR. SAGE: Mirtha, what you talked about was the rules for SAMHSA.
7 My question was for grants and service solutions and administration of the grants and
8 service, when you talk about food, for us in the communities of poverty, food is very
9 important for us, and traditionally that's one of the greatest gifts we can give anybody, is
10 food. So it impedes our progress in the community field of providing services. Just a
11 quick example.

12 Some of the programs yesterday reported they are providing services with
13 volunteers. For our situation, we have one car, and when it leaves in the morning, we're
14 not on it, we're stuck. It's just a quick example. If we've got \$5, our people have to
15 think do I use my \$5 to put in gas to go volunteer or do I use my \$5 to buy a meal for my
16 family, we know the answer to that. They're going to feed their family first.

17 Those issues are impediments to our service providers. My question is, is
18 it just for SAMHSA, or is it for the grant providers too?

19 MS. BEADLE: This is really about internal operations. This is really
20 around SAMHSA and what SAMHSA does, the kinds of things we can support and the
21 kinds of things we cannot. This is more about how we look at government function and
22 how we enhance the way that we are able to support it across the board.

23 This is not just SAMHSA; this is a broader government initiative to be
24 more efficient in how we spend monies operationally. I want to make that distinction. I

1 also want to say that we do understand the importance of food. We do understand the
2 connection that food has with community. We're not trying to say that that's not
3 important. This is more about being more effective in how we spend internal funds.

4 MS. KADE: The new policy applies to grants that are primarily focused
5 on conferences. If you're dealing with a grant that is not a conference grant -- and we
6 only have one of them in SAMHSA -- then whatever you have experienced as allowable
7 costs are still allowable costs.

8 MS. HYDE: Just understand, there are lot of us here in SAMHSA who
9 literally put up our own money to provide what is the basic normal human offerings when
10 people come to visit. We do lots of that. We really appreciate the importance of that.
11 We'll take one more comment, and then we need to get to a break.

12 MR. HAYES: Just quickly, I do appreciate the water, and I understand the
13 importance of efficiency. However, for me, there is a piece that is written in culture.
14 When I'm invited, when I invite somebody to my house, I usually offer them
15 refreshments. I'm recognizing that many of us come from so many different places.

16 I do appreciate the effort that's extended, but I also believe there is a
17 cultural piece that should be considered. When you invite someone in, then you offer
18 them a refreshment. That may be too simplistic, but I do want to offer that from a
19 cultural perspective because so much of what we discuss in such meetings, cultural
20 inclusions, cultural sensitivity, and sometimes the smaller things are overlooked. I just
21 wanted to mention that.

22 MS. HYDE: I totally appreciate this. I couldn't agree with you more.
23 You have to understand these are things that are directed toward us, and even sometimes
24 when we are willing to buy it ourselves, the perception is -- you've heard this -- of the

1 \$16 muffin or whatever. We have just been told we can't do that right now. Frankly, the
2 water is a gift from Geretta. She paid for it herself. These are kinds of things that we
3 often do to try to be at least human, but it is difficult.

4 We wanted to just provide you this operational thing so you would know
5 why we are struggling with some of these issues at the moment. Please don't think that
6 we mean to be bad hosts. We're just told we have to be for the moment. It's a little bit
7 like asking people to Thanksgiving dinner and then not having a turkey or something.

8 We're going to take a quick break. We're running just a little bit late, so if
9 we could be back in 10 minutes, it would really help us.

10 (Break)

11 MS. HYDE: Before we get started, I want to offer anybody who wants to
12 have a major paperweight, we have a copy of the SAMHSA Fiscal Year 2013 Budget if
13 you're interested, but we don't have enough for everybody. In all seriousness, if you
14 would like one of these, we have a few. If you do want one, come up at the next break
15 and we'll give them away to the first 15 or however many people we have connected to
16 the number of books that we have. If you want to just look at one, we'll try to make sure
17 it's up here as well.

18 With that, I am going to turn this over to Larke Huang. I'm never good at
19 titles, Larke, so I'm going to let you tell them your title yourself. I can tell you that she
20 does kids stuff. She does disparities stuff. She does juvenile justice stuff. She does
21 trauma stuff. She does a lot of stuff and is a great advisor and a great policy person for us
22 here at SAMHSA.

23 DR. HUANG: Thanks, Pam. I have a lot of titles, and sometimes I think
24 people think I can't keep a job because my titles change all the time. For this panel, my

1 title is Senior Advisor to the Administrator on Children, Youth, and Families. Tomorrow
2 for the NAC, I'll be the Director of our Office of Behavioral Health Equity. The next day
3 I'll be the lead on the Trauma and Justice Strategic Initiative. My signature block
4 changes, but it's a lot of really exciting work. Actually, believe it or not, all those issues
5 are really connected.

6

7 ***Agenda Item: Panel Discussion: Health Framework for Behavioral***
8 ***Health in Schools***

9 DR. HUANG: I was asked to moderate this panel. This panel actually
10 grew out of your discussions at your last joint NAC meeting where you wanted to hear
11 more about what SAMHSA is doing or what directions we're thinking about taking
12 around behavioral health in schools.

13 We have a very active and terrific Children, Youth, and Families Work
14 Group, which is a cross-agency work group from each one of our three centers. They did
15 pull some materials together in terms of what we are doing around the schools and mental
16 health and substance use issues. They are in the room to answer questions as they come
17 up.

18 At SAMHSA our work in schools can really be viewed through a public
19 health lens. We do population-based work. We do individual family and children
20 clinical intervention work. We do promotion and prevention work as well as treatment
21 and recover. We have different programs that focus on each one of those, and I think for
22 the panelists, at least, they got materials around each one of those programs.

23 Our promotion prevention programs, for example, are drug-free
24 communities, programs that link up with schools. Our Project LAUNCH, which is a

1 birth to an eight-year-old program that also links up with schools in early childhood good
2 behavior game, a prevention piece. A big signature effort we have is our Safe Schools
3 Healthy Students in terms of also prevention programs.

4 We have both treatment in our mental health, in our Children's Mental
5 Health Initiative, our Systems of Care program, as well as substance abuse treatment for
6 adolescents and their families. We span the gamut in terms of the public health view of
7 looking at how we interface with schools.

8 We also have strong partnerships with the Department of Education. In
9 fact, some of them are congressionally mandated partnerships, like our Safe Schools
10 Healthy Students programs, and other areas we're doing joint work, such as our
11 collaboration around the anti-bullying website, some around the seclusion restraint issues
12 in schools.

13 We decided instead of having us present about our programs here, many
14 of which you know very well, that we would use the Advisory Committee in advisory
15 capacity and we would actually ask them to share with us their thoughts about behavioral
16 health in schools based on work they're doing, giving us kind of a picture of what they
17 see as the landscape in the field.

18 We recognize that most of the issues that we deal with in terms of mental
19 health, substance abuse, HIV, other conditions related to mental health and substance
20 abuse, many of them have their beginnings or origins or initiations in childhood. To get
21 ahead of the curve, we really need to think about what we are doing for that
22 developmental part of the population, and certainly that's a population that spends a lot of
23 time in schools.

1 We are really pleased that some of the Advisory Council members stepped
2 up to the task and said they would share some of their thoughts about what directions
3 they might think we should go. Then we also posed five questions to them to each
4 respond.

5 Before they do their brief remarks and comments, we've asked Michael
6 Yudin from the Department of Education, the Acting Assistant Secretary for the
7 Department of Education, who has really graciously joined us for this panel this morning
8 to first open with some remarks from the Department of Education.

9 MR. YUDIN: Thank you all for the opportunity to be here. Thanks for
10 the invitation to speak. I want to thank Pam. I've actually had the great privilege to work
11 with Pam over the years. She's an amazing leader and advocate. To my right is Kristen
12 Hawker(?). She's my special assistant and expert on our safety and healthy students
13 programs.

14 What I'd like to do is just kind of lay out a little bit of the context of
15 behavioral health at the Department of Education, what our priorities are, where some of
16 our key initiatives are going, and how we want to move forward, just to provide a little
17 bit of context for you all. Then the great panelists here will discuss the issues that we've
18 mentioned.

19 I'm the Acting Assistant Secretary for the Office of Elementary and
20 Secondary Education. We are the K-12 programs. We're actually increasing that with
21 the P-12 programs, because we just got early learning programs are now a part of our
22 efforts. Our mission is to promote academic excellence and ensure equitable
23 opportunities for educationally disadvantaged students. That is the mission of my office.
24 We have about 50-some-odd active grant programs that try to achieve that mission.

1 We view our vision of success as making sure that kids are on track to
2 graduate from high school, college, and career-ready. That's how we will measure our
3 success. That is our vision of success. But there is no way that we're going to get all
4 kids on track to graduate from high school, college, and career-ready if they're not safe
5 and they're not healthy and they don't have learning environments that are constructive
6 and conducive to learning. I'm going to talk a little bit about that

7 We have this great longstanding partnership with SAMHSA for the joint
8 management of the Safe Schools Healthy Students program, allowing school districts to
9 implement comprehensive strategies to address student behavioral health. We also
10 appreciate working with SAMHSA over the years. Last year we announced with
11 Secretary Sebelius, Secretary Duncan, \$95 million to 278 school-based health center
12 programs to expand access to healthcare at schools, obviously critically important.

13 As we look at the results from the Monitoring the Future report and the
14 Youth Risk Behavior Surveillance survey, we all know full well that bullying, substance
15 abuse, violence, and other school-based risk factors, behaviors, continue to impact
16 outcomes for our students. We must do more to help build the capacity of our schools for
17 prevention efforts.

18 It's not just the physical and the emotional wellbeing of an individual
19 student; it's creating conditions for learning; it's removing climates of fear and disrespect
20 that really undermine students' best opportunities and abilities to achieve their full
21 potential.

22 At the Department of Education we look at the issue of behavioral health
23 from a number of perspectives, including the impact on student outcomes as well as the
24 capacity of schools to effectively manage student behavior. The key fact that must be

1 understood is that schools have in place disciplinary processes for managing student
2 behavior. But these often are not designed to actually improve behavior or health for our
3 troubled and at-risk youth.

4 Moving forward, our focus must be on how to help schools do a couple of
5 things. First, we must help schools understand the impact of student behavioral health on
6 school turnaround and learn ways to integrate positive discipline and behavioral health
7 supports into efforts to improve the learning environment. Second, we have to help
8 schools manage and improve student behavior in ways that actually respond to the
9 behavior and preserve instructional time for all students.

10 Those are really the two goals that we need to do without the need for
11 exclusionary disciplinary practice such as suspension, expulsion or, worse, referral to law
12 enforcement. All the while, strategies for doing this must take into consideration the
13 significant fiscal changes or challenges that we're actually facing.

14 I got the opportunity to hear a little bit from the last panel, and I know we
15 all are facing some pretty serious fiscal challenges. We have received some pretty severe
16 budget cuts to a number of our programs. Going forward, it's about looking for every
17 opportunity to leverage all of our resources, all of the tools in our tool belt. I'll talk about
18 that in a bit.

19 With that, I kind of want to just give the council an update on what we're
20 doing at the Department, a couple of our key initiatives and programs, just to provide you
21 with a little bit of context what's going on out there.

22 We have a number of programs at Ed that provide dedicated funding to
23 help schools improve behavioral health. Of course, as everyone knows here, I mentioned

1 earlier the Safe Schools Healthy Students program. In our fiscal year 2013 budget Ed
2 requested \$16.6 million for new awards under this program.

3 In 2010 we also launched the Safe and Supportive Schools program,
4 which provides \$50 million to 11 states to do a couple of critical activities, one, assess the
5 needs of participating schools on a variety of risk and protective factors that impact
6 learning in those schools, and second, begin implementation of interventions that actually
7 target the needs identified in those assessments, to increase the number of school-based
8 mental health personnel available to help students, implement positive behavior
9 interventions and supports, or the social and emotional learning programs.

10 Our Title IV state grant program, which provided grants to states for
11 funding on substance abuse and violence prevention, was last funded in 2009. That was
12 that big state grant program. We don't have that anymore. Last year we had the
13 Elementary and Secondary School Counseling program, which helps schools districts
14 develop and improve their school-based mental health services through staff training and
15 lowering counselor-to-student ratios. We will hold a new competition this year and
16 award approximately \$21.4 million to 61 school districts.

17 It's important, as I mentioned, to note that while we have these dedicated
18 funding streams, our appropriations have significantly decreased. The main thrust of our
19 office is our Title IV national activities programs, and we've seen these programs slashed
20 by hundreds of millions of dollars over the last couple of years. This is the money we
21 have left to do a lot of really critically important work.

22 It's imperative for us not only to continue funding the programs we have,
23 but leverage every resource that's available to us, use every tool that's available in our
24 administrative tool belt, whether that be through technical assistance, leadership, the

1 bully pulpit, partnering with other agencies, partnering with community-based
2 organizations, to really move forward with this very important agenda, continuing new
3 strategies to continuing to encourage schools to develop and improve their capacity to
4 reduce bullying, school violence, substance use, and other risk behaviors.

5 Moving forward, our central message to educators must focus on
6 integrating school climate and behavioral health into school reform. I'll give you just a
7 little example of some of the other kind of initiatives that don't have direct dedicated
8 funding, but we think are really important levers in this effort.

9 We have our Promise Neighborhoods program. It was originally launched
10 in 2010. It's modeled on the Harlem Children's. This year we got \$60 million for this
11 effort. It encourages communities to come together to really identify cradle-to-career
12 strategies to improve the breadth of outcomes that impact student life. Each applicant
13 must include in its strategy family and community supports, which many include child
14 and youth health programs or safe school programs.

15 Another key initiative that I think is really important for folks to recognize
16 -- and they may not think about -- is our school improvement grants, our SIG grants.
17 Since 2009, we have actually invested over \$4 billion in efforts to turn around the lowest
18 performing schools in this country.

19 It's formula grants to states who then compete it out to schools districts to
20 identify the lowest performing schools, those schools that, by definition, are not
21 achieving or are persistently low-achieving, and implement some pretty rigorous models.
22 We're pretty prescriptive about it. It's a little bit controversial, but the secretary feels
23 very strongly that these schools have been failing our kids for too many years, and they
24 require drastic and dramatic interventions.

1 Again, we've invested \$4 billion to turn around these lowest performing
2 schools, and under the majority of the models that schools are actually implementing with
3 this money, is the transformation model and the turnaround model. With both of these,
4 schools must partner with outside organizations to provide appropriate social, emotional,
5 and community-oriented services and supports for students.

6 There is no way -- and I think anybody knows it -- that we're going to
7 turn around our lowest performing schools, our schools that are mired in dysfunction, if
8 we don't address behavioral issues. There is a lot of money out there to do that. It's a
9 really important lever for us.

10 Under our Title I Part D Formula program, we provided states with \$200
11 million this year for students in correctional facilities and at-risk for juvenile justice
12 contact. While most of these dollars were really provided for educational services, they
13 may be used for prevention as well.

14 Moving forward, as we work with schools to encourage the integration of
15 school climate and behavioral health into school turnaround efforts, it'll be funding
16 streams such as these that states and districts are really going to be relying on to improve
17 opportunities and student behavior.

18 Just a couple of other really quick points I want to make on some of our
19 key initiatives that aren't directly funded through formulas or grant programs. First is our
20 efforts on preventing bullying. We're going to continue to make progress reducing
21 bullying, victimization, and perpetration, continuing our work with SAMHSA and other
22 federal partners for bullying prevention.

23 In December we released an analysis of state anti-bullying policies. We
24 did an across-the-board look at what states and school districts are doing to prevent

1 bullying. We provided that TA, that support, to districts and states to look at what's
2 working, what's not working, what are the various approaches that states are taking to
3 address bullying and related behaviors in their schools. Of course, with the help of HHS,
4 we're continuing to prove the stopbullying.gov website is a really great resource, and
5 we're getting ready to re-launch that shortly. It's a really great resource.

6 This summer the Department's going to convene a third bullying summit,
7 which is focused on helping educators and other stakeholders sustain bullying prevention
8 and activities during time of decreased funding and media attention.

9 The second key initiative I want to talk about is our discipline effort. In
10 July 2011 Secretary Duncan and Attorney General Holder announced the Supportive
11 School Discipline Initiative, which is a joint Education/DOJ partnership focused on
12 dismantling what has been called the school-to-prison pipeline by reducing school
13 reliance on suspension, expulsions, school-based arrests, and other forms of exclusionary
14 discipline practices, and by reducing the disparities we see in discipline practices across
15 subgroups.

16 It's organized around four main strategies. First is building consensus
17 around the policies and practices. Second is about data collection and research. Third is
18 technical assistance and outreach. Fourth is joint policy guidance.

19 Recently, as you all may know, our Office of Civil Rights released the
20 Civil Rights Data Collection Part 2, which examined the extent of these disparities in the
21 7,000 largest school districts in the nation. Our bullying prevention work has leveraged
22 the knowledge of several agencies and worked to improve school discipline and behavior
23 management practice built on the work of several philanthropic partners as well. We
24 couldn't do this without our partners.

1 We would love to have SAMHSA continue to work with us on this.
2 They're an amazing partner for us. Thank you all for your leadership, for all that you do
3 every day. At this point I'll stop. Thanks.

4 DR. HUANG: Thank you very much for sharing all that information.
5 Clearly we want to continue the partnership, and clearly our kids that we serve, the kids
6 with behavioral health issues, are often the target or really the focus of some of these
7 efforts as well.

8 We're going to now ask each of our council members to speak for 3-5
9 minutes about some of their work related to schools and behavioral health. We're going
10 to start with Bill McFarlane.

11 DR. MCFARLANE: Thanks. I think some of you are somewhat familiar
12 with what we've been doing over the last 10-12 years to apply a secondary or indicated
13 prevention strategy to the core of mental health services, that is folks with psychotic
14 disorders, schizophrenia or the psychotic versions of bipolar disorder and major
15 depression, in some cases PTSD and even OCD.

16 The basic idea is something we're all familiar in relation to heart disease
17 and cancer. That is we're not so good at curing cancer or alleviating and eliminating the
18 final stages of heart disease, but we're getting very good at eliminating at least the
19 secondary and tertiary forms of those diseases by just finding people earlier and treating
20 them earlier with, in most cases, interventions we already have.

21 Just translate that paradigm over to our core mental illnesses and you have
22 a framework for what we've been trying to do. It's relevant to this discussion because I
23 started this -- I'm an adult psychiatrist. I've worked for my entire career developing

1 psychosocial treatments for severe mental illness of the most severe type, which has
2 meant that we've studied people 25-50, roughly.

3 When we started developing an early identification system in Portland,
4 Maine, which is where we've piloted and now tested most of this work, the first thing we
5 noticed was that the first, and then many, and then almost all the cases coming in the door
6 who had been identified in the community were in the age range of 12-20.

7 This was a big shock and kind of a revelation that mental illness of the
8 most severe form really looks like -- and we've confirmed this over and over again now -
9 - a disorder that starts in adolescents, i.e., it starts in times when people are in high
10 schools, junior high schools, and usually in college.

11 Our strategy then for early identification has been to specifically train
12 particularly the senior and professional staff within school systems and college health
13 systems what to look for by way of early symptoms of these psychotic disorders. This
14 often involves really just about an hour and a half to two hours, sometimes even less, of a
15 presentation to those staff, and then a kind of an ongoing process as they make referrals,
16 refining their ability to identify the right person at the right time.

17 To make this a little bit short, we've been at this now in Portland, Maine
18 for some 12 years. Thanks to both SAMHSA and more recently Robert Wood Johnson
19 Foundation, we've been replicating that work in six cities throughout the United States.
20 Those include Albuquerque, New Mexico, a place Pam knows well; Sacramento; Salem,
21 Oregon; Ann Arbor; and Queens and Nassau Counties in New York and continuing in
22 Portland.

23 I can tell you that this is all obviously pre-publication. It's all actually in
24 process of being analyzed. But we found in six cities is that, first of all, that strategy is

1 feasible. It's effective. We get about the same proportion of the at-risk population
2 referred, which is roughly 40 percent in some cases, particularly as the whole community
3 gets better at this identification.

4 We see that as the young people come into these programs, about 80-85
5 percent of them are in school or working at the time that they enter, and when they leave
6 two years later, it's about 90-95 percent are in school or working. The usual trajectory of
7 development of schizophrenia seems to be completely interrupted. We're running about
8 6-10 percent conversion rate as opposed to what's expected, would be about 30-35
9 percent for the same age range. It looks like it works almost everywhere.

10 I thought I'd spend a minute telling you a story about where it didn't and
11 why it didn't. I hope I don't embarrass anybody's local sensitivities on this, but it's
12 totally emblematic of the challenges.

13 One of our sites was Hillside Hospital and Long Island Jewish Hospital in
14 Long Island. The experimental territory bridged the eastern part of Queens and the
15 western part of Nassau County, so we had Great Neck, if you're familiar with that
16 territory, and then sort of eastern Queens, which is highly mixed.

17 On surveying the school systems in Nassau County, the staff was rather
18 immediately welcomed into the school. They made presentations. They started getting
19 referrals. The schools would start to refer other schools to get trained. It couldn't have
20 gone better, actually, and that was our experience in most of these other sites and our
21 experience in Portland.

22 However, in Queens, under the leadership of the New York City
23 Department of Education, there was an absolute barrier to anybody from the clinical staff

1 doing outreach and education in the Queens schools. That went on for about a year.
2 Basically no referrals occurred, so there were no cases prevented.

3 Then a new staff member came on, a recent grad from a PhD psychology
4 program, whose previous career had been a Queens high school teacher. What did he do?
5 He simply started calling his friends and offering this kind of training, and pretty soon the
6 whole school system in Queens was trained, but from a completely different strategy.

7 I think one of the issues that would come up is it's beginning to look like
8 this approach is something that we could disseminated nationally. I think we've got
9 enough experience both in the United States -- and particularly this is much more
10 widespread work internationally, particularly in the UK, Europe, Australia, and so on.

11 I think we could really start to disseminate it, but we'd have to take into
12 account the fact that in some school systems this kind of guidance, education, and support
13 from the mental health system may not be welcome, and the next school system down the
14 road, it would be highly welcome and highly effective.

15 I think one of the questions is are we ready to expand some of our
16 awareness and educational activities from the mental health system into the educational
17 system to include the core mental disorders of our field? My answer is I think we are
18 ready to do that. There are a lot of things that would have to happen before that would be
19 implemented, but I think it's a big challenge and a tremendous opportunity to reduce the
20 burden of disease as we go forward with the ACA.

21 DR. HUANG: Thanks very much. We're going to move on to Leighton
22 Huey.

1 DR. HUEY: Yesterday I had a chance to hear a presentation about the
2 work that's going on in school systems and a terrific panel. I'm going to raise an issue
3 that I didn't have a chance to raise yet. This ties into my comments for today.

4 It's not just about schools and kids, from my perspective. The way I
5 thought about it yesterday and in hearing the panel's presentation is that this needs to be
6 tied into the larger system of healthcare into ACA, into healthcare reform.

7 Basically last August I trashed the diagnostic system that we have in
8 psychiatry here. I basically said what has happened is that we have created a culture of
9 kind of easy diagnoses -- and I can say this -- as if you're going to a Chinese restaurant
10 and ordering from this column and from that column. That's a simplified version of what
11 people are trained in.

12 Actually, if you look at the data about age of onset of child disorders, you
13 must take a developmental perspective as an adult provider in the populations that we
14 work with. I think that that is a huge problem in our field, but it relates to what's
15 happening in healthcare reform.

16 As patient-centered medical homes get set up, as primary care and
17 behavioral health and mental health get integrated, that's a very natural thing to exploit
18 and to discuss and to present as part of why this makes sense to have a developmental
19 perspective. We should all be developmentalists and have that perspective as we
20 approach adult populations. It's not just about the kids, but it has to do with the adult
21 issue.

22 I'm going to talk about a non-success -- you notice I didn't say failure -- in
23 terms of work that we tried to pull off in Connecticut. Depression in youth is a major

1 public health issue, and I think you all know that. One in four girls in large community
2 samples, and one in six boys, report noteworthy depressive symptoms.

3 We all know about the relationship of depression to increased risk of
4 youth conflict, isolation, violence, smoking, substance abuse, risky sexual behaviors, and
5 elevated levels of physical health problems, including illness and accidents. Untreated
6 childhood depression often persists or grows into chronic clinical disorders in adulthood,
7 so the early detection and prevention education and appropriate treatment for depression
8 is a vital and achievable goal for public health policy, should be.

9 I guess my comment has to do with not all great ideas are going to be
10 synergistic with the current system. The non-success that we had was trying to link a
11 depression education program for 10-year-olds, their parents and their teachers, with the
12 educational system. I think that there are some handouts that just show you some of the
13 stuff that we were trying to do.

14 We thought that it was a good idea to focus on preadolescents, a psycho-
15 educational approach. Some of the studies that have been done on preadolescents were
16 really pretty labor-intensive, and we were thinking about trying to expand the delivery of
17 that to have it be really a public health system in inner-city Hartford, which at that time
18 was the second-poorest city of its size only to Brownsville, Texas, and the suburban areas
19 outside of Hartford.

20 The good thing is that we took a positive approach. We took a look at the
21 literature on preadolescent and adolescent education about depression and suicide. It was
22 pretty scary stuff that kids were being asked to take a look at. We were trying to take a
23 positive approach. We created two 30-minute videos, one for kids, 10-year-olds that was

1 narrated by kids, and one for parents and teachers, to talk and inform about depression
2 and its link to other areas.

3 We focused on health behaviors with a message that health is all around
4 you and that you need to focus on who are the trusted adults in your lives so that you
5 could get help if you're feeling down. We tried to make a distinction between being blue
6 and being depressed as part of the education.

7 We involved seven school districts. We got involved with the state
8 commissioner, the school superintendents. We commissioned a children's author to write
9 a novel about depression so that it could be introduced into the curriculum. This gets into
10 a point that I'm going to raise in a moment. We went into the city of Hartford to try to
11 work with the economic improvement zones to try to begin a communitywide educational
12 effort about depression and its effect.

13 The problems were the commissioner changed, funding levels for
14 education changed, and schools became understandably preoccupied with their issues and
15 their survival, in many cases. So a great idea, from our perspectives, the academic
16 narcissists that we can be, really kind of went up against the reality of the school system.
17 We kept getting the message from the school system that we can't add anything into the
18 program because our curriculum is tight. We don't have any room for these kind of
19 things, even though at the outset there was a lot of interest, and how do you incorporate
20 this into school systems? People said it's a great idea, but we could not pull it off.

21 Schools are under their own pressure to perform, and, yes, there's public
22 health in school systems, as there should be, but it has to be synergistic and the timing
23 has to be right. Maybe the timing is right now for pulling things like this off. I don't
24 know. But we could never what was needed to demonstrate this program in our seven

1 school districts achieved attitudinal change, which was really the benchmark for whether
2 we were going to try to take this statewide in all school districts.

3 We never really got that far. Funding ran out and other priorities took
4 precedence, such as whether the University of Connecticut Health Center would continue
5 to have funding from the legislature. Things like that got in the way. The reality issues
6 affect what happens with good ideas.

7 DR. HUANG: Thank you, Leighton. It's very exciting to me that two
8 primarily adult psychiatrists have really seen the critical importance of looking at
9 children and their developmental trajectory. Our next presentation is Marleen Wong.

10 DR. WONG: Good morning, everyone, and thanks so much for inviting
11 me to be on this panel. I'm currently Assistant Dean at USC School of Social Work, the
12 University of Southern California. I'm probably here on this panel because I was
13 Director of Mental Health, Crisis Intervention, and Suicide Prevention for the Los
14 Angeles Unified School District for many years.

15 My perspective is kind of on the ground, dealing with the day-to-day
16 problems that children have brought to this school in what I call the invisible suitcase.
17 That is that teachers are trained at a very high level. They're taught to be subject matter
18 experts, and then they get to the classroom and something completely different confronts
19 them.

20 My school district is the second-largest school district in the country, Los
21 Angeles Unified School District. It's LA and 26 other municipalities. It is over 700
22 square miles large. It's a very large district, so it's not surprising that 2,500-3,000 crisis
23 incidents might occur per year that we would have to respond to.

1 I think what's really interesting is that they weren't necessarily things that
2 started in the school; they were things that happened in the community and then impacted
3 the school. You can imagine how all of these non-instructional situations disrupted the
4 school and the classroom environment.

5 As a crisis intervention director, I was very interested back in the '80s
6 when we had one of the first school shootings at the 49th Street Elementary School in
7 which a mentally ill man was across the street from the elementary school, and as the
8 children came out, just started shooting, and for an hour and half held that school under
9 sniper fire, killing two children and seriously wounding several other children and staff.

10 I think that began our question about community violence in general,
11 because as we began to talk to these children and we asked them, has violence ever
12 happened to you before in your community? From that time through the '90s, more often
13 than not, the children would say, yes, there's more than one incident that has occurred.

14 With my colleagues at Rand and USC Health Services Research Center,
15 which Jeanne Morand(?) is one of the great people there, we started to look at surveys
16 because when I spoke with my researcher colleagues, they said you're just telling us
17 stories. In the real world of academia nothing is real until you do research.

18 So I said let's do some research then, and we started with cohorts of about
19 1,000 children each, finally culminating in a survey of 28,000 -- actually, we sent out
20 surveys to 35,000 children. We got back over 28,800 surveys.

21 I really agree with you about the year. It was the first year of middle
22 school, 11-year-olds, in which we found that, especially in those areas of poverty and
23 high crime, over 90 percent of the children said that they had exposures to community

1 violence, and that definition was hit, kicked, punched, threatened with a gun or knife,
2 either victim or witness, and multiple exposures.

3 We started asking ourselves the question of we know a real experience
4 with violence is a risk factor for PTSD, and how many of these children, then, actually
5 have PTSD? What are rates of PTSD and depression? Very similar to your findings,
6 what we found is with these children in those areas, south LA and east LA, is that 27
7 percent of the children sitting in the classroom had clinical symptoms consistent with
8 PTSD and 16 percent of those children had symptoms consistent with depression. These
9 were children not identified. These are hidden disorders and had never been referred or
10 treated.

11 That's when we created CBIFTS, which is Cognitive Intervention for
12 Trauma In Schools -- the effectiveness article is in JAMA August 2003 -- which was we
13 need to do this in the schools because these are the same children that are failing. These
14 are the children not being touched by reform. What can we do? So we put that in
15 motion. We had really good outcomes.

16 But as time went on, I began to think I don't think this is the only way that
17 we can do things, and that you have to go the prevention side. Prevention was not with
18 mental health professionals. Prevention is with teachers. It's with parents. It's with
19 educational aid. It's with the custodian. It's with the personal who works in the
20 cafeteria. So we began to develop psychological first aid for schools listed for
21 TechConnect, which can be taught in 45 minutes.

22 I just think that whatever we do, we have to do it together, because these
23 problems are so pernicious and serious and come from communities of poverty. I think
24 one of our greatest partners has been SAMHSA and the US Department of Education.

1 I'm very saddened and really kind of upset about how some programs have been cut,
2 specifically readiness, emergency management for schools, which were competitive
3 grants that schools could apply for to really think about a comprehensive all-hazards
4 approach to manmade and natural disasters in which there was a strong mental health
5 component that was a part of it in terms of not just readiness, but response and recovery.

6 I don't know what happened to SERV, the School Emergency Response to
7 Violence. It's still there. That's good, because that's for school shootings and it's for
8 suicide clusters that are emerging all over the country among children in schools.

9 Having been a consultant since before Columbine with the US Department
10 of Ed since the Oklahoma bombing, I just think that there's a template now among
11 children who are distressed or disturbed, and it continues to act itself out in these large-
12 scale events. In fact, it's even in Japan where they don't have guns. It's the 10th
13 anniversary of the knife attack in Ikeda Elementary School in Osaka, Japan in which their
14 government and the Ministry of Education are announcing a readiness emergency
15 management throughout every school in Japan that is going to modeled after the US
16 program.

17 I just want to say that teachers pay the price. There was recently an article
18 that came out in the LA Times. It said 40 percent of all the hundreds of charter school
19 teachers that were teaching in the Los Angeles Unified School District region have left
20 the profession in one year. If you look at other OSHA statistics, 30, 40, 50 percent of
21 teachers within the first five years, depending upon what year you're looking at the
22 survey, that up to 60 percent of teachers leave the profession within five years.

23 There is something that's going on there that has nothing to do with the
24 commitment or the vision or the will to work with students. It has something to do with

1 the community and our students as well. Whatever we can do to work together, I think
2 that's the only way we can move forward. Thank you.

3 DR. HUANG: Marleen, thank you very much. We have two more
4 presenters. I'm going to ask them to keep their comments to 3-5 minutes so we can have
5 time for discussion. We have questions we want to pose to you and the other council
6 members. Next is Jane McGrath.

7 DR. MCGRATH: Good morning, I am Jane McGrath. I'm a pediatrician
8 from Albuquerque, New Mexico. I was for almost 15 years a school health officer in
9 New Mexico, so I have a lot of life experience with school health policy, but also with
10 school-based health centers, in particular.

11 I want to talk a little bit about the history. I'm going to suggest a slightly
12 different approach to -- Marleen, your talk was very profound, I think, for all of us here in
13 the room. But I think we have an opportunity with the current changes in the healthcare
14 system to not so much look at the schools to solve the problem of mental health services,
15 but to see how we can get the healthcare system itself to work within schools more
16 effectively to provide care to kids and families.

17 If you look historically at school health, the model was really developed
18 around combating infectious disease, and the primary aim was to make sure that kids had
19 appropriate immunizations. It's very important work, extremely important work, but no
20 longer the central condition for which children suffer in our country.

21 We need to think about a system that works with schools. We know a lot
22 of people have said that schools are the de facto mental health service provider for
23 children, but we know that that's not any kind of a thoughtful, organized system of care.

1 School districts have patchwork funding from grants, from different kinds
2 of -- children with developmental disabilities, some of that funding may support social
3 workers to work with those children, in particular. There might be a small grant here or
4 there, but basically there is no coherent system of care for kids that would start with
5 looking at screening for just the kind of children, I think, both Bill and Marleen were
6 talking about, those kids that are quietly suffering under the radar with conditions that
7 they could receive help and treatment for.

8 I'm going to suggest, in the interest of time, a number of things. First of
9 all, I think we need to think about a coherent system of mental health services and care
10 for children in schools K012, that it needs to be paid for and integrated with the
11 healthcare system that we have, that those services should be paid for through
12 commercial insurance, they should be paid for through Medicaid, or whatever other
13 programs are out there.

14 I think SAMHSA could take a very important role, and I'm going to
15 suggest a couple of things. I think SAMHSA needs an office of school mental health
16 services, and there need to be people who are specifically designated to work on this
17 issue. It is a critical time. There are huge opportunities for thinking about developing a
18 real system of mental health services.

19 My thought is that that should probably be integrated with school-based
20 health centers where you have primary care available as well. The benefit of that is that I
21 see a lot of kids in the school-based health center where I work who come in for a sore
22 throat or a cut or a bang or a tummy ache who have a lot of other things going on.

23 That is the safest way for them to come in the door. There's not a lot of
24 stigma attached to it. They can come and see me. I can use a screening tool and talk to

1 them and figure out what else is going on and make sure that they then are able to get
2 mental health services in school by a provider that I can walk them down the hall to meet.
3 I think those kind of services should be available in every school, and I think SAMHSA
4 could take a big role in helping to develop the advocacy and internal work that needs to
5 happen to develop that.

6 I think we need the development of infrastructure models, and we also
7 need to think about the workforce. Right now, in my experience in my state -- and
8 maybe it's different in other places -- the mental health workforce is equally sort of a
9 patchwork or hodgepodge of different kinds of people with different kinds of credentials,
10 experience, and ability to provide evidence-based therapies.

11 I think we need to work with CMS and make sure that there are
12 appropriate reimbursement models for these kinds of things. We need to really take a
13 serious approach to developing a system that is sustainable over the long term so that
14 we're not looking at funding in three- and two- and five-year cycles, but a system that is
15 sustainable over the long haul and does not drain educational funds and also does not take
16 away from the kind of maybe broader, more public health, awareness kinds of activities
17 that could be funded, perhaps, in less of a systematic way, although I'd argue that that
18 should be done too.

19 I want to just loop back and say that I think Dr. McFarlane's work really
20 highlights the potential cost savings and life saving work. If you were really able to not
21 only identify children who were at risk for much greater, much more serious illness, but
22 actually effectively treat them within the school system, imagine the impact of that.
23 Thank you.

1 DR. HUANG: Thanks very much, Jane. Our final presenter is Harriet
2 Forman.

3 MS. FORMAN: Good morning. I want to thank SAMHSA for the
4 collaboration that we're learning about with different agencies, particularly with
5 Department of Education. I'm an educator, retired. I spent 40 years in public schools,
6 elementary school, middle school, and then I spent many years as a consultant at two
7 different state departments of education.

8 I'm so thrilled to hear all of the things from the panel that I hear today
9 because schools have an enormous task. Schools are expected to perform miracles. Of
10 course, we all know that all teachers are terrible people who are on the public dole, they
11 work short hours, and they have a lot of vacations, when, in fact, we know that teachers
12 spend untold hours, untold dollars, and lose many hours of sleep over the problems that
13 their job present.

14 Our most precious product, our children, come into the schools, every
15 child from every family. When you consider the enormous variety, the wonderful
16 challenges we have, the wide spectrum, children no longer come to kindergarten all
17 knowing the same things. The gap between what privileged children bring to school and
18 underprivileged children, children who are second-language learners, children who come
19 from cultures that don't have a written language, it's enormous. They also bring
20 richness. They bring their culture. We expect our schoolteachers to teach them all.

21 Schools' goal is student achievement, and with all of the conflicting
22 pressures -- we can't teach this, we shouldn't teach that, the controversies that come into
23 the classroom and our other challenges to narrow the achievement gap between majority

1 and minority students -- all of the grant programs that we hear discussed don't get to the
2 most important place: the classroom.

3 We can offer all kinds of grant programs, but it seems to me that at this
4 point what I would see from SAMHSA is more what Kana was talking about earlier
5 today, putting the light on. We know that there are successful, wonderful programs, and I
6 think a major focus needs to be to get those out. When I was a principal, if I had had
7 these bullying materials that are available now, it would have been a blessing, because we
8 were feeling our way in the dark.

9 I think there are still schools in a lot of places that really don't know what
10 to do, and when confronted with the parent of a child who's accused of bullying who says
11 they're just acting like sisters, and you know how sisters fight, and they don't know how
12 to respond.

13 A basic commitment to the safety of children, helping the professionals
14 who are not mental health professionals know what to say, what to look for, how to
15 propose plans, whole-school plans, that keep children safe, all of the ways that we can
16 provide those materials, those hands-on materials that we know work, would be a major
17 help in creating that safe environment.

18 I also am very encouraged. I love Jane's idea of the health center in each
19 school. Most schools cannot even afford a nurse several days a week. I would love to
20 see more thoughts about how that could be funded, because we do deal with every issue
21 that confronts any of the people that you serve reflected in their children's lives.

22 Any way of helping us do that without taking funds from our instructional
23 mandate would be enormously helpful for all of us, for the families, for the juvenile

1 justice system, where we desperately want to keep our children out of. It will take the
2 combined wonderful thinking and magical behavior of all of us. Thank you very much.

3 DR. HUANG: Thanks very much to all of our council members. We
4 gave them a list of five questions to address. I'm not sure those are still the questions we
5 want to address.

6 Given what you all have presented as kind of key issues and what we've
7 heard from Michael from the Department of Education, I'd like you to help us think
8 about what should be some of the priorities that SAMHSA, with the resources we already
9 have around prevention and treatment for mental health and substance use issues, hearing
10 what Michael said were some of the programs that they have ongoing at the Department
11 of Education, some of the priorities that you all mentioned around early identification of
12 youths that might be prone to at-risk for mental health or addiction issues, depression in
13 schools, trauma, exposure to violence, this idea of using the infrastructure there of
14 school-based health centers to get more of our mental health issues and substance use
15 issues.

16 Where should we go? What would you say should be our priorities that
17 we might think of using our resources for, working with Michael, the Department of
18 Education? There's a whole range of things you presented. We need your guidance.
19 Where should we be -- and all this also, in the context of health reform, Affordable Care
20 Act. Michael, certainly if you want to respond to any of the comments you've heard,
21 you're very welcome and would like to hear your response as well.

22 DR. WONG: There are a couple of ideas that I really liked. One was
23 Jane's idea about having a school mental health department or office within SAMHSA,
24 because I think these issues are not simple ones. They go across the spectrum of what

1 every person at this table has spoken about. Of course, it is one of the recommendations,
2 I believe, of the president's New Freedom Commission that there be the expansion of
3 mental services in schools.

4 Certainly the idea of school-based wellness centers and health centers are
5 very important. In the early iteration of this in the Clinton Administration LA Unified
6 had a whole number of school-based health clinics with great controversy, of course,
7 because the idea of handing out -- one community member said he was completely
8 against handing out those "condominiums," also, in terms of birth control issues, et
9 cetera.

10 Something that we learned was that 44 percent of the children that went in
11 for health issues had mental health issues. The integration of behavioral health and
12 health, I think, really began in the school health clinics, the whole idea of early
13 intervention. But those two things really stuck in my mind as being wonderful ideas.

14 DR. MCFARLANE: I just want to continue that discussion by adding a
15 couple of points from our own experience. One of the things that we say in these
16 educational forums with school professionals or whole faculties of a high school is a
17 simple statement, which is these illnesses are the worst things that happen to most
18 adolescents.

19 So think about the epidemiology and the onset, and you come up with that
20 conclusion. Yes, suicide is terrible, but it's very rare. Car crashes with fatalities are very
21 bad, but they're very rare. But by the end of age 25-30, 2-3 percent of the population has
22 had the onset of a major mental illness, to say nothing of some of the other issues as well.
23 That's excluding substance abuse.

1 I think this idea of putting a capacity in the school that can deal with these
2 things, but primarily for identification, and then the triage for treatment, especially if paid
3 by insurance, is the way to go. Our experience over and over again in schools that have
4 been even minimally receptive to this idea is about a year later, they say it's just the best
5 thing that's ever happened to them because of a few things. One is they know what to
6 look for, they know what to do, and they don't have to treat these children. That is done
7 by experts in collaboration with them.

8 The third stage is even more wonderful, I think, and that is that the school,
9 particularly the individual's teacher, and the mental health clinician working on that kid's
10 issue start collaborating around their education strategy.

11 What that often leads to is not special schools, not special education, but
12 simple 504 accommodations that allow particularly a kid with depression or a prodromal
13 psychotic disorder, let's say, can continue in the school and slowly get back into a full
14 level of functioning without having a lot of disruption, a lot of cost, or a lot of burden on
15 the teachers and the professionals staffing the school to do treatment. I guess I would
16 really second Jane's idea, if there's some national curriculum that could be done.

17 The other thing I wanted to point out is, actually, if you look closely at
18 school systems, a lot of this is going on, and it's getting to be a little crowded. There are
19 initiatives for suicide. There are initiatives for depression. There are now initiatives for
20 psychotic disorders. There are initiatives around substance and drug abuse.

21 Actually, in some schools, the very fortunate ones, this stuff is starting to
22 get in each other's way. So there's a tremendous opportunity for SAMHSA to say this is
23 so important to all mental health and substance abuse issues. Let's try and pull things
24 together. I forgot to mention mental health first aid, which is another relatively

1 successful program. There's a tremendous opportunity to coalesce these things into a
2 kind of workable national disseminatable strategy that would get us a lot of what we need
3 for, I think, a relatively low cost, if the insurance companies step up to this.

4 The other thing I wanted to mention is that magic age in the ACA of 26,
5 has shifted some of the insurance companies around such that they are now starting to
6 worry about having to pay for hospitalizations for a whole population that they could
7 summarily dismiss (phone interruption) get sick. Anyone over 18 who get, say, psychotic
8 disorder, manic depression, drops out of college and can't work, goes immediately to
9 Medicaid or Medicare.

10 That won't happen anymore. All of a sudden we've got some customers
11 out there who are going to start to pick up these costs that never had to before, if they
12 follow the law, and I think they probably will. That's another opportunity that is brand
13 new.

14 DR. HUANG: It looks like we have comments from other council
15 members.

16 MR. FRIEDMAN: Thanks for the presentations. I think it's a critically
17 important area. I know my own work with children's mental health, consistently, with a
18 few exceptions, schools have been the hardest sector from mental health to be able to
19 have partnerships. I think part of it has been that schools are very focused on academic
20 achievement. High-stakes testing kind of rules the day, and it becomes harder for them to
21 see the relevance of some of these interventions for their achievement of their grades that
22 they need.

23 I think part of it has been their anxiety that if they identify kids with
24 special needs, they're going to be responsible for them, and, my god, what happens if

1 they don't provide the services. At best, is it going to be expensive, and are there people
2 out there who can provide the services?

3 I think a lot of the impetus has to come from working with the schools and
4 listening to them and building from the schools up. I think we have some isolated
5 successes, but the problems that Bill and Leighton talked about, of coming from outside
6 with wonderful programs into the schools has been a part of the history for years. I
7 believe, as Jane said, that we need comprehensive systems, that we're building a larger
8 and larger group of discrete programs. We need something broader and we need
9 something more comprehensive.

10 I like to look for successes. One of those successes, from my perspective,
11 has been positive behavior support, which, interestingly, in terms of your introduction,
12 comes all levels in a public health framework. It's very much school-climate-oriented,
13 and it goes to interventions for the kids with the most serious problems. It uses like
14 wraparound that emerged out of the care world and has been expanded broadly and helps
15 to focus on outcomes that I think are meaningful to the schools as well as to the
16 individual kids.

17 I think something we haven't talked about much is the role of the family.
18 It seems to me that there's pretty clear research that shows that school success is related
19 to meaningful partnerships between schools and families, and school success is related to
20 meaningful positive connection that students have with the schools.

21 If you ask students is there some adult in this school who you believe
22 really cares about me, there's clear research demonstrating relationship between the
23 answer to that simple question and the outcomes for the kids behaviorally, attendance-
24 wise, academically, in the schools. I think we need to look for successes. We need to be

1 comprehensive. We need to build from within the schools because our best ideas are
2 going to be resisted if we're the outside experts coming in telling the schools what they
3 consider to be their business.

4 DR. HUANG: I am wondering if we can ask Michael and Kristen if
5 they'd like to respond to some of these comments.

6 MR. YUDIN: Sure, real briefly, because I know there are other members
7 here. I think that's spot-on. I think what folks have been talking about, the challenges
8 that schools are facing from the outside sources, from within to various pressures, that
9 teachers, counselors aren't trained professionals.

10 I think you're right on. I think we need to identify from the ground those
11 best practices that are working. We have those opportunities in some of our grant
12 programs, like our Promise Neighborhoods program is designed to create a
13 comprehensive community-based approach recognizing that the school is the place, but
14 the partners are essential to improving all the outcomes in a comprehensive way for the
15 kids. We just started that a couple years ago, and we're just starting to get some money.

16 But again I'm going to go back to the school improvement grants. There's
17 a significant amount of money. We've invested \$4 billion that does go directly to
18 schools. It's up to \$2 million per school. An overwhelming majority of these schools
19 that are getting this money -- and there are over 1,000 schools that are getting up to \$2
20 million -- are required to partner with the community.

21 I think you're right on that we've got to get at the local level. I think a
22 good leader knows fully well that they need to address these issues if they want their kids
23 to succeed and should welcome the opportunities and the partnerships, because they don't

1 have the resources on their own, they don't have the capacity on their own, and they
2 would welcome those opportunities.

3 DR. AMARO: I really appreciate the discussion today. I think it's been
4 very rich. I wanted to bring up the issue about looking at more upstream factors. Pulling
5 people out of the river is important, that is what treatment connected through early
6 training, et cetera, and some of that is prevention, of course.

7 But most of the issues that were discussed are really issues that are greatly
8 influenced by the communities and the neighborhoods that families live in and the
9 economic and other social conditions. I was really heartened to hear the Promise
10 Neighborhood initiative because that's where some of those issues related not only to
11 violence in the community, but also to resources, to quality of housing, economic
12 development, et cetera.

13 I'm wondering what is SAMHSA's role and what does SAMHSA think
14 about addressing and being engaged in more activities that really help to improve
15 communities overall and address some of the more upstream factors as a complement to
16 the intervention approaches and collaborations that address the more downstream factors
17 that are more proximal to screening and getting treatment and the appropriate services.

18 DR. HUANG: I don't know if that's a question you're posing to
19 SAMHSA.

20 DR. AMARO: Two things. One, it's a statement that I think it's
21 important to consider. If we focus only on pulling people out of the river, we're not
22 doing much about what's happening upstream. I'm wondering how SAMHSA can either
23 thing about these things or collaborate with other federal partners to think about some of
24 these things like development, quality of housing, availability of housing, et cetera.

1 DR. HUANG: Thanks for your comment. I think what your comment
2 and what Michael said about their programs and how we can best kind of leverage our
3 resources or connect some of our programs might be a next step we have to do in our
4 thinking.

5 MR. JOSEPH: My name is Andy Joseph. I chair the Health and Human
6 Services Committee for the Confederated Tribes of Colville and the Northwest Portland
7 area Indian Health Board. I'm sitting here on a technical advisory group representing a
8 National Indian Health Board.

9 At home tomorrow night I'm missing the school board meeting. I am an
10 active member on school issues also. Our school, on my reservation, about 90 percent of
11 our students are students of Impact Aid schools. Impact Aid schools also serve our army
12 brats, my comrades' children. I served in the military as well as my brothers and my
13 sister.

14 At home we used to have a program that was in our Children and Family
15 Services, and what they would do is they were allowed to do case management. What
16 that would do is they'd take each of these families that were -- in Indian country a lot of
17 our young people become parents at a young age, and by the time they figure out what
18 they really got themselves into, some of them fall off by abusing alcohol or drugs or
19 different things like that.

20 So you might have a single parent trying to raise a family. Then you have
21 the Indian Healthcare Improvement Act and you have our Children and Family Services
22 that gets involved in each one of these cases of the children that are impacted by
23 separation. Some of them find out that the parents might not be suitable and they need to
24 go to their grandparents or to an aunt and uncle or someone else.

1 Anyway, those children are traumatized by being moved around and
2 shuffled around, and when they go to school, they're the ones that become the bullies.
3 They're the ones that are having a tough time trying to learn because they're having to
4 deal with what they do at home after school.

5 Anyway, before, we were allowed to do this case management with our
6 tribal program and are able to take each family case and work with them, and they would
7 bill for the services and train a young mother how to actually be a mother, how to take
8 care of her bills, how to render her home. By doing this, the children were actually being
9 better taken care of because they're finally getting the clothes on their back or shoes for
10 their feet or whatever, and that made them feel better and we had less problems in school
11 with those children.

12 But for some reason -- I don't know what year it was -- they stopped
13 allowing the case management to be something that it was built for. In reality, to me, it
14 was cost savings further down the road of having someone have to go through treatment
15 for a long period of time.

16 I think if you work on the family structure at home, that that would be a
17 big help. Being that this is the 20th anniversary, what always worked with me was when
18 I used to see those videos at school showing some of the harm that the alcohol and drugs
19 can do to my body. That really opened my eyes, and I think there should be a big
20 campaign going.

21 If there are grants, maybe send them out to some of the different area
22 epidemiology centers or to some of the national centers that work on those sort of issues
23 and do some radio campaign sort of things. It's really neat when you hear back home on

1 the radio or something, you have an elder talking at a local level what they can do and
2 maybe a call-in number if you're having any kind of problems, where to reach out.

3 It is the 20th anniversary, and I'd like to see something big happen with
4 SAMHSA. Department of Education, I'm glad that you're here. I think if we work with
5 our Head Starts also, that would be a big impact, because a lot of those young parents are
6 in those Head Start age groups. Thank you.

7 DR. HUANG: Thank you, Andy.

8 DR. GONZALES: I apologize for not being able to be there. I just
9 wanted to make some comments on the presentation by Jane McGrath. I believe that
10 SAMSHA

11 DR. HUANG: Autoro, we can't hear you.

12 MS. LEMELLE: I really appreciate the presentation this morning, but I
13 guess a subgroup that I didn't hear people mention too much about is the LGBT
14 population in the schools. In New York I worked with a not-for-profit organization. I
15 was screening kids coming out of Riker's Island.

16 I realized that there was a cohort of young minority women, in particular,
17 who were ostracized in school, ostracized at home, didn't fit into the community, but they
18 did fit into the gangs. They had serious histories of trauma, serious histories of
19 depression. They didn't fit into any of the school mental health programs. They didn't
20 fit into the community mental health programs.

21 I think they're a subpopulation that we probably need to think about as a
22 minority group within some of the programs that you're discussing, because I think that
23 they're at very high risk, and we don't have things specifically targeted towards that
24 population. It's just a group that we don't want to forget as we're planning this.

1 MR. SAGE: I am really glad that we have really an excellent panel. I
2 really applaud you all for doing a great job and all the areas that you covered. I'm glad
3 you guys all have your different perspectives and your different focuses of helping our
4 children. We're working with our children. Michael said it right. Our children have to
5 be safe before they can learn. I'm really glad that you guys got good presentations there.

6 We want to include and be aware that cultures of poverty will resist
7 change and support because they don't know what's right for them, even though it's
8 staring them right in the face. So we want to continue to be aware of that and help in our
9 communities. For Native children, our children start 2,000 words short when they come
10 to school, so you're right about different teachers having to deal with different levels of
11 children coming to school. At least they get two meals a day, breakfast and lunch, so
12 that's very important in getting them ready to learn.

13 We are starting with our home visitation program with ACF, and so we're
14 going to incorporate the Head Start and we're going to work in the school to get them.
15 The first five years is very crucial for our children to learn and to be ready. Thank you.

16 MS. GARDUQUE: I appreciate the different perspectives that the panel
17 brought to this discussion. I think you raised three really important themes from looking
18 at these issues from a broad public health perspective of also the importance of taking a
19 developmental perspective and also the critical need to mainstream behavioral health
20 issues into other systems of care, and with that, an emphasis, frankly, on using our
21 resources more cost-effectively, particularly during these difficult fiscal and economic
22 times.

23 I think what's most important, though, given the work that all of you have
24 talked about, is how schools have been a little late to the game in recognizing how school

1 discipline, truancy, and bullying all affect behavioral health issues that need to be
2 addressed in the context of schooling, and yet the difficulties of doing that, given the
3 schools' competing priorities. Somehow or another, we have to change the incentives so
4 that schools don't rely on exclusionary practices in terms of dealing with these problems
5 and asking the juvenile justice system to address them.

6 In addition, another system that needs to be involved in these discussions
7 besides behavioral health and the juvenile justice system is also the child welfare system,
8 where we see where parents and families are giving up their children not because of
9 investigations about child abuse and neglect, but because that's the only way their
10 children can receive the kind of mental health services and behavioral health services that
11 they need.

12 That suggests to me that both the Department of Education and SAMHSA,
13 along with ACF and other parts of HHS, need to rethink their grant-making strategies,
14 since you're not really in a position of launching new programs and services, but how to
15 use your existing grant-making strategies more cost-effectively.

16 That, to me, suggests, as Kana said earlier, how to shine a broader
17 spotlight, not just flashlights, in terms of diffusion of best practices or evidence-based
18 practices or practice-based evidence, because we're not in a position any longer of
19 inventing new delivery systems or new programs and services, but going to scale and
20 focusing on systems changes that will ensure better access to the available programs and
21 services that are out there.

22 You need to think about diffusion. You need to think about leadership.
23 You need to think about workforce development. You need to think about training. You

1 need to think about coming up with better financial strategies to put what we know what
2 works to greater effect.

3 With respect to that, neither the Department of Education or SAMHSA
4 has the broad social networks that are needed to radiate out all of this information to other
5 sectors. When I look at who applies for grants, it's usually the same suspects over and
6 over again that are sophisticated, and how to look for the federal or state dollars.

7 You need to partner with other allies, whether those are the private
8 philanthropy business interests or so on, and you also have to reduce the bureaucratic
9 hassles of forming those kinds of alliances and partnerships, whether it's because of the
10 Muffin Gate or the need for memoranda of understanding or cooperative agreements or
11 co-sponsorship agreements.

12 There's got to be a better way, and it has to start up front, not come in later
13 when the feds find out they don't have enough money to provide services, and then start
14 looking for private sector dollars. It needs to be done up front. I'm talking about a new
15 era, frankly, of grant-making and thinking about how we all need to use our resources
16 more cost-effectively.

17 MS. WENDEL: Good afternoon. I am Chris Wendel. I serve on the
18 CSAT. I just have a couple things I'd like to say. I come from New Mexico, and one of
19 the things we're looking into right now in New Mexico is the opportunity, because of the
20 rural and frontier nature of the state, the opportunity of opening school-based centers
21 more hours, so weekends and evenings, and having it be more of an opportunity for an
22 entire family to get services.

1 I want to echo that certainly my experience with substance abuse is that it
2 is a family disease, so the more we can get the family into any sort of healthcare, I think
3 is a good idea. That's one thing.

4 I am a person in long-term recovery. I am recovering from alcoholism and
5 drug addiction. With that perspective, I believe wholeheartedly that the reason I am
6 sober today is because of the people around me who are sober. I believe in the
7 fundamental principle of peer support.

8 That said, I have a question regarding sober high schools. I think for
9 adolescents trying to get clean and sober, it is imperative that they have the opportunity to
10 not only socialize, but also to learn with their peers. I use that term in the sense of those,
11 too, who are in recovery from substance abuse issues. I know there are places in the
12 country where sober high schools do exist, and so I wondered if someone could speak to
13 if that's getting any traction at the federal level.

14 My third thing I want to say just briefly in addition, I am a firm believer
15 that there are things happening grassroots around this country that we don't have a clue
16 about. One of the projects I do in New Mexico is trying to map community supports, not
17 what's funded by the feds, not what's funded by counties or the state, but where people
18 are truly helping people.

19 I got sober in Baltimore, so I used to live in this part of the world, and I
20 had the opportunity to come in Friday. I spent the weekend with a family who are very
21 close to me, and they have a daughter who's 17. When we were having dinner Saturday
22 night, she told the story of a good friend of hers who is a cutter. This young man had
23 recently had an episode of cutting.

1 What Sophia spoke to then was the grassroots reaction using cameras and
2 cell phones of this young man's friends drawing butterflies in the same area on their
3 bodies where the cutting of this man had occurred, and then they sent him the photos. I
4 found that to be an astonishing grassroots people helping people.

5 Other than I think it's a really lovely story of friends helping friends, I do
6 think there's a whole lot going on across the country in communities with people helping
7 people that we don't have a clue about. I don't know how you find out that information.
8 Trust me, I'm trying to do it in New Mexico and it is a daunting task. That said, I think
9 it's imperative. Thank you.

10 DR. HUANG: Chris, thanks for your comment. On these sober high
11 schools or recovery high schools, I'm going to ask you to confer with Bob Vincent(?)
12 who I see sitting in the back, who has been a strong in-house expert on that for us.
13 Maybe over the break he can give you an update on that.

14 MS. STEIN: This has really been a great discussion. I want to thank all
15 of you and everybody who's asked questions and commented as well. Our children are
16 really where we need to be focused a lot more than we are, children all over the world.

17 One of the things I think we need to think about are some other partners
18 that get involved in this. Just like in the larger society, violence and substance use
19 disorders bring in a group of other players. Like in North Carolina all our schools have
20 school resource officers who are police officers assigned to the school for safety and do a
21 lot of intervention with kids who have drug and alcohol problems and mental health
22 problems.

23 Then our other big partner that was just mentioned is the juvenile justice
24 system, because we still, as hard as we're trying, have about a quarter of our ninth

1 graders leaving school because they're suspended or they're behind or they have not had
2 any of these supports that were required to keep them involved. Then it's just a long drift
3 for many of them. It couldn't be a more important topic. Get more partners at the table
4 to come up with some comprehensive solutions.

5 DR. HUANG: Thanks very much. I want to just wrap this up and say that
6 your comments have been right on target and very helpful. It makes me think that what
7 we need to do here at SAMHSA -- we have multiple grant programs that probably touch
8 on each one of your comments in some way.

9 But we probably need to better coordinate even among ourselves all of the
10 programs that, in some way, touch schools. We have them spread across our centers. As
11 we think about a more coordinated approach, we could do some thinking here, and then
12 also talk with Department of Education around that so we're not doing a thousand little
13 discrete programs and bombarding you with things when you already have so many
14 efforts on your plate as well.

15 I think that's one of the things that I hear from all of you, that we probably
16 need to think not necessarily about new grant programs, which we don't necessarily have
17 funds for, but how can we use our resources and coordinate them better to address all of
18 the issues, many of the issues, that you all have brought up.

19 I really want to thank Michael and Kristen for taking the hike up from the
20 Department of Education, telling us about your programs. I think there are a lot of places
21 we can now have follow-up discussions on. I also want to thank very much our Advisory
22 Council members who, on relatively short notice, agreed to talk to us about their
23 perspectives on these really critical issues around children and families and schools. I
24 think that's it for this panel. I guess you have a virtual lunch or something.

1 MS. HYDE: Let me say just a word also to thank Michael and Kristen
2 and all the panel members. Michael, I think you can see why we thought it would be of
3 use to spend your time, although it is a schlep, to come up and spend times with us. I
4 always tell people that we have the best advisors anywhere. They stimulate us, and all of
5 the things that you've said have given me ideas. I always take lots of notes. Thank you
6 for coming. Thanks to all the panel members.

7 (Administrative remarks)

8 DR. HUANG: I just want to also thank the Children, Youth, and Families
9 Work Group and Monica Evans for helping to really pull this information together.

10 MS. HYDE: Thanks to the staff and all of you. This was a really good
11 panel. Thanks a lot. We'll see you at 1:30.

12 (Whereupon, a luncheon recess was taken at 12:19 p.m.)

13

1 **A F T E R N O O N S E S S I O N (1 : 3 3 p . m .)**

2 MS. HYDE: Rock and Roll? Everybody had a good lunch? Welcome to
3 our Thanksgiving dinner. For this afternoon, the first part of the afternoon, we have an
4 incredible panel up here of SAMHSA folks, SAMHSA staff or about to be staff, one or
5 the other. I just want to let you know that their biographies are actually in your books if
6 you want to see a little bit about them. I think Joan's is in there. It was in my book. It may
7 or may not be in your book. I may actually have her tell something about herself, since
8 she is our newest folk.

9 Behind tab six are biographies for I think most of the rest of the folks. If
10 you want to ask a question about their roles or what they do, you can do that sometime as
11 we get through the discussion. Joan, why don't I let you start, Joan Erney, who, as I told
12 you this morning, will be joining us sometime in May as the Director of the Office of
13 Policy Planning and Innovation. Joan.

14 MS. ERNEY: That's the first trick, actually, how to use all the equipment.
15 I am Joan Erney; I am really excited about the opportunity to come to SAMHSA. My
16 background is varied, from old crisis work, which was one of my first entrees in
17 Harrisburg, PA to actually leading the behavioral health system in Pennsylvania. I was an
18 appointment under the Rendell administration as the deputy secretary for mental health
19 substance abuse for seven and half years in Pennsylvania and had the opportunity to close
20 three state hospitals, run a major Medicaid behavioral health program, and create a whole
21 litany of successes for people in Pennsylvania. I'm very excited, and it was a great
22 opportunity. I'm currently with Community Care Behavioral Health Organization, which
23 is a regional non-profit behavioral health program out of Pittsburgh, PA. I'll be

1 transitioning from Pittsburgh to down here around Washington, so it will be a great
2 adventure. Would you like me to attend the question or are you doing intros now?

3

4 ***Agenda Item: Panel Discussion: SAMHSA Critical Issues***

5 MS. HYDE: No, I just wanted you to introduce yourself so that people
6 could recognize who you were. I'm getting a lavalier mic here in a minute so I won't
7 have to bend in order to do this. We decided that we wanted to introduce and talk to you a
8 little bit about some of the issues that SAMHSA is facing and get some of your feedback
9 about it, but we wanted to do it in a way that hopefully wasn't quite as difficult as
10 listening to each talking head talk a little bit about their areas.

11 We're going to do this a little bit as an Oprah Winfrey kind of approach,
12 or some other talk show host you can think of, whoever you want to. Would that I could
13 be as good as Oprah Winfrey and be that rich, then SAMHSA's problems would be all
14 solved. I'm going to ask questions of folks here. They know the questions I'm going to
15 start with. They don't necessarily know the questions I'm going to keep going with. Let
16 me only say that I have tried very hard to create an atmosphere of trust and willingness to
17 ask and say anything. I hope all of them will be willing to do that regardless of the fact
18 that I'm asking the question.

19 I'm going to start with Daryl, actually. We've had incredible budget
20 instability, and we've talked a little bit about that this morning, some of the challenges.
21 Daryl, can you talk a little bit about how you've been in budgets for a long time in the
22 federal government and you've seen quite a bit of budget instability in the last couple of
23 years, what has that meant for your role in trying to help SAMHSA formulate and

1 execute budgets and grants and contracts and just get money out the door? What are some
2 of the challenges you're facing?

3 MS. KADE: I don't go home. I don't go to sleep. There is no down time.
4 There is rarely any certainty. In terms of budget formulation, anyone who deals with
5 budgets know that you can't really think about the next year unless you know what you're
6 doing in the base year. Rarely do we know what we're doing in a base year because it's
7 up in Congress. To the extent that the base year is up in Congress and Congress is
8 considering something quite different from the President's budget, we're caught in
9 between those two parameters, and it's difficult to move forward.

10 You want to get consistent with the President's budget, but you also want
11 to be realistic. You also want to do formulation in the year of formulation not in the year
12 of execution, and yet you never have enough information to make decisions until the year
13 of execution if you're lucky, if you're not caught in repeated continuing resolution. When
14 we work with Pam to develop budgets, we usually start with scenario planning.

15 The traditional way of using a scenario planning is looking at your base
16 and then you have a plus or minus number that you're trying to reach in some policy
17 initiative. Based on the budget environment, the possibility of sequestration continuing
18 resolutions, and a disagreement in terms of where the major policy initiatives are, we deal
19 with a multitude of scenarios. It's very difficult to make decisions when there are so
20 many possibilities. Indeed, when we went from the year of formulation to the year of
21 execution, we started to develop policy option papers for contracts and grants. In some
22 instances, we were dealing with seven or ten different financing scenarios. What do you
23 do if, what do you do if? You start getting so involved in the "ifs" and the different
24 options that it's difficult to put all of that together. An individual program doesn't exist

1 by itself. All those little “ifs” have to aggregate up to a big “if” for the entire agency if
2 you want to move forward. That becomes very challenging for us.

3 I mentioned to Pam earlier that because of the uncertainty in terms of final
4 budget decisions, final policy decisions, our regular business processes are very much
5 stressed because you don’t have and cannot make decisions early in the year, and you
6 can’t space them out by quarter so that you’re not bunched up at the end of the year.
7 Bunching up has a major impact not only in terms of how our staff operates, but indeed,
8 how the field operates. You don’t want to get a whole bunch of grant announcements at
9 the same time. You want them to come sequentially. You want to have time to pick and
10 choose. You may want to have time to apply for multiple funding opportunities, but when
11 they come at the same time, it’s very difficult, or in the case of local communities or
12 tribes, you need that long decision period in order to reach consensus within a
13 community.

14 If you don’t know what you’re doing in the beginning of the year, you
15 can’t publish the grant forecast even before the announcement is out so that communities
16 have time to plan and to reach consensus. Just in terms of the technicalities of anyone
17 doing budgets, working with Pam is terrific. We get a lot of guidance, but we get a lot of
18 guidance. We go through multiple scenarios. Even the regular spreadsheets that we work
19 with, they are not multi-dimensional, which is good, because you can work with them,
20 but it’s bad, too, because you’re dealing with so many different scenarios that it also puts
21 stress on staff to be able to remember what the previous scenario was, what the different
22 permutations and combinations were, and where we are at any particular period of time,
23 which is really very important because even though we’re trying to deal with various

1 scenarios, so is OMB and so is the health, and so are the centers. We are a drug control
2 agency, so is ONDCP.

3 When we're doing all of these 10-20 scenarios, so are they. Then, at
4 different times of the year, we get guidance that will change, guidance that will be
5 contrary to what we're doing and we have to answer to so many people at different
6 milestones.

7 I was talking to the Program Integrity Council last week, and we pointed
8 out that the uncertainty of the budget is only going to become more pronounced. To the
9 extent that the budget uncertainty continues and grows, it really does challenge the
10 integrity of the programs, and indeed, not only whether or not you can plan and
11 effectively execute, but also in terms of the business processes, whether or not you can
12 actually spend all the money you have by the end of the year.

13 The possibility of lapsing funds because you haven't gotten the contracts
14 through on time, or you did, but you didn't have enough time to negotiate down to the
15 numbers, or you had enough time to review the grants but you have excess money at the
16 end of the year that you couldn't switch from grants to contracts because you ran out of
17 time, those become very serious challenges for an agency that is primarily grants and
18 contracts. It's something that we need to consider not only in terms of SAMHSA, but the
19 OPDIVS in total in the department in terms of how to accommodate the situation. As
20 Ellen Murray(?) said, it's only going to get worse; it's not going to get better.

21 MS. HYDE: So you sort of answered a question I was going to ask is you
22 have such a wonderful administrator that is so straightforward in what she wants to do.
23 How does this complicate things when you're trying to do new and creative policy
24 combined with-- how many different CRs have we had?

1 MS. KADE: About six or seven. We are facing the same challenge for
2 2014. Do you move forward on the President's budget as is? Do you move forward on
3 the President's budget with or without the policy initiatives that we are pushing? Do you
4 move forward on the President's budget with their financial projections? OMB always
5 has five-year financial projections. Do you assume sequestration? We are now working
6 on an exercise, an across the board cut of 7.8 percent. What does that mean? What does
7 that mean in 2013, 2014? How can you plan?

8 I think it becomes a challenge not only in terms of the numbers, but the
9 policy scenarios and then how they interrelate to one another. You have to start some
10 place, but I suspect with Pam we will start in multiple places and then work our way to
11 the center. Even, if I may say, for me it's very exciting, but for staff around the agency,
12 it's very disconcerting because it's unpredictable and you can't plan. That's an HR
13 feature that I don't think the department has dealt with yet.

14 MS. HYDE: So how many different budgets are you dealing with at the
15 same time?

16 MS. KADE: Well, three years--

17 MS. HYDE: At least, right? Sometimes we could be closing one out,
18 bringing another one--

19 MS. KADE: We're executing 2012. We've submitted 2013. We're about
20 to formulate 2013.

21 MS. HYDE: There was a time when we were finishing out '11, doing '12,
22 planning '13, and I guess not thinking about '14 yet, but getting there.

23 MS. KADE: Oh yes, always on our mind. Actually, with sequestration, ten
24 years on our mind.

1 MS. HYDE: So one thing you said I could say it the way a reporter said to
2 me one day, does this mean that the President's budget doesn't mean anything?

3 MS. KADE: Is this a trick question? It means a lot. It's a policy statement.
4 It's not only a policy statement, but the overall budget not only for SAMHSA but for the
5 entire federal government, when you look at the OMB appendix, not just the SAMHSA
6 budget, it's a financial statement as well. It's the President making a point, drawing a line
7 in the sand. From there, you experience or witness negotiations. Without it, you can't
8 start a process.

9 MS. HYDE: Most people think that Congress makes the budget decisions,
10 and they do, but you mentioned a couple of other players, OMB and who else did you
11 mention?

12 MS. KADE: ONDCP.

13 MS. HYDE: And who else?

14 MS. KADE: The department.

15 MS. HYDE: So, there are other players making decisions in this process as
16 well.

17 MS. KADE: Absolutely.

18 MS. HYDE: Besides me?

19 MS. KADE: You're a key decision maker.

20 MS. HYDE: So Wes, we'll pick up from here. You're a center director
21 and you're about to be a different center director and you're also an SI lead, strategic
22 initiatives lead on health insurance technology, HIT, electronic health records and other
23 electronic gadgets. You're about to be head of the Center for Behavioral Health Statistics
24 and Quality. You've been dealing with this administration now for about three years, but

1 you've dealt with other administrations. How has the last three years, with the budget
2 instability, with an administration that is what it is, and now with the executive exchange
3 coming up, what does that do for your leadership as a substance abuse leader in the field
4 and a leader within SAMHSA? What's that like for you?

5 DR. CLARK: Well, the past three and a half years have been obviously
6 quite exciting and marked by major efforts at transforming the context in which we do
7 business. This administration forges active lines of collaboration and cooperation
8 between the various departments and the various OPDIVs. Under your leadership, we
9 have been working much more closely with CMS, with HRSA, with AHRQ. In fact, the
10 creation of the Behavioral Health Coordination Council has been an effective way of
11 bringing behavioral health issues to the table. The administration essentially started with
12 the Parity Act and then very quickly with health care reform being put on the table put
13 the objective of navigating limiting resources that Daryl discussed and partnering with
14 the other agencies within HHS and the other agencies in departments outside of HHS, has
15 been a critical one.

16 There have been many more meetings. There are lots and lots of meetings.
17 Since the administration really fosters this comprehensive communication, we've got a
18 lot of notice of proposed rule-makings. I've been reading more-notice of proposed rule
19 makings – 450 pages, can you read this in a week, digest it, analyze it, and tell us what
20 you think about it? There are multiple episodes of that.

21 It has actually been a very impressive experience. This has been a test of
22 leadership because it puts the center directors in a position of having to work very closely
23 with staff so that they can understand the need to shift from, in previous modes of doing
24 business to this new environment where things are rapidly changing, where resources are

1 essentially unstable because of the lack of predictability, and yet, business has to go on.
2 Our job is to foster that.

3 I see the opportunity for the executive exchange as an opportunity to see
4 how another unit operates and to test my style of leadership in that context with another
5 unit and working with a new team as it were, but recognizing that the team is actually a
6 part of the larger SAMHSA team, so I don't see CBHSQ and CSAT as being, shall we
7 say, alien nations. I see them as being a part of a larger effort to bring behavioral health to
8 the fore, to make sure that behavioral health is a part of an integrated process.

9 As our rubric's go, behavioral health is essential to health and in order to
10 do that, we have to be part of the warp and woof of how things are done elsewhere. The
11 data that is generated by CBHSQ, we have used at CSAT very deliberately because
12 indeed we have been data focused at CSAT and the experience to get more immersed in
13 the data generated by the Household Survey, by BOM, by TEDS(?,) and by the other
14 data driving apparatus of CBHSQ, I think will be of great assistance. Being able to tell
15 you a story, being able to put numbers to those, and being able to establish the utility of
16 what you're doing is something that is very important when resources are short. You
17 need to be able to establish that you're accomplishing something and that you can align
18 what you're doing with a larger agenda articulated by the strategic initiatives.

19 MS. HYDE: So I know your administrator pretty well. I know that she has
20 asked you to lead what she calls horizontally, as well as vertically. Can you say a little bit
21 about what that means?

22 DR. CLARK: Leading horizontally as well as vertically. Well, I think
23 what the strategic initiatives' process does is that it encourages activity across the various
24 centers and various offices. The decisions are made collectively based on the experience

1 of the management unit, in this case, it would be CSAT, and the experience of the
2 strategic initiative lead who's often lodged in another unit within the organization.

3 MS. HYDE: So that means you're supervising somebody in somebody
4 else's unit?

5 DR. CLARK: It's like you're influencing somebody in somebody else's
6 unit.

7 MS. HYDE: Oh, that must go over well with that person's supervisor.

8 DR. CLARK: Part of the art form is negotiating how that is executed and
9 working with the other supervisors. If it is part of an organic team, what you want is
10 people who are committed to the issues and committed to the direction that is provided
11 by the senior leadership to make, in this case, my administrator who basically provides
12 the basic guidance, and then the execution is left to the strategic initiative lead
13 horizontally, and the focus of the management activity over the centers of the offices
14 vertically. Then we're working in concert so that we can accomplish the goals set out for
15 us.

16 MS. HYDE: So some people have said or would say that there are parts of
17 SAMHSA, or at least maybe at some point lots of SAMHSA that was pretty much in its
18 own stovepipes or in its own sections, which is actually a lot cleaner for staff in some
19 ways. Do you think this sort of mixing it up is making things confusing for staff?

20 DR. CLARK: I think mixing it up creates some anxiety and uncertainty. I
21 won't go so far as to say confusion. Clearly people have established a routine in getting
22 things done. When change occurs, my job is to elevate change as a positive force in the
23 areas in which I'm working so that we can achieve the golden objectives outlined by my
24 boss, the administrator. In so doing, it does mean navigating change with people, helping

1 to assuage their anxiety, and to forge a common process. Interpreting things, explaining
2 things, sharing information, making sure that people are aware of what is expected of us,
3 and also that we believe in their ability to make the transition from one mode of doing
4 business to the newer mode of doing business.

5 MS. HYDE: So you heard Deputy for Operations, Mirtha Beadle, talk a
6 little earlier about this concept of outsourcing and in sourcing. One of the things I've
7 heard said is that there is going to be some more technical assistance done by staff in-
8 source, if you will, or by staff. Can you say a word about that? What's that going to
9 mean?

10 DR. CLARK: Well, basically, in sourcing will require people to develop
11 the additional skills necessary to execute things that they used to monitor. I was a grant
12 project, a contract project officer they contracted to do this work. If we in-source that
13 expertise, then either I will do it or we will have to bring on team members who have that
14 expertise so that we can do it. It saves the agency resources, but it also enhances the skill
15 set of the employees who are now doing things that they did not do previously, that they
16 monitored previously. I think it's a good thing, so it's clear that we don't retire on the job
17 if the job keeps changing. We believe in people acquiring new skills. As somebody who
18 is now a senior citizen, the fact that I can acquire new skills compared to some of these
19 young whippersnappers is a good thing.

20 MS. HYDE: All the retirees out there now can clap. So, actually, Wes, you
21 have been pretty articulate about the need for us to do, for SAMHSA to do, more staff
22 development around expertise. I think you're reflecting that in the comment you just
23 made. Can you say a word about that? You are probably one of the most well-read and
24 well-understood people I know in terms of staying up with your field and staying up with

1 the field of behavioral health as a whole. What do you think about that in terms of staff
2 development challenges?

3 DR. CLARK: Again, we need to make sure that people have access to the
4 information streams. What we offer at the federal level is some stability, but, indeed, we
5 don't have to have all the information, but when we interact with our partners at the tribal
6 level, at the state level, community level, they will turn to us for a stable source of
7 information. That means we need to be able to have access to that information. Either
8 you're a triage specialist, i.e. you know exactly where to get that information, or you
9 acquire that information yourself. In either case, you provide, from a technical assistance
10 point of view, you provide a service to the community that is dependent upon you to help
11 forge what is the best way to do things.

12 MS. HYDE: So you better know what you're talking about if someone
13 asks a question?

14 DR. CLARK: That's right.

15 MS. HYDE: So Anne, you've played a lot of roles recently. You had
16 something to do with writing this paper about technical assistance, I think. What was
17 SAMHSA trying to do thinking about that technical assistance stuff? I know you've also
18 been working about bringing the regional administrators on, is there any relationship?
19 Are our areas going to do the technical assistance out there?

20 MS. HERRON: I think there is a huge relationship between the two. The
21 technical assistance paper really talked about the need for us to share information. We
22 have been doing technical assistance for years with grantees, with our state partners, with
23 other stakeholders, and we've been developing information and skills and curricula, and,
24 unfortunately sometimes, over and over. I think one of the things that we really struggled

1 with in the development of the paper and in discussions about how we want to do
2 technical assistance is to make sure that we're talking advantage of what we've done
3 before so that we're sharing information, we're not recreating information.

4 If a skill or curricula is developed about a particular strategy or
5 implementation process, that can be shared across, not just within SAMHSA, but with
6 our states and with our partners as well so that we can make the most use of what it is that
7 we're spending our resources on. In relation to the regional administrators in technical
8 assistance, I think one of the things that we are seeing in the early days of the existence of
9 the regional administrators is that they are really identifying some very broad
10 understanding of what the needs are in our states and regions around a variety of issues
11 and needs around technical assistance, not just specific to a particular grant program or
12 particular population, but to a system of care. To that extent, they certainly are related.

13 MS. HYDE: So, but somebody said, they're not going to replace, they're
14 not going to do all the technical assistance are they?

15 MS. HERRON: No, they might be having heart attacks if they hear me say
16 that. No, they are not going to be doing all the technical assistance.

17 MS. HYDE: There has been a lot of conversation even in the meeting
18 today about the need for us at SAMHSA to understand what is working out there and be
19 able to shine a light on it, get it out there, or whatever. Is there more thinking about how
20 to do that, either through the regional administrators, with them, through technical
21 assistance changes? Frankly, what does this mean for grants and contractors, people out
22 there who have either grants or contracts that are supposed to be doing the technical
23 assistance?

1 MS. HERRON: The providers of technical assistance? A couple of things,
2 really, I think that to answer the first question, the development of technical assistance
3 plans and strategies is going to have to include down to regional administrators. They
4 have a level of information about what is going on the ground that I think is really going
5 to add to the effectiveness of our work plans and our strategies. They certainly will not be
6 doing the technical assistance, but like Dr. Clark mentioned earlier, as our own staff
7 becomes more familiar and more comfortable with providing technical assistance
8 themselves, they're also going to have to be more familiar with providing the information
9 about what it is they're doing, so sharing their skills and knowledge with other staff,
10 including the regional administrators, so that we know where to get information and how
11 to tap into those sources of expertise that grantees, providers, states, stakeholders, et
12 cetera, are going to need.

13 MS. HYDE: You also played a role in the Block Grant application stuff. Is
14 that the application changes that happened last year and maybe even in some of the work
15 that is going on about that this year? Should we give you credit or blame for that?

16 MS. HERRON: Yes.

17 MS. HYDE: Do you want to say more? A woman of few words. What is
18 SAMHSA trying to do with this block grant thing?

19 MS. HERRON: The major changes that we made in the Block Grant
20 application, the uniform application last year in terms of the structural changes really
21 made the point that what SAMHSA is trying to do is to use our Block Grant to really help
22 the states position themselves for the future, for the way we want the systems of care,
23 behavioral health, mental health, substance abuse services, to be able to work together to
24 support the individuals who need our services.

1 We talked about developing a common planning process. We talked about
2 looking at making sure that the block grants were being used for services and for systems
3 that were not being paid for by other means. This year, we're tweaking that block grant
4 application a little bit. The major changes were made last year for 2012-13. This year, for
5 2014-15, what we're looking to do is to provide another emphasis and areas of focus that
6 are going to be significant in 2014-15, so to look more closely at what the prevention
7 system needs to be looking at, doing, areas of need in the states; to look more closely at
8 how Medicaid, the essential benefit, will be covering our services and where the Block
9 Grant needs to be focused.; to look at things like Daryl mentioned, program integrity; to
10 make sure that we're spending the Block Grant's dollars in those ways that they need to
11 be spent according to what our authorizing language is; to make sure that we're focusing
12 on the kinds of populations that need our care as identified by the states.

13 MS. HYDE: But Anne, the authorizing language is 20 years old. It's really
14 not relevant anymore, is it?

15 MS. HERRON: I wish that were true. We still have an awful lot of
16 individuals who are in need of mental health and substance abuse services, treatment and
17 prevention who have no other means to get them other than through the Block Grants.

18 MS. HYDE: But the language that is in the law about Block Grants is like
19 20 years old or something. Is there any effort or any thought to try to get that updated?

20 MS. HERRON: I'd like you to ask our administrator that question. We're
21 limited by the language.

22 MS. HYDE: There are lots of things that are confounding the Block Grant
23 application stuff. I also have heard lots of discussion in the field that this is really
24 SAMHSA's attempt to try to merge behavioral health as one thing, merge mental health

1 and substance abuse all together and make it all one. Is that really what SAMHSA's goal
2 is?

3 MS. HERRON: No way.

4 MS. HYDE: Can you say more about that?

5 MS. HYDE: There is no intent at all to merge substance abuse systems
6 and mental health systems into one system or to merge the Block Grants into one Block
7 Grant, but there is clearly an effort on our part to make sure that what is occurring in the
8 states around mental health services and substance abuse services, both prevention and
9 treatment, are coordinated and are thoughtfully planned. No, there is no intention to bring
10 them together.

11 MS. HYDE: So there are a lot of states that already have combined mental
12 health and substance abuse organizations, right? More are moving that way? Does this
13 give anything to the states by doing it that way?

14 MS. HERRON: Well, it gives some administrative relief to the states,
15 certainly, because we are allowing the states, those who chose to, to submit a combined
16 application. No state is required to, but if they wish to do so, they certainly can, and that
17 does provide some relief. The Block Grant application is also for a two-year period now
18 whereas earlier, at least on the substance abuse side, it was for a one-year period. For the
19 mental health side, they have the opportunity to do a multi-year plan also.

20 MS. HYDE: So you head up a division in OPPI, which is the Office of
21 Policy, Planning and Innovation. How many jobs are you doing right now?

22 MS. HERRON: Two or three.

23 MS. HYDE: So there are people under you-- what's under your
24 responsibility?

1 MS. HERRON: In my division, there are two groups. One is the group of
2 the regional administrators, and the other is a national branch, which is made up of
3 individuals with expertise in the really a variety of areas working with other parts of the
4 federal government, are legislative affairs, are the Native American affairs, disaster
5 management, emergency management, advisory council management, international.

6 MS. HYDE: So, all of those things are under you?

7 MS. HERRON: They are.

8 MS. HYDE: Do you have anybody helping you do that?

9 MS. HERRON: Everyone sitting at this table helps me. Not at the
10 moment, we also have some vacant positions.

11 MS. HYDE: So you have some positions you're looking for?

12 MS. HERRON: We do.

13 MS. HYDE: So Kana, talking about OPPI, this was something we started
14 or planned or developed or came about a year and a half or so ago, maybe going on two
15 years now. What was the point? There are an awful lot of things in OPPI. What was the
16 point of putting together that office?

17 MS. ENOMOTO: I think when Pam first came she was very bold and
18 aggressive in terms of her desire to outreach to all the staff at SAMHSA. I think it was
19 the first week that we did a walk-around, and shook hands with all 530 people in the
20 building. We went from floor to floor and we scheduled it. Afterwards she said about 30-
21 40 percent of the people told me they work on policy across all of the floors. Everyone
22 says they work on policy. What does that mean? How could that be that everyone on
23 every floor works on policy? I actually don't doubt that everyone on every floor is
24 working on policy. It meant that there's a lot of "policy work" going on.

1 I think it's the blind man and the elephant, people defining policy
2 differently and from their own perspective from their own place. What we came to over
3 time after that experience and realizing that there's lots of work going on in every corner
4 of SAMHSA was that it might be helpful to have an office that focused on certain cross
5 cutting issues as well as certain cross cutting policy functions. We had had the division of
6 policy coordination previously in our Office of Policy Planning and Budget, which Daryl
7 headed before. That had a couple of cross cutting issues in it, really. They focused on
8 some of the ones that Anne just talked about, with the addition of alcohol policy and
9 some HIT.

10 It was more challenging, I think, to kind of harness the energy throughout
11 the agency of who was doing what in the programs on crosscutting issues, some of the
12 crosscutting functions. Now in OPPI, we have three divisions. One is policy innovation.
13 The other - who Chris Carroll is the acting director of. Within that, we have a fantastic
14 branch of folks who are utility infielders. They're policy analysts who work across the
15 different policy topics. That's headed up by Steve Wing. We have a team also in there;
16 it's really our policy think-tank. John O'Brien used to be in there; Larke Huang is in
17 there. OBHE also sits inside of--

18 MS. HYDE: What's OBHE?

19 MS. ENOMOTO: Office of Behavioral Health Equity has its
20 administrative home in OPPI. In policy innovation we have the what should we be doing.
21 These are our advisors who are helping us think through the future of policy around
22 health reform, financing, HIT, behavioral health equity issues, alcohol policy, trauma and
23 justice. We also have advisors who are sitting in other parts of the agencies, so policy
24 innovation has the role of trying to keep track of the future thinking about policy.

1 Regional national policy liaison, they're not generation new policies per
2 se, but what they are doing is help us keep track of all of our partners, both internally, so
3 within SAMHSA. The policy liaison folks are trying to keep track of everything that's
4 going on across-- and then communicating that out to tribes, to the National Guard, to our
5 international partners, our regional partners, folks working on disaster et cetera. Policy
6 liaison has information-in, information-out function as far as policy goes, and they'll
7 have to work closely with communications who has a different way of doing that to the
8 general public.

9 Then we have a Division of Policy Coordination where we have, again,
10 more cross-cutting functions, so our executive secretary, which takes the correspondence
11 we get from the general public from the Office of the Secretary and helps organize that
12 throughout the agency as well as our OMB clearances, Office of Management Budget
13 evaluation clearances, and then very importantly, partner with the office of financial
14 resources. As we formulate our budgets and as we execute our budgets, there is a critical
15 financial component in grants management, contracts management component. There is
16 also an overlay of policy. Once the administrator and the administration have established
17 our policy direction, there is some level of effort to make sure that that policy direction
18 gets infused in the \$3.4 billion worth of activity that we have going on. That is no small
19 feat.

20 While that is certainly the charge of the centers and the staff and the
21 leadership who run the programs, in order to make sure that all the connections are made,
22 and that we are sort of evenly doing things across different programs and taking
23 advantage of the different partnerships and opportunities we have everywhere, the
24 Division of Policy Coordination helps get a common language and a common set of eyes

1 across all the activity to make sure that we're moving our strategic vision ahead as well
2 as we can.

3 MS. HYDE: So I am a little confused. You said a lot of things about
4 listening to Anne and you. It sounds like everything from legislation to international
5 affairs to regional stuff to policy coordination to alcohol-- there's a lot of stuff in there.
6 How comes some of that stuff-- how come alcohol policy isn't in CSAT or pick anything
7 else? How come something else isn't somewhere else?

8 MS. ENOMOTO: Well, alcohol policy is also in CSAT and is also in
9 prevention. Clearly, there are staffs that do that work, but we have 500 people and about
10 half to a third of the funding that CDC has. They have 20 times more people. We are
11 interacting exponentially with so many partners, that I think that we've found that on
12 certain topics, because we get touched by so many other agencies, ONDCP, FDA, others,
13 that it's helpful to have a point person who works across SAMHSA who can have that
14 view both of what's happening in CSAT and CSAP.

15 Other times, we do make the decision to have that leadership, that policy
16 oversight leadership to be, for example, with our strategic initiative leads. In the
17 prevention strategic initiative, Fran does have a role over prescription drugs and that's
18 within CSAP, but obviously prescription drugs have a treatment and a prevention
19 component.

20 While we can do that, other people outside of OPPI have some of those
21 roles. I think all of those people would acknowledge that it's very labor intensive to try to
22 be doing that kind of tracking and dogging and oversight when you have another day job
23 to do with the vertical and the horizontal leadership. People can get kind of maxed out.
24 Some people's job is to go deep, and our job is to go wide.

1 MS. HYDE: So a lot of people think about SAMHSA as primarily, and I
2 think Daryl maybe even said it and it's correct, that a fair amount of SAMHSA's
3 responsibility is to get the money that Congress appropriates and get it out the door.
4 Some of that money stays in SAMHSA. Are there other roles besides grants-making and
5 contract development that SAMHSA really pays attention to and does OPPI have a role
6 there?

7 MS. ENOMOTO: OPPI has a role everywhere. I love OPPI and thank you
8 to the OPPI team that's fantastic, and congratulations to Joan. She's going to love it. It's
9 a great group of people. But enough about OPPI, onto SAMHSA's roles. Our grant and
10 contract making roles are incredibly important and most of the \$3.4 billion that comes
11 our way does go back out by way of grants and contracts. However, we also have many
12 other roles. One is leadership and voice. SAMHSA, without a lot of grants money, has
13 taken certain issues out. I think the trauma informed care is one where, without a lot of
14 money over the years, SAMHSA has invested some of its leadership CHIPS to advance
15 issues around trauma. Now that you see trauma informed care is lots of places.

16 That was without a huge grant program. Same with recovery orientation,
17 consumer and family centered systems, many of these things SAMHSA has advanced
18 without grant programs but by exercising its leadership and voice. We also have
19 regulatory and oversight responsibilities, so workplace programs, opioid treatment,
20 protection and advocacy, SAMHSA plays a critical role in supporting the infrastructure
21 of the nation's treatment systems and prevention systems by serving in that role. Public
22 awareness, we see in our campaigns, recovery month, are obviously very important.

23 We have children's mental health awareness prevention, suicide
24 prevention. In addition, our data surveillance quality people will have an increasing role

1 in quality as we are able to release the National Behavioral Health Quality framework,
2 and practice improvement in our technical assistance. While some of our technical
3 assistance is done through grants and contracts, the ongoing efforts that SAMHSA puts
4 towards practice improvement through our publications and other things that many
5 people, as we got far out into the Pacific, people were talking about the TIPS and TAPS
6 and the materials that they have used from SAMHSA over the years that are very helpful
7 to them.

8 I think as we move into the 2014 budget formulation process, we really
9 need to think about not just the grant-making role, but also these other roles that we have.
10 Even within our grants, we need to broaden our minds and be thoughtful about-- it is not
11 just about supporting the services infrastructure. Three billion dollars or even six billion
12 dollars is not enough to fill the gap of what has been left. If not us, who will support the
13 innovation? Who will develop the practices for new and emerging issues? If not us, who
14 is going to support adaptation of programs to different populations for emerging issues?
15 Who is going to spend the money on the evaluation, the implementation science, and
16 furthering the dissemination?

17 Obviously, the widespread adoption that we would all very much like to
18 see. I think people sometimes get very fixed on how SAMHSA should give grants to
19 communities to do direct services. Those are very important. That's a very important
20 piece of what we do, but how we do it, where we do it, how we do it strategically is also
21 really important. We don't have enough money for our grants to just do one thing. Our
22 grants need to be doing many things at one time. They need to be supporting an
23 innovation. They need to be testing a new idea. They need to be pushing the boundaries
24 of getting people to do something new, different, better, more effective, or less expensive,

1 or with a value's orientation that we believe is important. Otherwise, we're not getting
2 enough out of our money, because we'll never spend our way out of the problem.

3 MS. HYDE: Earlier today, you told us about the four budget
4 appropriations. Three of them are pretty clear: center for mental health services, one
5 substance abuse treatment, one substance abuse prevention. Those seem to go, although
6 you said earlier they didn't line up completely, but those seem to go with the three
7 programmatic centers. Does that mean the fourth appropriation is all under OPPI?

8 MS. ENOMOTO: We should think about that. I don't know, but we
9 should consider that. The fourth appropriation is again cross-cutting so our offices of
10 management technology, the staff salaries go under the fourth appropriation, much of our
11 surveillance comes out of the fourth appropriation through health surveillance. Another
12 big chunk of our surveillance, as Wes will attest to, comes out of the Block Grants set
13 aside.

14 MS. HYDE: So the office of communications, OMTO, Daryl's shop,
15 OFR, and what else? OA, the Office of the Administrator, and OPPI are all under those
16 other things, that fourth appropriation, is that right?

17 MS. ENOMOTO: It's complicated. I'm going to defer to Daryl on that
18 answer. I think it's safe to say that most of our personnel costs are under that shop and
19 many of our cross-cutting activities get funded out of there as well as most of the Office
20 of Communications and CBHSQ.

21 MS. HYDE: So the point of that question was that the fourth appropriation
22 doesn't line up neatly with OPPI and it doesn't line up neatly with anything. It's a lot of
23 different stuff. Now, Wes and Daryl, really, OPPI has created an interesting dynamic,
24 right, for the centers and other offices?

1 DR. CLARK: What do you mean by an interesting dynamic?

2 MS. HYDE: How do the centers relate to OPPI and how does OPPI relate
3 to the centers?

4 DR. CLARK: Well, OPPI has created an interesting dynamic. I see it as a
5 filtration process by which it synthesizes the multiple inputs from the disparate units
6 within the organization so that they can harmonize those inputs with the view of the
7 administrator. That becomes very important.

8 MS. HYDE: That was pretty well stated, actually. He didn't know I was
9 going to ask him that question.

10 DR. CLARK: It is important that we be able to do that. It has introduced a
11 lag time that previously didn't exist. We're trying to negotiate the timeline resolution
12 issue so that we can make that more attritional. I think this is in the first year that this
13 process has been in existence. We're working out the bugs on that, but it's useful to have
14 a mechanism, especially given the horizontal management, vertical management, it's
15 useful to have a mechanism by which we can harmonize these disparate inputs.

16 MS. HYDE: Daryl, you used to have a real policy in your shop and didn't
17 have grants and contracts. Now you have grants and contracts and not the policy stuff.
18 What's with that?

19 MS. KADE: OPPI is a new office and so is Office of Financial Resources.
20 It wasn't putting things together under a roof. It was cognizing what financial resource
21 management is and having that as an underlying umbrella for these various activities.
22 Creating that office has forced me to identify or to ground the mission of OFR within the
23 CFO act and in doing so became a much more effective partner with policy. As we've
24 worked-- in fact, this is what we've been doing all day with Gretchen and myself,

1 working on the grants and contracts in a very collaborative manner because we have
2 everything to add to each other and to share with the different perspectives. Together,
3 we're far more powerful.

4 It happens in budget and now it's happening in grants and contracts. For
5 me, it did require understanding what my role is and what the nature of my partnership is,
6 not only with OPPI and OMTO, but also the relationship with the centers. Since the
7 execution budget is a shared responsibility, yet I am responsible for the apportionments
8 and some things like that and payroll, formulation is also a shared responsibility, so what
9 does that mean? I think someone said it before, I think it was Wes, we talk a lot more. We
10 meet a lot more. A lot of the interactions are more informal. Yes, we back it up with
11 email, but I think we're more of a team. I think that is what's happened.

12 MS. HYDE: Have you met people that you didn't know before in
13 SAMHSA?

14 MS. KADE: Mostly it's a musical.

15 (Laughter)

16 MS. HYDE: Daryl is quite a musician and singer, if you haven't heard her
17 do anything. So Joan, this has got to be clear as mud, and you're about to be head of this
18 thing called OPPI. I know you can't speak as a fed yet, but this is the last time you're not
19 going to speak as one with us. What's your thought about what you can bring to this and
20 what do you look forward to trying to do in the role of OPPI director?

21 MS. ERNEY: Well I had thought that my experience running a very
22 comprehensive program would have been my strongest skill set. I now think it was the
23 crisis intervention work that I did early on that may be really required. No, I think it's
24 really a tremendous opportunity. Truly, I think what I'd like to be able to bring is a

1 collaborative style and a history and hopefully some experience and a pretty broad scope
2 of background. I'm a family member, and I have all kinds of personal experience as well,
3 both on substance use and mental health, so I'd like to be able to bring that passion to the
4 work. It's a great group of people.

5 There's no doubt that I think that what SAMHSA has done is become
6 relevant in a different way. We are, and certainly at the state side, I think we face and
7 continue to face the most interesting time in our history. I date back quite a ways. It's just
8 a tremendous opportunity and tremendous challenge trying to figure out how to put all
9 these pieces together. I think what SAMHSA offers to us and what I want to contribute to
10 is an opportunity to help all the stakeholder community, and particularly state
11 government, be relative locally and be relevant in your own communities and in your
12 own state to make a difference. Some of the work I do now with community care is to
13 work with other states, et cetera, and when you've seen one state, you've seen one state.
14 They're all different. They all bring passion and history and politics to these
15 conversations. I think what SAMHSA offers is a lot of very-- what are the best practices.

16 This notion of actually being able to confirm what works, confirm for the
17 Medicaid director and have some ammunition to go into battle when you're trying to
18 argue for something that is relevant, certified peer-specialist work, recovery specialist,
19 recovery houses, community supports, those sometimes similar to prevention services are
20 considered soft or perhaps not as relevant in a lot of states. SAMHSA can really give the
21 stakeholder community and states a lot of really good, sound information to make good
22 choices. I do think as well that the financial implications in most states are really pretty
23 challenging.

1 I think the Block Grant money, certainly it was true in Pennsylvania, was
2 the most flexible funding I had. It was a way to use it to test things, to try things, to be
3 innovative. I think opportunities to continue to really think about that, your point Anne
4 and Pam about how these are dollars that we should figure out how to leverage, to really
5 create synergy with other dollars. How do you create an Olmstead plan? How do you use
6 Medicaid and supportive housing money and Block Grant money? One of my strengths
7 was putting pieces of money together to make things happen. I think that's our future.
8 There won't be more funds. There isn't going to be more money, so we have to really
9 think through where we get our support for the things that we really need at the end of the
10 day. I hope that's what I can offer.

11 MS. HYDE: We all are obviously really glad that you're here. Part of the
12 reason I spent time asking the rest of the staff about OPPI is that there is no question that
13 it's a new bird, a new piece of SAMHSA, different pieces that come from different
14 things. You've heard a little bit about it. It does everything from track correspondence
15 and get it answered, which has sometimes a really big policy perspective about what are
16 you going to say in that letter, all the way to our regional administrators which are a
17 brand new function we've never had before, to changes in the Block Grant, which
18 frankly, used to be driven primarily out of the programmatic divisions and is still
19 connected there, but is different.

20 This OPPI thing, tribal liaison is in there, disaster response on a Saturday
21 afternoon when there's a shooting in Ohio. The person who gets that call and makes sure
22 everybody knows about it and is on it is in OPPI. That's a pretty tall order. There's no
23 question that kind of change is creating some confusion for lots of folks. Can you say a
24 little bit, and I think I have to say as "Oprah" watching this, that Kana has done a terrific

1 job at sort of organizing it. We sort of threw it together and said, Kana, figure it out. Kana
2 and the rest of the staff have really done a good job of sort of organizing it and getting it
3 logical. There are probably still some issues about roles and confusion and whatever
4 words you want to use. What's your thinking about how you might come to this as the
5 second OPPI director?

6 MS. ERNEY: So I thought that maybe you were doing this to see if I'd
7 actually still sit here and not try to get out of the room. For me, fortunately, I love change.
8 I actually can live in a world of uncertainty. I think that clearly moving into a federal
9 perspective is a really tremendous opportunity to affect good change and make a
10 difference. That's really all of our, I think, ambition. Relative to OPPI and how it could
11 fit in this universe, I think a couple of things. One is, clearly, collaboration with all parts
12 of the organization, both internally and externally, is going to be critical. Trying to
13 understand, you build from strengths, that's all of our background, build from what
14 knowledge base we have.

15 If we're going to be the subject matter experts, if we're going to be the
16 folks who can really assist, then we're all going to have to sing from the same choir and
17 be able to have a perspective that is helpful, and also recognizes that the world is
18 different in each place we may touch. I think it's on us to be flexible and to be able to
19 respond based on what people need as opposed to dictating, and giving information and
20 good outcomes and performance, et cetera. I see the OPPI office as having some kind of
21 wide purview, but being able to really, hopefully, garner all of that expertise and that
22 talent that is here, use the external talent and resources that are available and really try to
23 strive to impact very significantly what's going to happen in 2014 and beyond.

1 MS. HYDE: So Kana, I am going to give you 30 seconds to think about
2 this. I'm going to ask you about roles. We used to have one deputy and now we have two.
3 You have been doing half of the principle deputy role because you've been doing OPPI
4 as well. There are frankly people who have asked this "Oprah", well, who is the new
5 Rick? Is that the principle deputy? Is that the deputy for operations? Is it neither? Is it
6 some of both? Can you say something about these roles?

7 MS. ENOMOTO: Rick is irreplaceable. We'll start there. Well, I think we
8 have divided things up differently. I think it's important to remember that we used to
9 have a deputy, and we also used to have a principal senior advisor, which is also me. We
10 no longer have a principal senior advisor. Nobody ever asks who is the new Kana.

11 MS. HYDE: Who is the new Kana? There is no new Kana.

12 MS. ENOMOTO: I wish there was a new one. I think we have switched
13 things around a little bit so that it's true, there is no new Rick. We've divided up some of
14 the responsibilities in a somewhat new way. I think as principal deputy, I'm sort of a
15 shadow to the administrator. Rick had always said that some people are CEO/COO
16 model, and some people are more president, vice-president or have an alter-ego deputy
17 and then someone else running operations. I think that's more-- we've run to a model
18 where the principal deputy is more of an alter-ego to-- the principal deputy administrator
19 is more of an alter-ego to the administrator, and then the deputy for operations has
20 oversight, reports to the principal deputy and has oversight of the very concrete
21 operational activity.

22 MS. HYDE: So if I am a person sitting in this audience or I'm a person
23 out there in the field and I want to know where to go, when it might have been clear

1 before, do I got to OPPI? Do I go to the centers? Do I go to Daryl? Do I go to you? Do I
2 go to Mirtha? Do I call Pam? Do I call Troyelle(?)? Who do I call?

3 MS. ENOMOTO: Always start with Troyelle. Troyelle is Pam's assistant
4 and she knows everything. I think it depends on the issue. Administrators are open, and it
5 take many contacts from the public from our constituents for more, hopefully, for policy
6 issues you'd be able to go to OPPI, for the grants and contracts, budget issues, it is Daryl,
7 or if it's more overarching, HR, facilities, management, technology type of things, you
8 can go to Mirtha or Elaine Parry. I take all the rest of them.

9 MS. HYDE: So if we wanted expertise about suicide prevention or about
10 opioid treatment, that kind of programmatic content and policies around that might be--

11 MS. ENOMOTO: The centers continue to go strong and carry with them
12 the subject matter expertise and policy expertise that they have always had, which we
13 appreciate.

14 MS. HYDE: Well these folks had no idea what I was going to ask them. I
15 didn't have any sort of idea of what I was going to ask them either. Would you like to ask
16 them any questions about how SAMHSA is weathering change and what we're dealing
17 with and how we're doing it? Yolanda?

18 DR. BRISCOE: So I just wanted to say thank you for explaining all your
19 different roles. You are modeling what we have to do, doing more with less. I appreciate
20 it from my level that the people dispensing the money are also doing the same thing.
21 With understanding comes compassion. I just wanted to say thank you for your hard
22 work. I love my job. You all are doing a lot of work for a lot of people in one position. I
23 just really appreciate it, thank you.

1 MS. HYDE: We love to think about it as doing different with less.
2 Stephanie?

3 MS. LEMELLE: I think this format is really informative. I'm trying to
4 understand SAMHSA over the years and reading it in the finder doesn't really do it
5 justice, but I think this model of having each person talk about what you do and how you
6 interact was really clear today, so I really appreciate that. The one area that I hadn't heard
7 mentioned, and I've spoken with Pam about this before, was the role of the medical
8 director of the psychiatrist as a medical director. I'm wondering how that fits into the new
9 structure or not, and what your thoughts are about where that type of person might fall if
10 that person were to exist?

11 MS. ENOMOTO: We do have a chief medical officer position on the
12 books and it will sit in the Office of Policy, Planning and Innovation. We've been relying
13 very heavily on Dr. Clark and his medical expertise for a full range of issues from sleep
14 apnea to chronic fatigue and everything else that comes under the sun, where they think
15 there might be a tangential behavioral health issue connected to it. Hopefully, we will
16 ultimately have a CMO on board.

17 DR. CLARK: We do have several physicians in CSAT who have been
18 addressing issues like prescription drugs, particular medications. We have both an
19 internist and a psychiatrist in the division of pharmacological therapy who have been
20 doing double duty. It's not that we have been ignoring some of the medical issues
21 associated with behavioral health. We, in fact, have been addressing them. We have a
22 number of clinicians who have the expertise. Once OPPI gets a chief medical officer, that
23 person will have additional ability working with the medical officers that we have in
24 place so that we can accomplish whatever goals are necessary.

1 MS. HYDE: So we actually haven't posted that position, yet. We've
2 interviewed several folks and for lots of reasons haven't found the right fit, yet, but
3 clearly our hope is to get that overall medical leadership. This is as long as I have ever
4 been without that in any job I've had in 35 years. We do rely a lot on Wes or people who
5 have other jobs, but we ask them sometimes. We really would, at some point-- we didn't
6 talk about HR's challenges too much here today, but other things have come first and
7 eventually we'll get that position open. Anybody who knows somebody who might be
8 interested in that and is willing to work in Rockville with the money the federal
9 government can pay, please--

10 MS. ENOMOTO: There's mental health and substance abuse prevention
11 and treatment and federal policy and the actual state and local policy.

12 MS. HYDE: Send them our way. When you find that magic, send them
13 our way.

14 MS. ROTH: Dee Roth, formally of the Department of Mental Health in
15 Ohio. I didn't hear much from the panel about the role of broadly stated inquiry,
16 evaluation, research, knowledge, and development. Is that because that's all in the Office
17 of Statistics and Quality, which I guess we're hearing from tomorrow, or is that
18 embedded in other places? Where do you see that being?

19 MS. HYDE: I think our new director of the Center for Behavioral
20 Statistics and Quality on Monday should answer that question.

21 DR. CLARK: Actually, currently CBHSQ -- we are working again in
22 horizontal and vertical processes. We do work closely with the National Institute of
23 Health and the Agency for Healthcare Quality and Research, and the VA and DOD. A lot
24 of the primary research occurs outside of SAMHSA. It is SAMHSA's role to help

1 synthesize research and work in partnership. For instance, we have a blending initiative
2 with the National Institute of Drug Abuse; we do the Behavioral Health Coordinating
3 Council through DCP's IWIC. We work periodically on key issues of service delivery. I
4 think that serves that purpose because the portfolio, at least the grant-making portfolio is
5 supposed to be synthetic, supposed to be evidence-based.

6 We refer people to the NREP, that's our National Registry of Effective
7 Practices. We refer potential grantees to programs that have been validated by that
8 process. Evaluation is an integral part of what we're doing and CBHSQ is moving toward
9 acquiring a better oversight of the uniform oversight of evaluation. We're also moving
10 toward a common data platform so that we can formulate a good overview of what's
11 going on across the various centers and come up with more comprehensive and more
12 synthetic data across the various centers so that we'll have a better handle on
13 demography, a better handle on epidemiology, and a better handle on outcomes. That is
14 also one of the questions.

15 CMS has charged SAMHSA, as was previously mentioned, what's a good
16 common system? What works? What doesn't work, empirically? We are able to
17 contribute to that analysis. We've been doing that over the past several years. We've
18 done that historically. We use our NREP system and we use our partnership with NIH,
19 FDA, ARC, and CDC and others so that we can achieve that. We don't do bench-level
20 research. We don't do a lot of community-level research. We can say that the research
21 that has been endorsed by the NIH or CDC or ARC needs to be put in place.

22 We can say we want the grantees to use evidence-based practices that have
23 been endorsed by NREP process. CBHSQ will work in concert with CSAP. Well, it does
24 work in concert with CSAP, CSAT, CMHS, so that we can foster that. There are some

1 services oriented in almost research, quasi-research that goes on in each of the three
2 centers, but we don't hold ourselves out as being the primary source of research. We'd
3 like to evaluate the programs that we fund. We like to see whether the outcomes are
4 acceptable. We'd like to see that they're using evidence-based practices that have been
5 endorsed by various processes.

6 MS. HYDE: Let me let the current CBHSQ director if you want to talk
7 about the evaluation stuff and SET real quick? There's a microphone back there. The
8 next question that comes about substance abuse, I'm going to have you take. This is Pete
9 Delany, current head of the Center for Behavioral Health Statistics and Quality.

10 MR. DELANY: So, what we have been doing with the evaluation, one of
11 the directives from OMB and the President's office is really to re-think how everybody is
12 doing evaluation and to move forward to a couple of things. One is that we're using the
13 evaluation more pointedly to really drive programmatic decisions as well as policy
14 decisions using evidence in a different way than we have in the past. The other part of
15 that, too, and there is a corollary is that as we develop the evaluations going forward is
16 that we gather data in a very systematic way that is enough to answer the questions.

17 There has been a history in HHS especially, but across the federal
18 government, where a great deal of data has been gathered that has not been used for the
19 evaluation, but it has been gathered. SAMHSA as part of the data outcome and quality
20 initiative has been moving forward to really re-think evaluation and put it into the next
21 generation. We now have a couple of really cool parts. One is the policy paper is done,
22 and I think we're ready for going forward, but we'll talk to Kana later about that. We
23 have a guidance which includes a SET team, which is a SAMHSA evaluation team,
24 which has representatives from each of the centers and offices who are really working

1 together developing criteria about things like what should be evaluated, when should it be
2 evaluated, and how much should be evaluated.

3 For example, if we have ongoing projects that are pretty much on track
4 and we know what's going on, do we really need to keep evaluating the over and over
5 and over again, getting the same answer, or do we need to focus just on those sections
6 that may have had drift and want to see if they drifted. Also, there are a number of things
7 that really aren't that complex. We really just need to make the assessment. A lot of that
8 can be done through the data gathered through the common data platform that Dr. Clark
9 was just talking about. Then, there is some in between.

10 We're still working on the teams coming up with criteria for when do we
11 evaluate it, how much do we evaluate it, and how long do we evaluate it as well as where
12 does it sit? Some of the evaluations will sit in the centers. Some will be joint projects
13 with the centers and CBHSQ. Some will be CBHSQ directed and managed. Some will
14 be, for example there are some things like the Primary Behavioral Healthcare Integration,
15 whatever those initials are because I'm not really good at them yet, that we may for many
16 myriad of reasons want to have that done by an outside evaluator, that we manage the
17 process but we are not doing the evaluation because we want a little bit more objectivity
18 in the discussion. That's where we are. That guidance should be getting ready to go
19 through ELT clearance.

20 There are a number of things that will happen. Not only will you see all of
21 the designs go up on the web as well as interim reports and final reports, that's another
22 requirement of open.gov. Our findings will all go up on the web. We're also working on
23 a new set of confidentiality agreements that will allow us to create warehoused evaluation
24 data sets so that people can replicate our results. We have to do that very carefully

1 because, as you know, in certain situations, we have to be able to de-identify programs
2 because at some levels, you can take a couple of pieces of off the shelf software and tell
3 who everybody is in the program. Those are some of the things that we're working on
4 with our human subjects expert as well as our confidentiality expert.

5 MS. HYDE: So there is a lot shifting about this as well, taking a different
6 kind of look and a more comprehensive look at evaluation. Trying to figure out, Pete said
7 it, but we do have programs that have been being evaluated for 20 years. The question is
8 whether or not that's the best use of resources since the resources are declining.

9 MR. DELANY: Another part of the realignment or reorganization is that
10 we do have a service analytic component now. As we build up that unit, we will be able
11 to do some services related research, mostly secondary but also some primary working
12 with our colleagues at NIH. We are starting to develop those capacities as soon as we
13 staff up.

14 MR. COUTY: Just to follow up on some of the comments that were made
15 talking about how SAMHSA should be the expert within the areas because we look at
16 prevention, we look at mental health, we look at substance abuse, you are the expertise
17 within those areas. You're talking about the budget, the declining budget, and having to
18 put out falling over a three-year period looking at the '12, '13, '14. In doing so, and I
19 know that in the past we were also trying to work with other departments and when
20 you're looking at putting out best practices, how are you also still able to influence DOC,
21 the DOJ, the OJJDP, the CMS, and the child welfare, and the Department of Elementary
22 and Secondary Education? There is still funding going out there and, especially when
23 you're hitting areas of mental health issues, co-occurring issues, substance abuse issues,
24 how is that being influenced in making sure that we're getting evidence-based practices

1 out there or getting the best practices with the most qualified personnel actually
2 delivering the services? There is so much happening.

3 MS. HYDE: Joan, you're going to take this one.

4 MS. ERNEY: Well, I'm an unofficial federal worker, but however, what I
5 think SAMHSA can offer are state behavioral health leaders, the tools they need to
6 influence those other agencies. In some states, there really is an existing relationship or
7 an infrastructure where there could be some parts of that. It's really how do you give
8 folks the tools they need to actually be able to go into a department of corrections
9 meeting and say, if you do "x", such as a mental health court or do something on the back
10 end where we could really try to impact re-offenses, et cetera, that there is a way to
11 influence it and here is the evidence that we have that really supports that. I do think that
12 it is an effort, but each state really is fundamentally different about how those
13 relationships might work. I think it's the tools that we could offer.

14 MR. COUTY: I am seeing it from a funding source, not from a state
15 source, so you've got the various departments, such as the Department of Justice, OJJDP,
16 actually coming out with those funding streams across the--

17 DR. CLARK: We work in concert with the Department of Justice and
18 ACF, et cetera. We have joint projects. We have multiple meetings. We co-fund in terms
19 of, for instance, with drug courts, they may fund the infrastructure and we fund the
20 behavioral health services associated with that. Especially with this administration there
21 is no shortage of collaboration. As a result of that, I don't think that is a critical issue;
22 they also have different jurisdictional imperatives, so the multiple meetings help serve to
23 recognize the various boundaries. When you deal with corrections, safety is one of their
24 principle objectives and so we have to negotiate best practices with their imperative.

1 Ours is a public health imperative, theirs is a safety imperative. They
2 recognize the importance of public health and we have to recognize the importance of
3 safety, so we negotiate that. We have some joint projects that we're co-funding, and the
4 same thing with ACF, et cetera. The collaboration at the federal level and when you
5 convene, you also bring in state, tribal, and local leaders to help figure out what is the
6 best approach. Our staff is working with that. OPPI has helped serve that purpose both at
7 the center level, we participate in that discussion. For instance, for adolescents, we have a
8 JAMI(?) meeting.

9 We're bringing people together so that they can talk about what's the best
10 approach for adolescent care involved with the juvenile justice system. You have the
11 OJJDP, you've got SAMHSA, you've got NIH so that, indeed, we're on the same page
12 even though we may have different paragraphs and then sometimes we have an
13 integrative paragraph depending upon how we see things. We also have to respond to the
14 dictates of the budget process.

15 The administration wants integration where it's feasible, and then we may
16 have to recognize that Congress has some goals and objectives. We work with Congress.
17 We work with cities, counties and tribes, and we also work with non-profit, the NGOs,
18 the trade organizations that have an interest in the calculus.

19 This is not about SAMHSA going off doing it by itself. I think the
20 Department of Justice has the same view. They're not trying to do it by themselves. We
21 recognize with limited resources that it's important to collaborate, and OPPI, under
22 Kana's leadership, and clearly, Joan brings the integrative approach from the state, she
23 will be doing the same thing, help to facilitate those conversations both at the staff level

1 and at the policy level. Anne has met with the various leaders of the Department of
2 Justice, meets with them.

3 There is a re-entry council for using re-entry, since you've invoked the
4 Criminal Justice issue, which meets periodically. She's been party to that, advising the
5 secretary about the various issues because the re-entry council has secretarial levels.
6 There's a lot of discussion and a lot of hammering out, and then there is some
7 collaboration in the execution of a specific grant portfolio.

8 MS. KADE: I think we have to be cautious though from the CFO point of
9 view. You need to be able to work within your authority, not outside of the authorities.
10 We have programs that have rated funding within SAMHSA and outside of SAMHSA.
11 We could have pooled funding, but that is also a challenge, so that when we're talking
12 about cross-collaborations, it is important to understand what the rules of engagement are
13 in terms of collaboration and working within statutory restrictions. There are some
14 programs that are more lenient. There are other programs that are not. We actually cannot
15 provide technical assistance to other departments or agency grantees, but we find creative
16 ways of providing technical assistance to the field. I caution that to the extent that we are
17 trying to leverage funds and leverage funds across the department and across
18 departments, we are bound by some of our statutory restrictions.

19 MS. ENOMOTO: That being said, I think it used to be a few years ago
20 where we'd have a lot of our advisory committee members as well as other stakeholders
21 come in and say, why isn't SAMHSA at this table? Do you know so and so is doing this
22 and you're not there? That happened quite a bit and we were sort of that whiny child,
23 they're always doing this without us. I think one of the many things that Pam has brought

1 to us is a tremendous leadership with her peers and her bosses about how relevant
2 behavioral health is almost everywhere.

3 We've gotten now to the point where I think behavioral health, mental
4 health, substance abuse is at a tipping point. People are really getting it, how relevant we
5 are. You have the director of CDC emailing a document to Pam saying, just a head's up,
6 CDC is going to issue this. That never happened ever before in 100 years before. That's
7 happening now. We have CMS on speed dial. It's to the point where the demand for our
8 expertise and our participation is outstripping our capacity to be at every single table
9 where behavioral health is relevant. It is, it's DOD, it's Labor, and it's Justice. We're
10 doing this Juvenile Justice Policy Academy together.

11 It's everywhere. It's education. We are in those conversations, and people
12 are inviting us. They're seeking that expertise from us. This is why Pam was asking
13 what's that question about. What are we going to do to boost up our capacity to
14 participate meaningfully in all those tables? It's not just about spending money, although
15 sometimes it is. We have also, we can't get into all the drips and drabs, but we are
16 making very strategic investments, where, for that little bit of money, we get to play in a
17 much bigger sandbox. We're doing that quite a bit, but to enumerate all of our
18 partnerships really would take us all day because our staff has been excellent about
19 pursuing that.

20 MS. HYDE: Actually one example we didn't mention this morning, we
21 are actually providing some dollars to the Department of Education to do their technical
22 assistance center to the schools. We're providing a piece of that. Rather than create our
23 own TA center, we are helping them support theirs so theirs can be more able, within our
24 authority. Did you want to follow up?

1 MR. COUTY: Not always was I inquiring that we had to put money out,
2 but that we would influence through policy and whatever. I know we have been talking
3 about that for many, many years. I just wanted to know where we were at this point,
4 because, yes, we would always say that we were not at the table. I'm glad to hear that we
5 are now, that you're getting information ahead of time, head's ups, and things of that
6 nature, where it should become second nature that they're sending you information,
7 getting your expertise from the various centers just to make sure that there are no issues
8 that might come across as it hits the field.

9 MS. HYDE: I think the summary answer to that is that we are clearly
10 getting asked to the table. We're getting asked to the table more than we can actually
11 respond. Frankly, sometimes we're still not getting asked to the table. It's like, duh, why
12 are they asking these seven people when SAMHSA is the one doing the program? We
13 still have a little of that, too. There is a little of all of that, and we're working on it.

14 MR. FRIEDMAN: As a stake holder I have very high expectations for you
15 all, and I love hearing what you're doing, but I guess I have to think also of alternatives,
16 and just thinking of our discussion so far today, for example, Pam, I think that your
17 introduction of Larke, that US 3 hatch(?) is the head of the Office of Behavioral Health
18 Equities, and children and youth and families coordinator, trauma -- each of which could
19 be a full-time-- I think of the suggestion that was made about an Office of School Mental
20 Health.

21 I personally would love to see much more invested in just knowledge
22 development, learning lessons from what you all have done already. Yet, you all have
23 taken a course that sounds reasonable. You've created ten regional administrators.
24 You've created a large OPPI operation. There have been and there are potentially other

1 alternatives that could be done. I guess my question is an evaluation question of a
2 different sort.

3 Now that you have taken these steps and you have done this, how are you
4 going to get input from outside stakeholders and how are you, maybe even important,
5 internally going to take a look at operations? You just mentioned, Pam, there are tables
6 you're not getting invited to. How are you going to take a look and assess internally how
7 well are we doing? Is this working? How do we need to adapt or change or modify what
8 we're doing?

9 MS. HYDE: It is a great question. I'll say a word or two, but if somebody
10 else wants to jump in. Anne, maybe you want to jump in because of the regional
11 administrators. You've heard already in three months the kind of reaction we're getting
12 from that. Most of the functions and people, not all of them, but most of the functions and
13 people in OPPI already existed, they just existed in a bunch of different places that
14 weren't very coordinated. A lot of those people have-- three new FTEs out of all of that,
15 not counting the ten, not counting the regional administrators-- so that's not a lot of extra
16 people. It is reorganizing and refocusing and redirecting efforts.

17 On the other hand, the ten regional administrators was a very explicit,
18 thoughtful decision to put the dollars and resources there. We didn't get any dollars for
19 that. We had to figure out where to get that. Because of the work that was going on across
20 agencies, sort of like what Mike was talking about, although the key agencies that are out
21 there in the regions are CMS, which of course is Medicaid, and ACF, which of course all
22 the children and family stuff and child welfare and a ton of stuff we're doing with them,
23 and HRSA, which is of course the workforce and other big issues.

1 There are other folks out there, but those are the three big ones. We were
2 doing a lot of relationship here, but a lot of their decisions get made out there. We were
3 also struggling with how to just stay in touch with the field and make sure that as the
4 states have more and more of a role over the next couple of years and the decisions that
5 are getting made about everything, health reform and otherwise, that being able to be
6 closer to the states was important and then, obviously, also closer to the communities, the
7 tribes and others. Tribal consultations, you can name a billion things where getting out
8 there is getting difficult.

9 We made a very conscious decision that that was a good and right thing to
10 do and a good way to use resources. We did that, frankly, with some of our colleagues.
11 The assistant secretary for health and CMS and the regional directors that are out there
12 from the other agencies were begging, literally begging for behavioral health help
13 because it was coming at them in a deluge. We made it that decision. They've only been
14 on board three months or so, and you've had your first meeting where they've come back
15 to SAMHSA to talk a little bit about their experience in the first three months.

16 Anne and I had an opportunity at the dinner with NASMHPD and
17 NASADAD, both of whom are saying, oh my God, the amount of information we get, the
18 amount of connection we feel, the amount of ability to really move the bar out there is
19 huge, even after three months. What do you think regional administrators are telling?

20 MS. HERRON: Just to add to that, we've also made a really conscious
21 decision of checking in with our stakeholders about how is this working. You mentioned
22 NASADAD and NASMHPD, but also with the other federal agencies and their regional
23 coordinators, is how are we working with you? How are you working with us? We're
24 invited to regular meetings in the regions about what is going on in those regions. We've

1 had an opportunity that has been, to me, unprecedented. In the first six weeks of the
2 regional administrators' presence in the regions, the ten of them made over 200
3 presentations on substance abuse, mental health, prevention, behavioral health, and
4 SAMHSA.

5 It's an incredible thirst for information. I think, perhaps, if I'm reading
6 into your question, is so what, is that going to make a difference? That's one of the things
7 I think we are absolutely committed to continuing to check in with people to make sure
8 that we're having an impact and we're a value-add, and internally as well, not just
9 externally.

10 MS. HYDE: Granted, it's been three months, but one of the things that
11 they're telling us is that the folks don't even know what SAMHSA is, the acronym,
12 what's that? Spell out the acronym. When you tell them it's Substance Abuse and Mental
13 Health, they're saying, oh my God, we need your help. We need your help with models.
14 We need your help with service issues. We need your help with grant connects. We need
15 your help with all kinds of stuff. Clearly, there's a thirst for it. We've clearly touched the
16 right vein in that regard.

17 I probably think the most telling thing is that we wouldn't have been able
18 to do what Iowa has been able to do had we not done the two years of work before we put
19 them out there, which is that they were having a little trouble getting CMS directors to
20 pay attention to them. With one email here with my colleague, we were able to get a
21 meeting with the CMS directors out there. They are the ones making the decisions or at
22 least reviewing the applications of every state's Medicaid agency that goes into the
23 federal government. To have somebody sitting there, where somebody can walk down the
24 hall and say, Carl Rudd has proposed this thing about behavioral health. What do you

1 think? Or something like that, because that's what is going to happen. So far, we think
2 that that is a pretty good investment.

3 MR. FRIEDMAN: So you can gather some of those tangible outcomes,
4 such as just--

5 MS. HYDE: They are anecdotal at this point. I think there's no question--

6 MR. FRIEDMAN: That doesn't mean that they're not valuable in
7 addition. I just, it's tough choices because there's so much work to be done and so few
8 resources. I know that you all invest a lot of energy and resources into strategic initiatives
9 and in most cases the person who is in charge of strategic initiatives wears another hat or
10 two or three other hats in addition. My question is not-- I think it's great to have all of
11 these positions, it's just when one has to make tough choices, how does one measure or
12 look at on a regular basis, have we made the right choices? Do we need to adapt? Do we
13 need to change?

14 MS. HYDE: Those are very good questions that I think we ask ourselves
15 all the time, but whether or not we're getting all the right input is a good question. Maybe
16 it's something we should put to all the advisory committees, a common question about do
17 you see certain differences being made by certain things? Thank you for that idea. It
18 might be something that we come back at you with, because you're our advisors telling
19 us what you see out there.

20 DR. MCFARLANE: My question has to do with a little bit of the future.
21 We've heard recently that there are two million more people insured as a result of the
22 ACA than there were before. If you look a little closer, that's almost entirely young
23 people being insured by their parents' insurance.

1 MS. HYDE: They're very clear about that. It's two and half million kids
2 up to the age of 26 that are covered--

3 DR. MCFARLANE: That's tremendous progress, but that actually is a big
4 hint for SAMHSA, which is for the entire history of public psychiatry in the United
5 States, it's been focused initially on state providers, then county providers, then some
6 degree of state, local, and-- what the future suggests is that the new provider group under
7 ACA will be almost entirely in the private sector, insured privately. I don't think any
8 federal agency has ever really faced up to that.

9 In terms of policy, I would suspect some of those insurance companies are
10 going to start to get very interested in the same kinds of questions that SAMHSA has
11 always tried to answer for the public sector. The question is, what would SAMHSA do to
12 prepare for that? It would suggest that a lot of the policy issues would have to do with
13 what are we going to tell the insurance companies if they ask, and what are we going to
14 tell them if they don't ask?

15 MS. HYDE: It is a great question for the next session, because we're
16 going to talk about healthcare and we're going to talk about what we're doing in all of
17 those arenas, both more about Medicaid, more about Medicare, and more about private
18 insurance. If you don't mind, if you'd hold that question, bring it again. Any other
19 comments about SAMHSA's stuff, things we're doing and struggling with and trying to
20 think about SAMHSA's role? I have been very clear, probably to the chagrin of the staff,
21 but I have been very clear that there is a vision for SAMHSA in addition to a vision for
22 behavioral health in the field that we are trying to implement, and that is for SAMHSA to
23 be a different kind of entity.

1 Change is hard. I wouldn't even begin to say I have been the clearest
2 about it. I am clear that SAMHSA needs to be different, and it needs to take the
3 leadership it has and live it large, if I can say it that way. We need to be much bigger
4 voiced. We need to be yelling and screaming for all of behavioral health out there. We
5 need to be that champion, not alone, but perhaps the spearhead in some cases, or the good
6 follower. You all are the ones pushing that out there, but nevertheless, we're trying to
7 make that shift, and I really just wanted to give you a flavor of the good people that we
8 have and the good leadership and also some of the struggle that it is to make these kinds
9 of changes, especially in a bureaucracy that, by definition, doesn't want to move.

10 It's part of our job to move it, but it moves slowly. Sometimes it looks like
11 that ice thing coming at the Titanic as well. Any final comments? Kana and I have
12 dueling analogies, but hers are always better, so I steal them often. That's not hers. That
13 one is mine. Any final comments from any of the panel here? Anything else you guys
14 want to say?

15 MR. MONTGOMERY: I haven't heard very much discussion about
16 HIV/AIDS and where it falls into SAMHSA these days, and I'm a little confused about
17 the direction things are going with your HIV/AIDS portfolio.

18 MS. HYDE: Have you had a chance to meet Gretchen, yet? Briefly? You
19 are on here because you have that HIV/AIDS background, so Wes do you want to talk
20 about that a little bit? It's in all three of the programmatic centers, but Wes can talk about
21 it a little bit.

22 DR. CLARK: We have got a fairly large HIV portfolio. The investment
23 has been on testing and making sure that we deal with substance abuse services and
24 mental health services and prevention services around HIV/AIDS. We work very closely

1 with CDC, the last initiative was linked with the Twelve Cities effort and we continue to
2 be interested in that. We want to prioritize our funding to those who are in need. We
3 work with the CDC very closely. As was mentioned, you mentioned yesterday, we had
4 one brief, shining moment where we dealt with needle exchange, but we got permission
5 to do needle exchange for about nine months, and that was taken away.

6 MS. HYDE: Congress made a different decision.

7 DR. CLARK: Congress made a change. They changed their mind. They
8 made up their mind; they changed their mind. We work very closely with the department,
9 very closely with CDC, and the effort is to forge active lines of collaboration,
10 coordination, and non-duplication of effort. Our expertise is the mental health and the
11 substance abuse prevention and treatment services associated with HIV. It is a corner
12 stone of our efforts, a major component of what it is that we do in the larger agenda. In
13 fact, we collect data on risk factors associated with the use of substances.

14 At the Center for Substance Abuse Treatment, we make sure that all our
15 grant portfolio address the issue of this factor as we look at sharing needles and having
16 unprotected sex, then we're trying to promote education across the portfolio. We also
17 recognize in our homeless portfolio that HIV/AIDS is an issue for the homeless portfolio,
18 so across the portfolio that is across the centers. We recognize the importance of that.
19 Then we work with Ryan White, various teams. The teams meet collectively in concert so
20 it's not CSAT by itself, or CSAP by itself, or CMHS by itself. Plus, OPPI, as was
21 mentioned, Gretchen plays a leadership role in facilitating that. We have providers in the
22 community, and our grand portfolio is a wide variety from Street Works in Nashville to
23 faith-based organizations, to traditional organizations. We prioritize the full spectrum of

1 individuals at risk, of women, African-Americans, Hispanics, Asians, Native Americans,
2 LGBT, youth, et cetera, et cetera.

3 We recognize it's a complex issue and it's both vertical and horizontal. As
4 Pam pointed out, we have not retreated from our investment. Of course, it all turns on
5 what the Congress does, but the administration hasn't retreated. In fact, we're now, in
6 2013, we're trying to bolster the mental health aspect of our HIV portfolio by shipping
7 some of the treatment dollars to mental health dollars. Again, the objective is non-
8 duplication of services. We don't want to duplicate what Ryan White is doing. We want
9 to augment, facilitate, and assist.

10 The question is, other than testing, we really foster, from the prevention
11 point of view, know your status, test people, facilitate rapid testing, work with CDC, look
12 at viral loads, looking at test results, and involving people at the community level. I
13 mentioned Street Works in Nashville. I was just at a meeting on homelessness and HIV
14 was integral part of that whole discussion about homelessness, in fact, we had one person
15 speak who was HIV positive, and she was telling her story and her quest and the saga that
16 she lead in her life. The key issue is that, for this meeting, we didn't have an opportunity
17 to go over all of the slower line activities, but we want to make it clear that the leadership
18 is both vertical and horizontal.

19 It is an essential part of what it is that we do. It is an inescapable part of
20 what we do. Our division of pharmacologic therapies, we link Hepatitis also with HIV, so
21 we haven't forgotten the Hepatitis. Gretchen can talk about the additional funds from the
22 traditional portfolio to look at other activities like Hepatitis screening and medications
23 associated with hepatitis, making sure that that's a priority and making sure that across
24 the various slower lines we deal with the issue of HIV in an integrated fashion.

1 MS. HYDE: I think on the discretionary side, it is the single biggest
2 program area, if you had all the line items on the discretionary side, so not counting our
3 block grants.

4 DR. CLARK: It's about 120 million.

5 MS. HYDE: It is our single-- and then there's money out of the Block
6 Grants as well that goes to it. You put those two things together and it's about 175-178
7 million. It's gotten reduced less than some of the other things, just in part because of the
8 major commitment from the Secretary and the White House about it. We have tons more
9 to do. We can talk more about that at some other time perhaps. All right I am going to let
10 us have a break. Thank you for the good questions and for listening. We have two major
11 things left to do. One is to talk about health reform and where we are with that, and the
12 other is to hear a little public comment. We'll be back here-- it's 3:20-- how about 25
13 until? So fifteen minutes, 25 until we'll get started again. Thank you panel.

14 (Break)

15

16 ***Agenda Item: Update: Health Reform***

17 MS. HYDE: We actually have a gym on site. Sabrina is the person that
18 kind of runs the gym. She would have come down here and done this with us, but I guess
19 she is out today. So what we are going to do for the next little bit is I am going to talk to
20 you a little bit about where we are with health reform. If John were still here, he would
21 have done this, but he is not so I am going to try to do it.

22 I want to take us from the really high level and remind you what health
23 reform is all about. I know that sounds funny, but sometimes it is helpful to go back and
24 look at everything that is in health reform. I am going to do that at a hugely high level.

1 Then I am going to go through some of the work that we have been doing in the
2 behavioral health arena about this. I can tell you right now there is more information on
3 these slides than I am going to spend doing.

4 I am going to sort of show you some of this and move on. If we decide at
5 the end that you would like a copy of these slides for more detail, we will give them to
6 you. Nevertheless, I want to just try to, again, stimulate you with all of the things we are
7 working on or at least as much as we can in a few short minutes and then have you ask
8 some questions. We will start with Dylan -- his question.

9 Let's see if this works. The Affordable Care Act, do you remember what
10 it does? It does several things. All of the stuff that is going on in the Supreme Court
11 right now -- those are just a few of the many things that the law does. It protects from
12 insurance company abuses. It makes health care more affordable. It gets better access to
13 care for people. It strengthens Medicare. I am going to talk to you about each one of
14 those really quickly.

15 In terms of holding insurance companies accountable, there is no more
16 denial of coverage for children's pre-existing conditions. Kids who have behavioral
17 health issues or other kinds of things can't be denied coverage for pre-existing conditions
18 anymore. There is no more lifetime caps on how much insurance companies can pay for
19 an insured. That is also important for our population sometimes. Insurance companies
20 can't cancel coverage anymore when a person gets sick by sort of finding some problem
21 on their paperwork, which is something they did quite a bit. They can't do that anymore.

22 It also makes healthcare more affordable. Before the Affordable Care Act,
23 there was sort of a 60/40 practice of kind of on average or there were lots of insurance
24 companies that only spent about 60 percent of your premium on coverage or on care.

1 The other 40 percent was spent on administration or profit or other kinds of stuff. There
2 is now an 80/20 rule. There are a few exceptions to those rules, but for the most part,
3 companies have to spend at least 80 percent of the premium on actual care. If they don't,
4 they have to pay the money back.

5 There is also a requirement now that there is public justification for rate
6 increases above 10 percent. All of these 20 percent increases and 30 percent increases --
7 they can't do that anymore just by pronouncement. They actually have to justify why
8 they need it if it is above 10 percent. In certain circumstances, state can stop it if they
9 think it's unreasonable. In fact, if state's say they don't have a way to do that, the federal
10 government can stop it and the federal government has, in fact, held some of those rate
11 increases unreasonable.

12 There are also small business tax credits to help pay for coverage. Small
13 businesses are getting some help in paying for that. That is to try to keep people on
14 employment insurance that they already have.

15 There is also better access to care. This is the issue that Bill raised.
16 Young adults under the age of 26 can now stay on their parents' health plan. There are
17 about 2.5 million young people, who are insured now because of that part of the
18 Affordable Care Act.

19 There are also a significant number of preventive services that are free
20 now, including screening for depression and tobacco-cessation counseling, also
21 mammograms, birth control, blood pressure, cholesterol, vaccinations. There are lots of
22 preventive services that are free.

23 There is also new Affordable Plans in every state for adults with pre-
24 existing conditions. In some cases, there were states that had that already. There is now

1 a plan, however, that is nationwide and is operating in every state for adults that have pre-
2 existing conditions. Eventually, even adults with pre-existing conditions won't be
3 allowed to be discriminated against.

4 There are also thousands of new primary care docs and nurses that are
5 being invested in getting into the system and lots of prevention and quality strategies. I
6 will talk more about that in a minute. Behavioral health is a part of both of those --
7 prevention and quality strategies.

8 The health reform law, Affordable Care Act, also strengthens Medicare. It
9 provides for Medicare recipients and beneficiaries free preventive services such as
10 mammograms and colonoscopies and a free annual wellness visit. There, again, are some
11 screenings in that, that are of relevance to us. There is a 50 percent discount on covered
12 brand name medications for those people who are on Medicare that are in the donut hole.
13 I presume most of you know what that means. That averages out to be a savings of about
14 \$600 per person in 2011. By 2020, the donut hole will be completely closed.

15 There are also some strong anti-fraud measures, which is important
16 because that is frankly paying for a lot of the costs of additional coverage and subsidies
17 and such. Doctors are also being arranged differently in accountable care organizations
18 and other ways to try to allow them to have more time to spend with patients and pay
19 more attention to the outcomes of care and care coordination.

20 That is generally what the law does already. Think about this when people
21 say they want to undo or get rid of or eliminate the law. They want to eliminate all of
22 those things? Actually, no, most people do not want to eliminate all of those things.
23 Really, the thing most people don't like is the personal responsibility requirement. I will
24 say more about that in a minute.

1 In two years, by 2014, it will become impossible or illegal to discriminate
2 against anybody for a pre-existing condition, including adults. Insurance companies
3 won't be able to charge more for women than for men, which they kind of sort of do now.
4 Tax credits will make buying insurance more affordable and some subsidies will be in
5 place for people at certain poverty levels.

6 There are going to be new state-based market places. You have heard
7 about these and I will say more about them in a little bit -- insurance exchanges. Private
8 insurers will compete for insurance business. Most people don't know or don't
9 remember that members of Congress are going to get their coverage there, as well.

10 Medicaid expansion for those under 133 percent of FPL -- right now, in
11 most states, you have to have a kid in the home or you have to be disabled in order to get
12 Medicaid. That won't be true after 2014. A single adult or anybody else who is under
13 133 percent of the Federal Poverty Level will be covered by Medicaid. That is a major
14 expansion.

15 There will be a requirement of personal responsibility for obtaining
16 coverage, but what they don't say on the newspapers and the radio is that if you cannot
17 afford it there will be subsidies. There are significant subsidies for people at different
18 levels. Above 133 percent of the Federal Poverty Level, there will be subsidies and help
19 in doing that, including through the exchanges.

20 That is the big picture. I wanted to just kind of put that out there. The law
21 is very complex. There is a lot that has already happened in the law. It is not like it is all
22 going to happen in 2014. There is also still a lot coming, not only in 2014, but all the
23 way up through 2018. We have been frantically trying to get ready as well as frantically

1 trying to be part of the conversations where the regulations have gone into place for the
2 things that have already happened.

3 I am going to move now to behavioral health. The uninsured populations
4 that we know exist out there right now have a disproportionate rate of behavioral health
5 conditions. I will show you some data about that in a minute. There are lots of reasons
6 from the symptoms to their income to their housing volatility -- lots of reasons why they
7 are particularly challenged for accessing and maintaining coverage.

8 Sometimes we call that the churn. There is lots of churn in the system for
9 lots of people, but people with behavioral health needs are particularly susceptible to that
10 churn and particularly disproportionately uninsured. Behavioral health providers have a
11 very varied billing experience and a limited enrollment experience in some cases. I will
12 talk more about what we are doing about that.

13 Then there are the traditional outreach workers, the people who are really
14 sort of charged with doing outreach for enrollment, who don't typically have a lot of
15 training on behavioral health conditions. It is sort of a connection that is set up to fail for
16 our populations.

17 Here is some prevalence data. I am not going to spend a lot of time on it.
18 Basically, of the 20 million people who have incomes between 133 and 400 percent of
19 FPL, about somewhere between four and six million have either serious mental illness or
20 a substance use disorder or a serious psychological distress. There are different numbers
21 and different issues there.

22 Among the Medicaid population or the Medicaid expansion population,
23 which are those people who are not currently eligible and 139 percent of FPL, there are
24 also about 18 million there and somewhere between four and six million of those are

1 equally in our populations. The percent with serious mental illness, the percent with
2 serious psychological distress, and the percent with substance use disorder, there is some
3 overlap in those populations.

4 Two years later, meaning 2012 -- it was passed a couple years ago and its
5 birthday was last week -- two years later, where is behavioral health? These are some of
6 the things that we have managed to accomplish. I would venture to say that SAMHSA
7 has been front and center in helping to make every one of these happen.

8 That is that mental health disorders are one of the ten service categories
9 for essential health benefits. That was actually in the law, but some of us where we were
10 sitting when the law was passing were actually trying to make some of that happen.
11 Essential health benefits are also at parity. I will come back and say more about that in a
12 minute. Mental and substance use disorder providers are highlighted in exchange
13 regulations. I will say more about that.

14 We now have 64 primary behavioral health care -- that number may have
15 changed a little bit -- integration sites. We also have a bi-direction of a TA center with
16 HRSA. It is a jointly funded center. There are over 15 state health home consultations
17 that we have done because the law requires that state who want to do a health home
18 having to do with mental and substance use disorders have to consult with SAMHSA.

19 There is a National Prevention Strategy. We are two of the seven major
20 priorities in that. There is home and community based service opportunities, which have
21 been expanded. There are some regs coming about that. That will have some good
22 implications for behavioral health. The National Behavioral Health Quality Framework,
23 which SAMHSA has actually done -- Pete and his shop have been the lead on that -- that
24 is actually part of or flows from the National Quality Strategy. You have heard us talk

1 about this before. I will come back and talk about where we are working on it now. That
2 was actually named in the report to Congress as the only OPDIV that has taken the next
3 step on that. We are getting a lot of credit for that.

4 You have heard us talk about tons and tons of collaboration with federal
5 partners, whether it is HRSA or CMS or AHRQ or any number of others that are working
6 in this area -- ONC, which does the electronic health records standards, et cetera.

7 We have done a lot in two years. Our focus over the last two years -- you
8 have heard us talk about this. Again, this is very high level. We have done Good and
9 Modern Services identification. We have revised the block grant application and really
10 try to get states thinking about getting ready for 2014 differently. We have done
11 consistent regulation review. For the first time, I believe, every regulation now that
12 comes through CMS is coming through SAMHSA for clearance. That didn't used to be
13 the case.

14 Stakeholder outreach has been another major issue that we have been
15 working on. We have also done tons and tons of technical assistance with states and
16 providers, webinars, and actually consumers and people in recovery and family agencies
17 as well. We have been part of the discussions around the National Prevention Strategy
18 and are part of that, as I said earlier. We have developed the first cut at the National
19 Behavioral Health Quality Framework and we are working on measures now. I will get
20 back to that in a second.

21 Our focus for the next two years is to do -- you have heard us talk about
22 some of this -- to do the Service Definition work that is being led by some other players,
23 but we are actively involved in that and assessing the evidence base is a part of our role
24 for some of the key behavioral health services. We are doing training on essential health

1 benefits. We are doing some work around network adequacy and the exchange rule. I
2 am going to come back to a lot of these.

3 We are working on enrollment and eligibility. We are working on more
4 technical assistance for states. We are doing a provider business operations effort to
5 make sure that our providers are ready. We are working, as Anne said earlier, on the
6 2014-2015 block grant application, doing lots of work on parity outreach and
7 communication. We are developing quality measures and doing lots of work around
8 recovery support with peers and navigators and others.

9 That is about seven years of work of about 200 people. That is what we
10 are focused on for the next two years. I did that really fast. You will get a flavor for the
11 breadth of what we are trying to touch on.

12 Service definitions and assessing the evidence base -- here is where I start
13 mentioning these things and not going through every single bullet or we would be here all
14 afternoon. I have talked about this one so I don't think I will go too much more into it.
15 Miriam is leading on some of this and others in our staff. Kevin and Steven are in the
16 back. They do a lot of this work, not all of it, but a lot of it. They are here. You can ask
17 them additional questions that I don't know how to answer.

18 Essential health benefits -- the Essential Health Benefits Bulletin came out
19 not too long ago. It was released in December of 2011. There are two things in the
20 statute that the bulletin is sort of based on. One is that a typical employer plan, which is
21 in the law, it has to be based on and no discrimination by age, disability, or lifespan.

22 The Bulletin, when it came out, had ways that that would -- basically, the
23 Bulletin was signaling what HHS was expecting to do in its reg about this and was
24 seeking input in some areas. If you are interested in where those are, they are one these

1 slides. You can find them. If anybody wants these slides, we will figure out sending
2 them out to you later.

3 What was important about the Essential Health Benefits Bulletin is the
4 way it was described. It is very clear that parity has to exist not only in the essential
5 health benefits in the exchanges, but also in the other plans that are offered in the state
6 outside of that in order to be a part of this process.

7 The next six months are really critical in assisting states and a group we
8 call CCHIO. It is a center within CMS, who review coverage options for the essential
9 health benefits. We are beginning to develop the process to monitor the coverage of
10 benefits and access to benefits and MHPAEA, which is the parity law, and other parity
11 issues that impact this. We are continuing that work around assessing the evidence on
12 services and which ones we want to make sure get in these things.

13 Essential health benefits by and large are not going to be listed by the
14 federal government. That is not the way it is going to happen. The federal government is
15 going to have the states select what is going to be an essential health benefits package
16 based on what is going on in that state. There are reasons for that.

17 The way the law is set up is very complex. It says something about large
18 employer plans. It also says something about what the states have to pay for and what
19 they don't have to pay for in this. Each state has different mandates. It lets each state go
20 sort of with their frame and what is going on with them. At the same time, it doesn't let
21 them get away with selecting a benefit plan of essential health benefits that doesn't come
22 up to parity in mental health and substance abuse.

1 The other thing we are working on is same day billing. Some of you who
2 are providers may know that this has been an issue for years and years and years. Do you
3 have a question here, Pat?

4 MR. RISSER: What is essential health benefit?

5 MS. HYDE: Essential Health Benefit is essentially the list of benefits, if
6 you will, the essential benefits that have to be in something called a qualified health plan.
7 A qualified health plan is what gets offered through the exchanges. The exchanges are
8 the marketplace for people above 133 percent of the Federal Poverty Level, who can get
9 insurance through that mechanism if they don't have an employer or some other way to
10 do it.

11 What benefits are offered in that plan is going to be important to those
12 people, who are pretty much uninsured now between 133 percent and 400 percent. It
13 would be like outpatient or inpatient or certain medications. You have the idea.

14 Same day billing is an issue within Medicaid and Medicare. We are
15 currently -- this is something that has been sort of an issue for 20 years or longer. Some
16 providers feel like in some states they are not allowed to do two procedures and bill for
17 them on the same day. There are lots of complexities to this, both at state decision
18 making as well as at the federal level. We are starting with Medicare because, frankly, it
19 is a little easier than the Medicaid problem. Medicaid is a state by state decision in some
20 cases.

21 We are looking at a comprehensive review of code pairs. It is very
22 complex and detailed. The bottom line is we are working on this issue. It is the first time
23 that I know of that the federal government has actually collectively taken on trying to
24 deal with this issue. We thought it was a fairly simple policy decision that we just need

1 to clarify. It turns out it is not anywhere near that simple. HRSA is involved. CMS is
2 involved. We are involved. A lot of people are involved in trying to sort through this
3 issue and see if we can get a resolution to it.

4 The Exchange Rule -- there are lots of things going on in the Exchange
5 Rule, including that there must be consumer-focused non-profits in the navigator
6 program. Nobody defines the word consumer in this rule. That both offers an
7 opportunity and creates a challenge.

8 The Qualified Health Plan that Pat just asked about will be offered through
9 the Affordable Health Insurance Exchanges. The QHPs have to maintain a network of
10 providers sufficient in number and types to assure that services are accessible without
11 unreasonable delay, including for mental health and substance abuse. There is language
12 that we were able to get into the rule about including mental health and substance abuse
13 so it clarified -- it makes very clear -- that they have to be sufficient mental health and
14 substance abuse providers as well. This is really important.

15 We did not get in what we originally thought we would like to have,
16 which is a designation of community mental health and community substance abuse
17 providers as essential providers, essential community providers. We sort of decided that
18 was kind of okay in the long run. The language we did get in there we think may be just
19 as good if not better.

20 We are also trying now to think about how people look at or insurance
21 companies and others and states look at this issue of sufficiency. Unreasonable delay
22 usually means an amount of time or an amount of time to either drive or get to a provider
23 or sometimes it means an amount of time to get in to see a provider -- how long you have

1 to wait for an appointment. Sometimes it is those kinds of issues. Parity is going to play
2 a big issue in this. We are going to watch this and see how it unfolds.

3 On network adequacy, we are watching guidance to plans about the types
4 of organizations and practitioners needed and trying to see what we might put together
5 about that. We are trying to look at enhancing clinical and operational capacity -- so
6 trying to provide improvements to provider practice on existing services and using new
7 tools and new services and addressing some of the barriers to billing authorization and
8 compliance and other things.

9 We have a business operations RFP or contract going out to get some
10 folks to help us work with about 450 providers -- I think it is in here somewhere -- over
11 the next year. I will come back to that because it is actually up here.

12 The Medicaid Eligibility Rule -- if you aren't lost yet, you should be. I am
13 trying to give you a sense of how wild and big and complex this stuff is. We are trying to
14 touch all of it to the extent that it is appropriate to do so. Oh, by the way, Joan, this is for
15 you because you are going to have to help with all of this.

16 Medicaid Eligibility Rule sets minimum Medicaid eligibility at 133
17 percent of FPL. That is what the law said. It also consolidates some eligibility
18 categories. There are four categories. This is pretty important if you know anything
19 about the way Medicaid works. It is important to sort of put those out there.

20 There are multiple eligibility categories in any given state these days so to
21 have it down to four is really helpful. It streamlines and modernizes the enrollment
22 process. Instead of our people, behavioral health people, having to go through these
23 complex disability processes, it will be based essentially on income. They are trying to
24 do everything they can to make that as simple as possible, either literally showing a tax

1 return or if not that, just a declaration that is subject to audit, but nevertheless a
2 declaration, which will be really important for people who are homeless, for example, or
3 people who otherwise don't have access to records and that sort of thing.

4 Timeliness and performance standards are still open for comments. This
5 web link is important for you to go in and look at and perhaps comment on the eligibility
6 issues.

7 Enrollment activities -- SAMHSA is working on a whole bunch of stuff
8 about enrollment. We want to make sure that consumer organizations and organizations
9 who are representing people in recovery are able to take advantage or understand or can
10 help with this. We have picked eight states under our BRSS TACS technical assistance
11 capacity and trying to provide those consumer groups with some assistance -- not very
12 much assistance, but attention, a little bit of money, and help in sort of figuring out how
13 to position themselves to be helpful about enrollment and eligibility of our populations.

14 We are also doing some campaign work, enrollment campaign work for
15 uninsured 18-34 year old men. These are the young invincibles. These are the folks who
16 are most likely to have difficulty getting through the process. We are also trying to look
17 at this issue of churn. We are developing communication strategies and enrollment
18 assistance best practices and a bunch of other stuff to try to make available to the field.

19 We are also providing state technical assistance. If you have followed
20 this, we are providing some help to consumer organizations, some help to providers to
21 make sure their plumbing is in place to work and to be able to help with enrollment and
22 other things and also to provide some information to states.

23 What we want states to be able to do and state advocacy groups to be able
24 to do is know how to go in to the insurance issues in Department in their states and figure

1 out what is going on so they can be good advocates and be able to talk about essential
2 health benefits and be able to talk about essential health benefits and be able to advocate
3 for it in the right way. There have been some webinars. I think they are posted on our
4 website. You can look at them if you like. There is going to be some more coming up as
5 you can see.

6 The goal is to provide our state substance abuse authorities and mental
7 health authorities with as much technical knowledge to ensure that they are the best state
8 partner organizations on health reform implementation that they can be.

9 Provider technical assistance I talked about. TA to over 450 provider
10 organizations per year in five areas of practice that are listed up here. It is everything
11 from compliance to enrollment and eligibility issues of HIT. We have some learning
12 collaboratives around HIT that we are working on with some special focus on providing
13 peer and recovery support services and racial and ethnic minority and other vulnerable
14 populations. We know even within our behavioral health population, those groups have
15 specific difficulties with enrollment and eligibility.

16 Our 2014-15 block grant application -- I don't think I will spend too much
17 time on this because Anne talked about it a little bit this morning or earlier today. We are
18 essentially moving one step beyond the 2012-13 block grant application. That should be
19 out for public comment on the federal register in the spring. We are in the spring.
20 Hopefully, it will be sometime before summer. The reason I am a little iffy about that
21 one is because it has to go through some internal Department and OMB clearance before
22 we can get it out for public comment. It will come out for public comment soon.

23 Actually, let me go back to that for just a minute. This one is pretty
24 important in the sense of timing. Our goal is to have this available so that the states can

1 get their block grant plans back into us by next spring before most of the state fiscal years
2 start in July of next year? Did I get that right? Am I getting my years confused? I am
3 looking at the crew back there.

4 Yes. We have to get this out by this fall. Pay attention here, guys, you
5 have to help me. We have to get it out this fall so they can do the block grant planning so
6 they can get it back into us so we can get it approved and back out to them before the
7 fiscal year starts a year from now. That is a lot of stuff to do.

8 All right, parity. You all know about the MHPAEA and what it does. I
9 want to just remind you of the second bullet here. MHPAEA -- that law, while it was
10 incredibly important at the beginning, it does not require anybody to do anything about
11 mental and substance use disorder benefits. What it requires is that they be dealt with in
12 the same or no more restrictively than any other medical and surgical procedures.

13 If someone does a lousy job of medical and surgical procedures, they are
14 allowed to do a lousy job at mental and substance use disorder benefits. If they don't
15 provider mental and substance use disorder benefits that is okay. They don't have to. It
16 is only if the plans provide it that they have to do them equally.

17 The important part about that is it is a very important floor, but it is not
18 enough. The third bullet is what is important. The Affordable Care Act -- another reason
19 why we wouldn't want it undone is parity is actually extended in 2014 through the
20 Affordable Care Act to the QHPs or the Qualified Health Plans that are sold through the
21 exchanges, which will have a profound impact on the overall insurance market in the
22 country.

23 Work done or underway with regards to parity is a bunch of stuff -- rules,
24 data development, discussions, TA. We have developed a communications plan. We

1 have identified some dollars to do something with that. We are working on that and then
2 trying to incorporate parity into every part of health reform. For example, there are regs
3 still in the process about transparency and decision making by health plans. We want to
4 make sure there is transparency about behavioral health decisions as well. That is an
5 example of how we are continuing to try to incorporate it.

6 The National Behavior Health Quality Framework is another thing we
7 have done. You have seen the first version of that. We are now working with NQF,
8 NCQA, ASPE, all of the acronyms in the world on critical measures. We hope to have
9 those out for public comment sometime spring or summer of this year.

10 We are going to use those measures to try to assess quality not only within
11 SAMHSA funded projects and programs, but in all practitioner and programs out in the
12 communities at the system level and also population-based measures. This is a big deal.
13 Nobody has done this before. Nobody has tried to say folks, these are the measures we
14 should be looking at. You are going to want to watch for this. You have already had
15 some presentations about that so you know it is coming.

16 All right, that is just a little bit of what we are doing in health reform. I
17 wanted to do that really fast because the goal here is not to give you a bunch of detail
18 behind this. It is to try to give you the overview from soup to nuts and also from the high
19 level, the sort of 30,000 foot level about what the Affordable Care Act does and how
20 behavioral health fits into that and then all of the stuff we are working on about it -- and I
21 might say working on about it with nobody having said, gosh, here is 27 more staff for
22 you to go work on this about.

23 It is another one of those issues of where do you put your resources. We
24 have made a decision to sort of do that partly in OPI and partly throughout the

1 organization and then in partnership with other federal agencies who are working on this
2 issue.

3 I think all of you know that John O'Brian was our lead on that. He did a
4 tremendous effort on all of this work with the staff that are on the team working with
5 him. They are continuing with his good help and with a little help from me at the
6 moment. He is actually moving to the Center for Mental Health Services. He will be in
7 Medicaid. He will still be in the HHS family. We expect to still call on him for
8 additional help.

9 Let me stop there. I don't know how long that took. I was trying to do it
10 fast. Let's let you ask questions. Bill, you had a question. Did you want to ask the first
11 one? We will then open it up to others?

12 DR. MCFARLANE: Sure. Thank you, Pam. I thought that was helpful.
13 My question really just to repeat was in anticipation that large numbers of people,
14 beginning with youth and young adults, but followed by I think masses of people will
15 move from populations who are currently insured by the public with Medicaid and
16 particularly in Medicare with mental illness or developing mental illness to private
17 payers, who have almost no experience and certainly a long history of discriminatory
18 practice in relation to specifically that same population.

19 Just running the future forward, we could anticipate some problems that
20 the Aetna's and the United's of the world will not do a very good job with this. At worse
21 case, they could ignore a lot of what we have learned about, particularly through
22 SAMHSA's toolkit processes and so on. How could SAMHSA leap into that breach to
23 assure that there would be quality of the kind we have worked towards in the public
24 sector as providers with this very new population of providers?

1 MS. HYDE: First of all, let me start with your assumption. You may be
2 right. We used to talk about that it would be about 32 million people that were going to
3 get coverage through this process. It is probably closer, frankly, to 40 million. About
4 half of them are going to go into Medicaid programs, but into Medicaid programs that are
5 not necessarily the full blown disability program that we are used to with people who
6 have serious mental illness. This is particularly a problem for people with substance
7 abuse and addictions because they can't get into Medicaid through a disability approach,
8 but they are probably more likely to be in need of that kind of resource.

9 Those benchmark plans in Medicaid probably will be less extensive than
10 the Medicaid in some states, at least. That is a problem. It is still the public system, but
11 it is different parts of it. It is a problem. There are a significant number of people who
12 are going to continue to grow into the Medicare world just because of aging. That is
13 going to be important because of the way Medicare plays a role in some of these issues
14 that I laid out there just a bit.

15 In both of those cases, it could be run by states or the federal government
16 or it could be run by, for example, the Medicare Advantage Plans, which are some of the
17 private insurance companies or in the managed care world and Medicaid where it could
18 be private companies. The point of that is there will be a real mix of public systems and
19 private insurers, who may or may not have a good view of the expansiveness or the type
20 of services that ought to be there for the people we care for.

21 That is part of the reason why the work with the block grants is so
22 important. We are trying to shift the block grant from delivering all of D's care because
23 she is not covered at all to the parts of D's care that she doesn't get other places. It is
24 going to create a coordination of benefits issue that has really not been there a whole lot

1 before. That is part of the reason we are trying to get states to think about this a little
2 differently and do some analysis on what is there and what isn't there.

3 There are also going to be lots of D's who still aren't going to be eligible
4 for coverage in any of these systems for lots of reasons or are going to be in between
5 coverage. Those are the kinds of things we are really trying to focus the block grant on.
6 We are trying to partner up with other agencies to provide some services for those folks
7 as well.

8 The insurance companies, themselves, a lot of times will carve out
9 behavioral health, not always, but a lot of times they will. We are trying to do work there
10 through Pamela Greenberg's group and -- there are a limited number -- you can almost
11 count them on two hands -- of those companies that do that work. We are working with
12 them. Some of them are very sophisticated.

13 They do a lot of public sector work in addition to private sector work so
14 they know what these issues are. I told somebody this week that we should stop
15 worrying about going to the public sectors and we should start going to those companies
16 and saying, look, pay me for a -- I guess this was at the Women's Committee that we
17 talked about this -- pay me for a successful adolescent treatment outcome rather than
18 paying me for this service or that service or whatever.

19 Some of the companies are starting to get that. They get the money.
20 Additionally, they are getting the outcomes. Increasingly, people are saying they want to
21 buy the outcome, not the particular services. There is lots of stuff that we can do and are
22 trying to do.

23 DR. MCFARLANE: It may be emblematic of that future that the two
24 biggest insurance companies in Maine have been starting to talk to our medical center

1 about taking on the PEER program proactively as a bundled service for prevention of
2 onset. That was being led by the two Medical Directors of those two companies.

3 MS. HYDE: The thing that is good about those companies is they are not
4 limited in the way government is by the rules and regs around a box that they are put in
5 around benefits you can pay for and what you cannot and dollars you can do and cannot.

6 They are limited only by their bottom line and by what the outcomes are
7 that they are being incentivized to create. They have lots more flexibility in many ways.
8 It may be an opportunity to engage with them in a different way. It is probably the
9 reason why so much of our work is around helping advocates understand this stuff,
10 helping states understand this stuff, helping providers understand this stuff. We have a
11 lot of providers out there still who have never billed an insurance company or maybe they
12 have billed Medicaid, but nobody else. We are really trying to do that business ops kind
13 of work as well.

14 MR. RISSER: Your last slide was the one that most concerns me, the
15 quality and the outcomes. I love it. Your third bullet up there under your main heading,
16 treatment is effective -- as I look around the room, there may be a few who are old
17 enough like me to remember a time when we used to talk about getting everybody well
18 enough and we could put ourselves out of business. Instead, I have seen the system grow
19 almost out of control.

20 There are lots more screenings and testing and entryways into the system,
21 but I don't see the corresponding exit doors out. I really pray for recovery. Yet, what I
22 am seeing are my peers dying ever younger, more than 25 years younger than the general
23 population now. What can you tell me that we are going to be looking for in terms of

1 recovery, quality, outcomes, people able to get on with life and get away from the system
2 and have a life that is recovered -- a full and complete life in the community?

3 MS. HYDE: Let me answer that at the highest level first and then go
4 down to the specific level you are asking about. I think that the Affordable Care Act and
5 certainly the way that HHS has taken it forward is trying to both transform health care in
6 America or strengthen health care in America -- so the delivery of the health care
7 experience when you need it. They are also trying to improve the health of America.

8 All of this work around prevention, around wellness, the million hearts
9 campaign, and a whole bunch of stuff has really tried to focus on, look, we really don't
10 want to just wait until people are sick or ill or need health care. We want to deal with
11 prevention. We want to deal with wellness. We want to deal with people taking their
12 own responsibility for their health, et cetera.

13 There is a lot of work going on there. We have really taken on -- in fact,
14 Paolo is back in the back. He has done a lot of great work with the Million Hearts
15 campaign. Frankly, we know that so many of the people you are talking about who are,
16 in fact, dying earlier are people who have some of those conditions -- blood pressure,
17 cholesterol, heart disease, smoking, things that we really haven't paid as much attention
18 to.

19 I think we have totally won them on the Million Hearts. The person who
20 leads that I think has really gotten the message that if they want to be successful in the
21 country, then they have to take on some of the issues for people who have both addiction
22 and mental illness in those areas.

23 There is other stuff we could say about wellness. I don't know, Paolo, if
24 you want to say anything about this, you are welcome to come to the mic and add to it.

1 We are focusing on not only health and wellness for people who already have a serious
2 mental illness or are designated in that way, but also health and wellness among
3 populations in general. We should be a part of that.

4 MR. DEL VECCHIO: I would just add to the end of your comment about
5 the Million Hearts. Our estimates are -- again, the goal of the Million Hearts is to prevent
6 one million heart attacks and strokes over the next five years. Our estimates that one
7 third of that million people, some 300,000 plus are people with mental health and
8 addictions. Absolutely, we have to focus on cardiovascular health for our well being.

9 MS. HYDE: There is a fair amount of work that we are trying to think
10 about this and not just improve the quality of care, although we are trying to do that, but
11 also trying to think about the health of the populations that we care about, not just the
12 particular illness care that they may need when they come in.

13 Frankly, we have always supported people's right to make their own
14 decisions. We have done some work around self-direction. Frankly, we are doing that --
15 Paolo and his shop have led that. Our substance abuse folks -- we are involving them
16 now, too. I think, frankly, as medication assisted treatment becomes a bigger issue in the
17 substance abuse world, we already have some judges saying you are not allowed to take
18 that medication.

19 We have other people who I bet you it is only a matter of time before they
20 are going to force people to take that medication. We are going to have some of the same
21 issues on the substance abuse side that we have had on the mental health side over the
22 years. I think that we are really trying to look at pathways to recovery being very
23 individualized and self-directed.

1 There is work going on about that not just in behavioral health. That is
2 what is so cool about it. The whole health care arena is taking on this issue of pathways
3 to health and individual self-directed care. I just saw something I sent to Paolo today --
4 there is a big webinar about that. There is just stuff going on in that arena. I think it is
5 healthy for the whole country to be on that issue.

6 MS. STEIN: I just want to echo how critical I think SAMHSA's role is. I
7 know you are already doing this in preparing these new providers. I think there are going
8 to be lots of new providers, licensed practitioners. I think some of the casualties we are
9 seeing already in integrated care where poorly prepared prescribers are killing people. It
10 is happening in larger and larger numbers.

11 It is such a big problem in our state that we have Governor's Task Forces,
12 Legislative Task Forces. Everybody is trying to look at pain management and emergency
13 room management because everybody is giving out these drugs in their primary care
14 setting that they don't understand. That is one thing. I think they are going to be part of
15 our provider network, but we have to get them better prepared.

16 Just another little thing in addition, one of our primary care management
17 networks called me last Thursday and said we need you to get your programs up. We
18 need more intensive outpatient programs immediately because all of these people are
19 going to be coming and we want to send them from our emergency room over to your
20 program. I said, well, for the next two years we will be really hard pressed to keep what
21 we have got. There isn't a payer yet.

22 The other part of it is in all of the studies I have ever seen of the
23 economics of the demand curve for addiction services, just having a payer doesn't change
24 that problem behavior of engaging people into treatment. They can think they can send

1 them across the street, but I am not sure they are going to arrive. There is just a whole lot
2 of training of the system to help that engagement occur.

3 MS. HYDE: Also the assumption that I can just send this person to you as
4 a public program and you will do it for free or you will take care of it without
5 understanding that they need you is important to. The business operations is also sort of
6 meant to try to help providers know how to negotiate those deals and how to go in and
7 say I will take 27 referrals a month for this much money a person. There is lots to be
8 done about that.

9 MR. CAPOCCIA: Thank you. It is clearly a huge agenda. I think it is an
10 agenda that tracks well with the implementation of the overall law and really enhances
11 the role of not on SAMHSA, but all of the providers and people. What I wanted to
12 underscore was the functions and items that you had up there related to enrollment and
13 disenrollment. You talked about it in terms of outreach and the enrollment process. I
14 think that those are really critical points because reaching our populations that we are
15 concerned about is going to be more of a challenge than the population as a whole. That
16 was the experience in Massachusetts, which has been through this.

17 The piece I would really underscore is not just the enrollment process, but
18 the disenrollment and the verification and the re-verification. Again, using the
19 experience that Massachusetts has had already with this, we find that of the people who
20 are seeking treatment in community mental health and community based addiction
21 centers, almost a third of them have been dis-enrolled. Most of them may not know it.
22 Here are people who are eligible for coverage, who have had coverage, but at the point of
23 coming to service are not getting it.

1 When you peel that back, it isn't just the question of do we have enough
2 advocates to get them re-enrolled. It is the question of the system's design and/or the
3 verification systems designed in such a way that they act counter to the interest of people
4 that we are serving. I think how we pay attention to that as we are going out and working
5 with the enrollment systems in the states is really going to be a critical piece.

6 MS. HYDE: I totally agree with you. I am going to say this only in a way
7 that tells you I understand the problem. I did have responsibility for the agencies around
8 the state that did enrollment for food stamps, Medicaid, all of that kind of stuff. I can tell
9 you it was just a nightmare constantly dealing with it.

10 It was also extremely complex rules about when you could keep
11 somebody on the roll and when they had to drop off and all of that. I think a whole
12 bunch of it from my point of view is going to be watching what comes out and obviously
13 we are trying to be at that table to influence it on what the enrollment form and process
14 looks like and what the maintenance of enrollment process looks like, whether it is
15 assumed at the end of the enrollment period that you have to do something to re-up or
16 whether it is assumed you stay on unless told otherwise. There are lots of ways to go
17 about this. We have lots of commitment to simplifying enrollment processes. I think we
18 still have to see what all of that comes out before we are done.

19 MR. CAPOCCIA: The other to implication of this is there is a huge
20 interaction between the consequences of this issue and the block grant and the block grant
21 use.

22 MS. HYDE: Yes, absolutely.

23 MR. CAPOCCIA: When you were talking about the use of the block
24 grant in other forms if, in fact, the system either discourages the re-enrollment process or

1 if people don't know it or the providers are not active in terms of the use of then they turn
2 to the block grant and it gets inappropriately used.

3 MS. HYDE: It has some implications for us and our ability to audit what
4 is going on with the block grant, too. We are far from being able to do that perfectly.

5 MR. CAPOCCIA: I debated, but I will say one more thing. This is on a
6 slightly different topic, but related. As we sit here, as we have been reminded, and as we
7 hear the news this week, as this profound and incredibly significant legislation is going to
8 be judged and determined to remain in place or not and we need to continue all of our
9 planning and all of our work assuming that it is. I have to think in the back of my head as
10 we have talked particularly about changing use et cetera of the block grant, as critical as
11 it has been for people of uninsured, if we are also thinking about a plan B? I am not
12 looking for an answer to that question. I just needed to give voice to it.

13 MS. HYDE: Let me reframe your thinking about that just a little bit. First
14 of all, if you look at the polls, 14 percent of the American public think that the Supreme
15 Court has already decided that the law is unconstitutional and thrown it out. Number
16 one, the assumptions about what this means is pretty ridiculous out there. That is number
17 one.

18 Number two, while there are three or four issues that the Supreme Court
19 are looking at are pretty profound and pretty big, they are all -- one of the issues is is it
20 severable? Are these things severable from each other? One could argue that a couple of
21 pieces are not very severable, but that is for the courts to decide.

22 Those three things are just a little, tiny piece of what is in this health
23 reform. That is the reason I did those first few slides. In fact, the thing I didn't put up
24 there is the Indian Health Service Reauthorization is all in there, too. The likelihood of

1 any congress throwing out the whole thing -- they can talk all they want and the pundits
2 can say all they want and the bravado of an election year they can say all they want.

3 They would have a very hard time politically -- they being anybody you
4 want to pick -- would have a very hard time throwing out the whole ball of wax. There
5 are some pretty profound shifts in the healthcare world that have already started and are
6 taking place that would be very difficult to undo. I think there are advocates that have
7 nothing to do with behavioral health who would be up in arms if they began to see what
8 some of that unraveling would do.

9 I don't think a plan B is as simple as, oh my gosh, what if all of this work
10 went away? I think it is much more subtle and nuanced about how is it going to shift and
11 flow and what are we going to do then?

12 MR. CAPOCCIA: Maybe I should have been clearer. The plan B that I
13 really was referencing was if, in fact, we don't end up with the population covered with
14 this benefit that we thought, not the other features. I think the other features -- I couldn't
15 agree with you more. That is a train on a track. They are going. We are going to have
16 integrated care, et cetera.

17 It is really the point about will we still end up with a more significant
18 number of uninsured people with behavior health issues than we would have -- and this is
19 the end June -- than we would have in May?

20 MS. HYDE: I think those are legitimate questions. I think those are good
21 questions, whether the health reform law was being debated or not. Some of the
22 decisions that are being made at the state level right now are having almost as profound
23 an impact on those issues as the health reform law are.

1 I want to make sure that I don't forget before I do it I was laughingly
2 referring to Kevin and Steven back there, but would you guys literally stand up and wave
3 your hands? If you don't know these guys, you should. Kevin, on my left, is sort of
4 leading our enrollment and eligibility work. Steven, on the right, helped me with these
5 slides and helped with a lot of the other communication pieces. He has a lot of effort on
6 this as well. I wanted you to know those two guys. There is another person named
7 Alison, who I don't see. She was down here. She is helping Anne on the block grant
8 application change.

9 All of them are in OPPI. Then there are tons of other people, who are in
10 CMHS and CSAT and others. There is a big team of people who are working on this.
11 The reason I wanted to say that is because while I am standing up here and John used to
12 stand up here we have been trying to infuse and have, I think, gotten a great number of
13 wonderful folks in SAMHSA who are starting to get this stuff and beginning to work
14 together to try to move this stuff along as well.

15 I saw a couple other hands. Yes?

16 DR. BRISCOE: Hi. My name is Yolanda Briscoe, the Committee for
17 Women's Services. At our facility, we take no less than seven insurance plans.

18 MS. HYDE: Good for you.

19 DR. BRISCOE: One of the first questions is do you have benefits. The
20 devil in the details -- when I read this it says that yes, you have to treat it like you would a
21 medical procedure, but only if you offer it. So all they would have to do is not offer it?

22 MS. HYDE: That is true, but the Qualified Health Plans, in order to
23 participate in that, they are going to have to offer it.

24 DR. BRISCOE: So they will have to.

1 MS. HYDE: Yes. That is why I am saying this issue about what each
2 state requires and what the mandates are are important. New Mexico does have some
3 mandates and not some others. Every state has some kind of something. You need to go
4 back and know what your state's mandates are. That also has implications for what the
5 state has to pay for, which means that will have implications for the policy decisions they
6 make. It also has implications for what small employer plan or large employer plan gets
7 ultimately picked to be the model for the behavior health parity.

8 This stuff is hugely complex, but it is why we have been trying to teach
9 people how to look at this and think about it and stuff. It is exactly the right questions
10 that you are asking.

11 Somebody else had their hand up? Anybody else? If not, we need to go
12 to public testimony. Part of your job is to listen to the public. Any other comments or
13 questions about this?

14 MS. GARDUQUE: Laura Garduque with the CMHS Advisory Council. I
15 am curious about how you are letting folks know about the kind of training and technical
16 assistance that you are offering to both providers and states? Making it available is one
17 thing, but who gets access to it and who takes advantage of it? I am curious because
18 there are great divides, a lot of variability across the states, how well the states are
19 working with their counties to address this. How is it getting out there? Do you have a
20 sense of what the need, demand, and take up rate is?

21 MS. HYDE: I will say 30,000 foot, but Steven may want to come to the
22 mic and say something about this. We are using everything from our website, e-blasts,
23 our partners' websites, some organizations that we work with like provider organizations,
24 both the substance abuse and mental health provider organizations and state

1 organizations. We are just using every method we can think of to reach the right people.
2 Our consumer organizations, people in recovery -- we meet every couple of months with
3 a variety of stakeholders, who are engaged with us around this. They have networks
4 throughout everywhere.

5 Even having said all of that, I think we have just blasted the airwaves with
6 it. Even at that I can go to a speech or a conference or something and have somebody ask
7 me a fairly fundamental question that is pretty clear that it is just now starting to get on
8 some people's radar screens.

9 There are other states, frankly, mostly the 26 states that are suing the
10 federal government and are in the Supreme Court right now, but a lot of them have been
11 told by their Governors and their AGs that they may not participate in any of this stuff.
12 That is a struggle for them. They are trying to figure out how to manage that and how to
13 stay somewhat engaged around information flow, even when they are told not to be a part
14 of it.

15 I don't know if that will change by July. Let's say the Supreme Court
16 decides everything in the favor of the Affordable Care Act, if that would mean those 26
17 states will then free up their people to start figuring this out, I think that is anybody's
18 guess. I think we won't know that. A lot of it will depend upon the politics of that state.
19 We have lots more work to do about that.

20 STEVEN: Just very briefly, to echo what Pam said, actually, yes, we are
21 using a lot of our stakeholder networks, the state associations. We are using some
22 provider associations, some consumer associations like Legal Action Center. A lot of the
23 information you can actually find on the SAMHSA website, particularly the webinars
24 that we have done a lot of TA through at SAMHSA.gov/healthreform. There you will

1 find a lot of resources around prevention, Medicare, primary care, behavioral health care
2 integration and some general just health reform resources.

3 MS. HYDE: Again, if you guys have advice, thoughts, ideas, we have met
4 a time or two with Grantmakers in Health. They have been very interested in what we
5 are doing. We will take any avenue that we can. If you have thoughts about that, we are
6 open to it. You can also tell Joan because she will be supervising all of these people.

7 Any other comments? Anything up here you guys want to add? Any
8 other comments about this? All right, we are going to move to public testimony.
9 Nobody signed up? One person did. Come on up. State your name and where you are
10 from and take just a couple minutes. Let's see who else is on the line, could you do
11 something to tell people on the line?

12

13 ***Agenda item: Public Comment***

14 DR. FRIZELL: I guess I will have to attach little smoke signals because
15 this happened last year, too. I am Dr. Linda Bane Frizell. I am with the Northwest
16 Portland Area Indian Health Board. I serve as a Technical Advisor to our elected
17 leadership, which are sitting in the audience.

18 The first comments I would like to make are kind of unfortunate because
19 we did have some folks that are at the tables that wanted to comment in regards to the
20 school-based health centers, but ran out of time. The first comments are in regard to that.
21 These are assets that we see and have seen for a number of years in Indian country, in
22 regards to school-based health centers. They are often called health stations.

23 I speak from personal experience because I used to have a school-based
24 clinic for the tribe that I work for. I can absolutely guarantee you that the immediate

1 access to behavioral health professionals saved -- that I know of -- two lives. Two lives,
2 folks, because there were professionals there on site. Who knows how many that went
3 unreported? That is a huge, huge access asset for school-based health centers.

4 The other is all of the issues that go around the drug abuse and other issues
5 and even the bullying that happens in our schools. If we have access to behavioral health
6 professionals and not all school-based health centers do, these are some of the real acute
7 benefits.

8 The other benefit that happens is you start to see an evolution of two
9 subcultures joining together. You have the health professionals and the educational
10 professionals. They develop teams. In particular, whenever there is an individual
11 education plan that is being developed, the team is mostly onsite. What I have seen
12 happen in Indian country with regards to this is unbelievable. It doesn't reach the height
13 of what the Mayo Clinic does for managed care, but it certainly is an improvement.

14 Secondly, in some states, IPs are reimbursable through Medicaid, not all.
15 It just depends on what is in the state plan for covered services. Lastly, with regard to
16 that, the issue that we have in Indian country is the lack of behavioral health
17 professionals. There is an extreme disparity with regards to that. Once again, the
18 covered Medicaid services vary times 50.

19 The other comments I would like to make and these are available -- the
20 National Indian Health Board provided extensive comments with regard to the essential
21 health benefits. We argue that if the term benefit had not been used, then we would have
22 been a lot further ahead. The term benefit is in regard to health insurance plans. Here,
23 the issues begin.

24 The put out to comments, which were due the end of January, the 31st to

1 be exact, we did meet that deadline. It was a bit of a challenge. One of the biggest issues
2 that we had initially is that it is proposing to states for the exchanges that they take the
3 health plans with the most enrollees. There is no credence given to whether the enrollees
4 happen to be satisfied or not or whether the services are of high quality, nothing, just the
5 most. A comment was provided for that.

6 The other -- I think this is the straw that is going to break the back. If you
7 look at the data and we did a lot of research, currently, in this country, about 97 percent
8 of all the major health plans offer behavioral health services of some sort or another. The
9 small health plans don't. That is a whole different issue. I don't have time to go into
10 that.

11 Ninety-seven percent currently offer. The literature also shows that over
12 the last 20 years, those offerings have been decreasing. It was mentioned about the Parity
13 Act. I work with Senator Wilson personally. I am from Minnesota. Before he was
14 tragically killed about 30 miles from where I lived, he had a parity act. I am here to tell
15 you that the Wellstone-Domenici Parity Act is nothing like what was originally
16 developed.

17 It was over 600 pages. This was back in the day before you had track
18 change sorts of tools to use. I gave up my packet to the staff that was working on it. I
19 don't have a copy. In his original parity act, it was parity. You have 20 physical health
20 services, then you have 20 behavior health services. That is what parity is.

21 What came out of the parity act is the disturbing part. Certainly, as was
22 alluded to on the slides, if you outsource physical health, you have to outsource
23 behavioral health. If you have X number of visits as a cap, it has to be the same for
24 behavioral health. Everything has to be in parity from that standpoint. However, if the

1 employers or the insurance plans costs go up by more than two percent in the first year, it
2 doesn't apply. In subsequent years, if the insurance plans' costs go up by more than one
3 percent, it doesn't apply.

4 That is quite concerning. I am hoping in some of the new legislation and
5 even some of the opportunities within the ACA that that can be stopped because it
6 doesn't have any teeth. You say parity. That is a good thing. If you read the literature
7 and you read the law, it isn't what it is cracked up to be.

8 Secondly, we tend to disagree in Indian country -- this is kind of food for
9 thought for people that aren't in Indian country, but if the feds do not prescribe a core set
10 -- in the National Indian Health Board, if you go to NIHB.org, then you will find the
11 essential health benefits comments. They are all listed there. We listed them out. If you
12 don't find a list somewhere as to what that will be, then you are going to have 50
13 different situations.

14 We have huge issues with across state borders. Some of our friends in
15 other states have no covered services. It could be a pretty healthy list, but if the federal
16 government doesn't step up and require that the states offer a core set of behavior health
17 services, then we are going to have states that have zero. A Kaiser report in 2009 had
18 zero covered services in seven states for rehab and rehabilitative services as an example.
19 States like South Dakota, which is closer to where I live, very meager the covered
20 services. This is what is going to happen.

21 It makes it hard, I would think, for our federal friends because you have 50
22 different plans you have to deal with from the states and all the waivers that you have to
23 be concerned with with CMS. It is just a catastrophe waiting to happen. I didn't mean to
24 be the bearer of bad news, but in reality, the ACA has numerous, numerous possibilities,

1 but some of the interpretation, particularly by CSIO can have a very damaging effect to
2 what we are trying to do.

3 MS. HYDE: Thanks a lot for your comments. Let me make just one or
4 two comments in response. I have you comments from NIHB. I appreciate getting those.
5 I do not know who sent them to me, but whoever did, I appreciate it. They are very
6 helpful and very thoughtful.

7 I would say two things. One is, as I said when we started talking about
8 parity, MHPAEA is just the beginning. It is not a panacea. It has expanded in the ACA,
9 but that also isn't a panacea. Clearly, the decisions that have been made at this point
10 move the advocacy needle to the states. There is a reason for that. There is a positive
11 reason for that.

12 In some states, parity and mandates for behavioral health are actually
13 higher and bigger and better than they are at the federal level. If the federal level had to
14 pick a place and start at the lowest common denominator, we actually could be bringing it
15 down in some areas. While that might seem problematic or difficult, actually allowing
16 the states to make these decisions means that we are going to have some of those
17 decisions made in places and in ways that states have managed to do that with their
18 advocates and others about getting those mandates in at higher levels.

19 The one thing you said that I want to correct because I don't think it is
20 correct is no state will be able to have no behavioral health services. It is required in the
21 Affordable Care Act. They must include mental health and substance abuse services.
22 They actually have another word for behavioral health, which I think in that context kind
23 of sort of means other stuff.

24 DR. FRIZELL: I didn't mean -- if I said that, I didn't meant to say that.

1 MS. HYDE: I may have misunderstood, but I just wanted to clarify that
2 every state will have to have some. In the Qualified Health Plans, it gets a little funkier.
3 In fact, we are still working with CMS on the Medicaid guidance for the states because
4 that is yet a different issue. How the states implement parity in Medicaid is yet a
5 different issue. That guidance is still coming.

6 DR. FRIZELL: I certainly understand your comment about some states
7 having better plans. I didn't mean to imply that the states should -- if there were a set of
8 core services that was designated by the federal, I would deem that to be the baseline.
9 Whatever states want to do above that, hey, that is the best. It is for those states that do
10 not that it is concerning.

11 MS. HYDE: Thank you very much. Any other public comments? Is
12 there anything online? Okay, let's see if we can -- I know Geretta has some final things
13 for us, but let's see if we can wrap up here just a little bit.

14

15 ***Agenda item: Closing Remarks***

16 MS. HYDE: First of all, I want to just again thank all of you as our
17 advisors. Your comments, your questions give us ideas and thoughts. I know these days
18 are hugely intense. They are intense for us, too. We kind of wear you out and put you up
19 wet -- ride you hard and put you up wet on these days, but it is really important to us.
20 The dialogue is important. We think about it. We talk about it. We take it to the next
21 step in whatever work that we do.

22 Again, I can't thank you enough for being willing to give us your time and
23 your energy and your effort. You are a tremendous group across the country and across
24 different sectors and across different capacities and interests. We really appreciate it.

1 I also want to say a word of appreciation to the staff. A lot of them do a
2 lot of work to make these things happen -- these meetings happen. Thanks to Geretta for
3 her first one out of the box. She has been terrific and she is learning a whole bunch of
4 stuff.

5 To our contractors and the other folks who are helping us with taping and
6 keeping notes and the public webinar and all of that as well. We also have staff behind
7 the scenes that do things like make these microphones work and set up these chairs and
8 all kinds of things like that. I just want to give a public call out to them.

9 Thank you to the Leadership team, the Executive team, and others who
10 participated. Thanks for the work yesterday in all of the committees that you all
11 participated in. Tomorrow, we have the National Advisory Committee, which is the
12 group that will help to take all of what they have heard in the last couple of days and help
13 me and us think about what to do with it all, as well as look at some other issues.

14 We also have the SAMHSA Tribal Technical Assistance meeting
15 tomorrow. Several of us will be participating in that. Another day of it to come, for
16 some of us. For those of you who are leaving here this evening or tomorrow, again,
17 thank you for being here. Any of you are welcome to come and listen to or observe those
18 other meetings if you like. The agendas are available. You can see what is on them and
19 what is going to be discussed.

20 Do you have anything else that you want to add here? Any other
21 comments from any of you before I turn it over to Geretta to let us out of here? All right.

22 MS. WOOD: I want to remind ACWS and NAC members to leave all of
23 your meeting materials at your seat. Also, any members attending meetings tomorrow,

1 please bring back your federal badge so you can get back into the building more easily in
2 the morning.

3 While the administrator kind of stole my thunder, I did want to say thanks
4 to a lot of people that participate to make these meetings work. In particular, for this
5 meeting, we have the various SAMHSA DFOs, Designated Federal Officers, who work
6 with you to get their meetings up and going and stay in contact with you about
7 arrangements. The logistical contractors from Westover, CRP, and from Kauffman for
8 making sure that everything worked smoothly at the meetings and also the web support
9 and Chorus Call, the video support from ICF Macro.

10 Additionally, a really personal thank you to Julie Stevens, who
11 coordinated and picked up your lunches for you. If it hadn't been for her willingness to
12 help us out, we would probably all be feeling a whole lot worse about now. Again, it has
13 been a pleasure to meet all of you. I look forward to working with you in the next few
14 years.

15 MS. HYDE: That is great. Thank you. I think we are adjourned. Thanks a
16 lot.

17 (Whereupon, the meeting ended at 5:30 PM)

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