

1 SUBSTANCE ABUSE AND MENTAL
2 HEALTH SERVICES ADMINISTRATION
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6 NATIONAL ADVISORY COUNCIL MEETING

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11 1:09 p.m.
12 Wednesday, August 6, 2014

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17 SAMHSA ROCKVILLE HEADQUARTERS
18 ROOM 4-1066
19 1 CHOKE CHERRY ROAD
20 ROCKVILLE, MARYLAND 20857

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- 1 PARTICIPANTS:
- 2 FRAN HARDING, Director
- 3 MATTHEW AUMEN, Designated Federal Officer
- 4 MIRTHA BEADLE, M.P.A.
- 5 ALEXANDRA SHABELSKI, M.P.A.
- 6 JORIELLE BROWN, Ph.D.
- 7 RICH LUCEY
- 8 KATHLEEN REYNOLDS, L.M.S.W, A.C.S.W
- 9 STEVEN GREEN, L.C.S.W.
- 10 DIANNE HARNAD, M.S.W.
- 11 RUTH SATTERFIELD, L.S.W.
- 12 MICHAEL COMPTON, M.D., M.P.H.
- 13 MICHAEL MONTGOMERY, M.Ed.
- 14 CLARESE HOLDEN, Ph.D.
- 15 MARY ANN TULAFONO
- 16 PATRICIA WHITEFOOT, M.Ed.
- 17 COSTELLA GREEN, M.H.S.
- 18 JOSEFINE HAYNES-BATTLE, M.S.N., B.S.N., R.N.
- 19 FLO DWEK
- 20 ILENE BEMUREDS
- 21
- 22

1 P R O C E E D I N G S

2 AGENDA ITEM: CALL MEETING TO ORDER

3 OPERATOR: Good afternoon. My name is Stephanie,
4 and I will be your conference operator today. AT this
5 time I would like to welcome everyone to the CSAP
6 National Advisory Council meeting conference call.

7 All lines have been placed on mute to prevent any
8 background noise. After the speakers' remarks, there
9 will be a comment session. At that time, you will be
10 able to press star, then the number one on your
11 telephone keypad to add a comment. If you would like to
12 withdraw your comment, you may press the pound key.
13 During the conference, if you would like to ask a
14 question, you may do so by using the web Q&A box on the
15 web view.

16 Thank you. I would now like to turn the call over
17 to Matthew Aumen.

18 MR. AUMEN: Hi, everybody. My name is Matthew
19 Aumen. I'm the Designated Federal Officer for the
20 Substance Abuse and Mental Health Services
21 Administration, Center for Substance Abuse Prevention,
22 National Advisory Council. I will now call the meeting

1 to order.

2 A few notes really quick to get started as well
3 with the operator. Just to be sure to speak clearly for
4 the council members into the microphone, and state your
5 name when speaking. So the public participants, again,
6 will be in listen-only mode until the public comment
7 period.

8 So, without further delay, I will turn it over to
9 Fran Harding, the Chair of the Council.

10 MS. HARDING: Good afternoon, council members,
11 SAMHSA staff, public attendees, and welcome to the
12 Substance Abuse Prevention's National Advisory Council
13 meeting, one of our virtual meetings that we work --
14 this is our second one. We work very hard to improve on
15 the ability to have these meetings virtually so we can
16 extend our time together throughout the year.

17 My first announcement is an exciting one. Since
18 we last met, we do indeed have a new Secretary. Her
19 name is Sylvia Mathews Burwell. We are very excited.
20 She came to SAMHSA already, and she met with the
21 executive leadership team, and we had a short
22 conversation with her. And then she met with a randomly

1 selected group of SAMHSA staff so she could get an idea
2 of what life is like in SAMHSA from what I'll call the
3 real people. And then she stayed with us for another
4 hour and a half, and did what we call an all-hands
5 meeting, which is a meeting for everybody in SAMHSA
6 where she took questions.

7 She's very personable. She's very dedicated to
8 our field. And I believe that the feeling from the
9 staff, which you should know, is that she's very
10 approachable. She's very down to earth. She's
11 incredibly hard working. She gave us some pretty strong
12 directives, but her passion definitely is her work, and
13 we are part of that vision, so we are all feeling very
14 good.

15 We know she's going to be tough. We know that
16 she's going to be asking us to turn around documents on
17 a very quick order. But we're all -- I believe that we
18 became very energized to see that she will definitely be
19 a great next step from our first beloved Secretary, and
20 life will continue to go on for us.

21 I also want to make a note that this is Mary Ann's
22 and Patricia Lightfoot's last meeting, and we want to

1 thank them very much. It's always an awkward time to do
2 that virtually. However, know that we are in the room
3 thinking of you and thanking you for your work. Now
4 that I've said that, because this is government and we
5 never can predict to the point when departure --
6 although on paper your departure -- this would be your
7 last meeting. If we -- with the new Secretary things
8 may not have progressed as quickly as we thought, and we
9 might not have a full complement of new replacements by
10 April.

11 So you may indeed get an email from Matthew saying
12 would you be willing to extend your time for another
13 meeting. And you will obviously know that, especially,
14 Mary Ann, I know you would be very concerned about the
15 timing of that call, that there would be enough time for
16 you to come. So we will assure that to the best of our
17 ability we will do that.

18 So if you don't mind, I'll ask the people around
19 this table to give you a round of applause because if
20 you were here we would give you one. But this is the
21 only way I can think of of you knowing a little bit of
22 our appreciation. And those of you on the board can do

1 whatever it is that you want in your minds to give them
2 well wishes. So we just want to thank you.

3 (Applause.)

4 MS. HARDING: So I thought that -- what I'd like
5 now is to, around the table only, we're going to have --
6 actually we could probably do all of the SAMHSA staff
7 that are here in the room to introduce themselves so
8 that you know who is in the room and who will be
9 speaking with you. Charles?

10 MR. REYNOLDS: Good afternoon. This is Charles
11 Reynolds. I'm the Director of the Division of Community
12 Programs within CSAP.

13 DR. BROWN: Good afternoon. This is Jorielle
14 Brown, the Director of the Division of Systems
15 Development.

16 MR. LUCEY: Hi. I'm Rich Lucey, the Special
17 Assistant to the Director and CSAP.

18 MS. GREEN: Costella Green, Branch Chief, Division
19 of Community Programs.

20 MS. BEADLE: Good afternoon. I'm Mirtha Beadle,
21 Deputy Director for CSAP.

22 MS. SHABELSKI: Good afternoon. Alexandra

1 Shabelski, Director for Office of Program Analysis and
2 Coordination.

3 DR. HOLDEN: Clarese Holden, the Acting Division
4 Director for Division of State Programs in the absence
5 of Richard Moore.

6 MS. HAYNES-BATTLE: Josephine Haynes-Battle,
7 Branch Chief, Division of Systems Development.

8 MR. JONES: Linton Jones, Intern in the Office of
9 the Director of CSAP.

10 MS. HARDING: Thank you very much. Let me take a
11 moment and ask Matthew if we have a quorum.

12 MR. AUMEN: We do not yet, and we will get on the
13 line with the members who may be trying to dial in. So
14 right now we have four, and we need seven for a quorum.

15 So we will skip the approval of the minutes from the
16 April 2nd meeting, and we will come back to it as we get
17 a quorum.

18 MS. HARDING: Thank you very much because
19 sometimes when we start meetings like during the virtual
20 meetings and staff members hop on quickly, sometimes I
21 miss it, and I'm assuming that we don't. So we will
22 have a quorum before the end of the meeting so we can

1 have our closed session. Just before we go into closed
2 session, we will make sure that we review the minutes
3 and approve them. And that will be Matthew's
4 responsibility to make sure that happens.

5 So we're going to jump in unless, somebody has an
6 objection around the table, to the major conversation
7 that we're here to discuss. We've learned from our
8 mistakes for those of you who were on the last virtual
9 meeting. Our agenda was so packed, we had some issues
10 with trying to get all that information done during the
11 virtual conversation and major issues that we're going
12 to discuss at great length.

13 And it's my understanding, Matthew, that you sent
14 our members homework around our integrated meeting. We
15 had -- after our last meeting in April, we talked about
16 the integration of prevention programming into primary
17 care, ACA, general medicine, overall health, and all the
18 above.

19 So what we -- I think we were putting together in
20 our heads and after the meeting, we decided to have a
21 special expert meeting. And we brought in nine or 11
22 specialists across the country to help us, and the

1 specialists came from all different fields. Not only
2 did we have substance abuse specialists, we also had
3 prevention specialists, treatment specialists, mental
4 health specialists, researchers, doctors, and several
5 other community and business representatives. It was a
6 great collection of staff, which I think you all have a
7 copy of the members. That's why I'm not taking the time
8 to go through each and every one of them.

9 I found that our conversation was very robust. We
10 did an awful lot of work in a day. The first takeaway
11 message for me was that our next meeting will be two
12 days long. We just were -- as usual when you have a
13 one-day meeting, we were just really getting into the
14 heart of the conversation when time was called. So the
15 -- so you can expect that we will have much greater
16 discussion moving forward.

17 So I will turn this over to how we are going to --
18 we're going to spend an hour on the integrated meeting,
19 and then an hour on the SI, is that correct?

20 MR. AUMEN: An hour on the integrated team, and
21 then the SI will be roughly a half hour.

22 MS. HARDING: Okay. So I believe, you know, these

1 virtual meetings are always interesting, that as we go
2 through the integrated meeting, we'll have some slides
3 for them to look at for those of them who have them.

4 MR. AUMEN: Right. So if you wanted to give them
5 a download of what we've provided them with the results
6 of the meeting, just a synopsis.

7 MS. HARDING: Okay.

8 MR. AUMEN: And then what we can do is then have a
9 conversation among the members. A few of them had
10 responded with their top 10 of the priorities that came
11 out of the expert meeting. And so, what we could do as
12 a council is see if we can narrow down some of the
13 priorities that came out of the expert meeting, and if
14 the Council has a recommendation on the top four or
15 five.

16 MS. HARDING: Okay. So as I mentioned, we covered
17 an awful lot of ground during this meeting. We first
18 had a -- we first started off the meeting a little bit
19 differently than meetings are begun. We started off the
20 meeting with asking our special expert what they're
21 bringing to the table, what their experience has been in
22 the discussion of integration, why do they think they're

1 here, and what can they bring to the conversation. And
2 that was a very interesting facilitated discussion in
3 getting us started on moving forward with --

4 The first thing that I think we learned just even
5 while we were getting started was that looking at our
6 title of our day was the "Integration of Substance Abuse
7 Prevention and Mental Health Disorder Prevention Into
8 Primary Care." And we found out within the first hour
9 that primary care was too limiting and that we really
10 should be discussing -- we should be discussing -- one
11 moment. We have already have our first virtual glitch.

12 SPEAKER: The uploading, we can definitely upload
13 them. Once the meeting is done, they can get the files.

14 MR. AUMEN: Did you have an update on the members?
15 Okay.

16 MS. HARDING: Okay. So I just found out that you
17 can't see the slides. I hope you're not seeing me
18 because I'm not as entertaining as slides.

19 (Laughter.)

20 MS. HARDING: So they're not seeing me, are they?

21 MR. AUMEN: The current --

22 MS. HARDING: They are? Well, actually, okay.

1 (Laughter.)

2 SPEAKER: But they can see us, too, if it's any
3 consolation.

4 MS. HARDING: We will tour the -- you can type in
5 and say, okay, enough of Fran's face; now show me
6 someone else at the table. I'm quite all right with it.
7 I just got back from vacation. I look my best.

8 (Laughter.)

9 MS. HARDING: So go for it. I had a wonderful
10 time. Thank you for thinking about asking me that.

11 So getting back to business, once we realized that
12 we were going to -- when the conversation was brought to
13 us, or the suggestion rather, that we needed to broaden
14 this, I knew immediately, and I believe most of my
15 colleagues around the table felt the same way, that we
16 really -- and thank you very much because a lot of this
17 came out from your advice and the Council. We really
18 realized that we're in the right place having the right
19 conversation with the right people. So that -- I'm just
20 telling you that so you know how we really started off
21 in bringing this.

22 So the -- we went through the meeting on several

1 areas after we found out people's point of view. We
2 wanted to get the perspective on what would be -- what
3 would be the ideal situation of integration. What do we
4 -- what do we think integration will look like? How
5 will we know we've met our outcomes and our goals?

6 I'm being told that I need to raise my voice,
7 which is -- I'm just checking to make sure. It's okay?

8 We had several large conversations, and then we
9 broke out our conversations into both a state
10 perspective and a community perspective as we went
11 through.

12 So the overview of the meeting and some of the key
13 points was on the perspective of integration of
14 substance abuse and mental health in primary care. We
15 talked about the successes of what we have done so far.

16 We have -- then we talked about some of the challenges
17 and opportunities that are preventing us from
18 integration or that we would have to identify
19 integration on that. So some of the --

20 DR. BROWN: Actually we went backwards because I
21 had gone too far ahead. So you're just doing the
22 summary piece right now.

1 MS. HARDING: Okay. So we also talked about -- in
2 our small group sessions we talked about cross-system
3 collaboration and how we would be building new
4 stakeholders. We talked about some gaps in services.
5 And I think that -- I think that what we would really
6 like you to do is have -- let's have a conversation
7 about some of the ideas that -- what we came out with
8 were the identified priorities for CSAP to look at, and
9 ones that we wanted to share with the Council so that we
10 could get a better handle on how we should move forward.

11 And I believe there were -- how many? Twenty --

12 MR. AUMEN: Twenty-seven.

13 SPEAKER: Twenty-seven.

14 MS. HARDING: I was going to say 29. I was going
15 to add a couple more.

16 (Laughter.)

17 MS. HARDING: So we have 27 ideas that came out of
18 this full-day conversation about how we engage
19 stakeholders, what are some of the challenges that we
20 have, what are some of our successes that we're
21 building, how do we build bridges, who do we build
22 bridges with. We really covered the full range of

1 issues around programming.

2 We came up with 27 priorities, and all of you know
3 that 27 priorities are just a little bit large for us to
4 wrap our arms around. And I believe, Matthew, you sent
5 a challenge to our members to narrow this down to a few,
6 correct?

7 MR. AUMEN: I did.

8 MS. HARDING: And did we want to share those or
9 discuss them? How would we like to proceed?

10 MR. AUMEN: Let me find them quickly. All right.

11 So we had a few of the members who were able to get
12 back to me with their rank order list of what the expert
13 panel came up with as far as the priorities for CSAP.
14 What we want to try to do is get the members' feedback
15 on if the Council as a whole can think about priorities
16 it would like for CSAP to engage in from this list.

17 And I have the list in front of me. They're on a
18 number of slides. And I'll ask the members -- I'll try
19 to advance the slides for us as we go through and speak
20 about them. But we have the slides here, and I will run
21 off a few of the numbers that we have.

22 We had three that each of the members who

1 responded chose those as their top 10, and those were
2 number seven, and I will advance to this one. It is,
3 "Provide support to statewide coordinating coalitions to
4 accomplish prevention and primary care coordination."
5 They also chose number 11, which is "SAMHSA to provide
6 leadership around advancing a public health approach to
7 plan and implement multi-level comprehensive
8 strategies." The third one was number 14, which is
9 "SAMHSA can provide leadership of aligning, leveraging,
10 and coordinating resources in a way that creates a point
11 of inference with primary care or other disciplines."

12 We had three more that not all the members had
13 ranked as their top 10, but several of those overlapped,
14 and those were numbers 13, 17, and 27. So 13 was
15 "SAMHSA can develop guidance or toolkits that could be
16 provided to primary care settings on screening, and how
17 and where to refer people when needed." Number 17 was
18 "More effort at recruiting and engaging champions --
19 youth, physicians, and community leaders -- in advocacy
20 planning and strategy implementation promoting
21 integration and primary care." Number 27 is, "Develop a
22 business plan that builds upon current workforce

1 strengths, agrees upon common language, and send on
2 direction to become viable for the next three decades."

3 So out of those, those are the six that the
4 Council may want to come in on as far as discussion and
5 see if there are three to five that the Council as a
6 whole is interested in recommending CSAP or SAMHSA to
7 engage in.

8 Kathy, would you like to start the discussion on
9 what you thought about the ones that you ranked? I know
10 you had seven, 11, and 14.

11 MS. REYNOLDS: Sure. If you could pop back to the
12 slide with 14, I think that was one of the -- my top
13 ones. And so, and I think we talked about this at our
14 meeting when we were all together at my first meeting
15 there in D.C., is the effect of SAMHSA's leadership.
16 And I put into that number 14 the conversation that we
17 had about when SAMHSA issues RFPs, or requests for
18 proposals, or other sorts of requests that they lead by
19 example in terms of having those requests help create
20 that interface with primary care and other disciplines.

21 So I think that my top 10, if you will, and I
22 think some of them are reflected here, were ones that

1 put SAMHSA in that leadership and policy role in helping
2 us move this out. And just so excited because I
3 actually see integration as a major way to bring
4 prevention into the fold with healthcare. It's been
5 critical to the work that we do out on the ground, and I
6 think it will be critical moving forward.

7 So finding a way that SAMHSA can align within
8 SAMHSA and align within the division of SAMHSA the
9 resources and programming I think would be critical.
10 And I don't know, Steve, what you think about that, but
11 that seemed to me to be a priority for me.

12 MR. GREEN: I agree with you, Kathy. I think you
13 make some very good points. I would also, if I could
14 just comment, I like item number 27. I think it gives
15 the needed structure and definition that integration
16 with primary care and prevention needs.

17 MS. HARDING: Now, Steven, the business plan idea
18 came up a lot during our conversations in the meeting
19 because it put in some structure. And, Kathy, within
20 that conversation, your -- not your idea, but I think
21 you are the one that began that conversation in April on
22 the first day that the -- no one actually came up with

1 your idea of integrating grants and contract language.
2 But we did discuss at great length how the business plan
3 would and what -- one part of the business plan would be
4 learning how to align and leverage this concept of
5 primary care. And as we got further into our
6 conversation it ended up being more of general medicine
7 and overall, you know, behavioral health into overall
8 health.

9 MR. GREEN: Yes.

10 MS. HARDING: But both of those comments came up.

11 MR. GREEN: Yes, and I think number 27, you know,
12 you talk about the structure. It just sets a foundation
13 for so many options I think that we need at this point
14 compared to so many ideas that are out there, and we're
15 all trained to get our arms around them. So I really
16 like 27.

17 MS. REYNOLDS: Matthew, could you push us down to
18 27 so we could see that again? I apologize. I have all
19 my things on the computer, and I understand if I go to
20 it, I'll change everybody's computer to mine.

21 MS. HARDING: Please don't --

22 MS. REYNOLDS: Please don't do that, I absolutely

1 agree.

2 MR. AUMEN: And my apologies. I should've had the
3 slides in the files pod, and they didn't go up there.
4 So we're trying to get those into the files pod so that
5 everyone has them as well. That way you can download
6 them, but we're working on it.

7 MS. REYNOLDS: I just had a question for number
8 27. When you talk about agreed upon common language,
9 there's some work that's been done from AHRQ and some of
10 the other Federal agencies on a common language
11 integration. So are you speaking to common language for
12 integration or common language for prevention in
13 integration?

14 MS. HARDING: Is that a question?

15 (Laughter.)

16 MS. HARDING: That's why we had a meeting of
17 experts. Does anyone else have -- around the table who
18 could jump in? That's a really good question. I think
19 that -- I think we feel like we have common language for
20 prevention, but not as it relates to -- it's still too
21 clumsy because we're talking about mental illness and
22 substance use disorder prevention.

1 So the behavioral health rubric in bringing that
2 discussion into primary care or general medicine still
3 hasn't been -- we struggled with that a lot. It
4 depended upon whether it was one of our physicians who
5 spoke. In other words, if you were to close your eyes
6 and listen to the conversation and didn't know which
7 person, you know, didn't have their name placed in front
8 of you, you almost could tell this is a prevention
9 trained person versus a physician versus a public health
10 professional, that kind of thing. So language is going
11 to be a problem for us, and maybe the Council can help
12 us with that.

13 MS. REYNOLDS: I would certainly -- I would be
14 certainly happy as a Council member to show, Matthew, if
15 you don't have them, some of the documents and the terms
16 that we're starting to come up with in the integration
17 space that's addressing some of this language issue.
18 But, yes, it's a real challenge because I'm kind of one
19 of those doers, and I love talking about language and
20 getting it together. But I want to make sure we get
21 things done. So that was just what I was wondering on
22 27 is which is the common language that we're talking

1 about.

2 The other part of 27 that -- and again, I think
3 this is the Federal perspective, is viable for the next
4 three decades. That's a pretty long time with the
5 challenge and the speed at which healthcare is changing.

6 MS. HARDING: Looking at --

7 MR. GREEN: This is Steven. I certainly agree
8 with Kathy. I apologize -- yes?

9 MS. HARDING: Go ahead. Go ahead.

10 MR. GREEN: Okay. I should go ahead?

11 MS. HARDING: Yes.

12 MR. GREEN: Okay. Yes, you know, I would like to
13 see maybe a limit, too, in the next decade or so, but
14 certainly not the next three decades. I agree that, you
15 know, things are moving rapidly and changing, and we're
16 always adjusting and adapting. But I would like to see
17 that parameter shortened.

18 MS. REYNOLDS: Dianne, I see that you have
19 thoughts on 27 here as Steve and I and the group are
20 talking?

21 (No response.)

22 MS. REYNOLDS: I'm sorry. Dianne, I don't know if

1 you've come off mute, if you're talking to us. We're
2 not hearing you.

3 MS. HARNAD: Oh, I'm sorry. I shut it off by
4 mistake. Yes, what I was interested in in number 27 was
5 the part related to building upon the current workforce
6 strength. While there are a lot of strengths within the
7 current workforce, as a previous MPN from the State of
8 Connecticut, I know many of the MPNs had issues and
9 concerns in terms of being ready to work within an
10 integrated system, not only with substance abuse, but
11 with mental health promotion, as well as primary care.

12 And so, some of the goals that -- some of the
13 priorities that I selected that were not put up on the
14 slides are related to this, and they're number 15 and
15 20, which really speaks to identifying state and local
16 models that showcase what has worked in terms of
17 integration. And also creating some actionable steps so
18 that states and community are still ready to do this
19 work.

20 MS. REYNOLDS: No, I absolutely agree with you,
21 Dianne, and I think SAMHSA through the PBHCI Program has
22 some state and local models. The only reason I didn't

1 select some of those is I thought that some of that was
2 already being done there within SAMHSA with the PBHCI
3 Program in the different states and the 100-plus sites
4 that have that out there. So again, they may be getting
5 back to what I think we said several times, which is
6 just communicating the information that is available.
7 And even in my two short meetings, I think we need to be
8 more inclusive of prevention in all of those documents.

9 But absolutely getting those preventions into the
10 primary care setting.

11 And I think building as one of the top of three, I
12 think, that Matthew talked about, building on your
13 community coalitions and bringing whole health into
14 those in a more substantial way I think is critical.

15 MS. HARDING: I'm looking for that one
16 specifically, and we'll locate it. Can I digress for
17 just a little bit of a digression for a second, Kathy,
18 something that you said around the PBHCI?

19 MS. REYNOLDS: Yes.

20 MS. HARDING: It didn't have a vote in this
21 meeting. We were really trying -- as a matter of fact,
22 all of the SAMHSA leaders who were in the room, we

1 really tried, and I think succeeded, in speaking less
2 and listening more because what's the purpose of
3 bringing in experts if you're going to talk to each
4 other again.

5 [BACKGROUND NOISE.]

6 MS. HARDING: That was interesting. And one of
7 the things if I had a vote I would've entered in on the
8 conversation, and you reminded me of this, is when you
9 say PBA from your perspective, you think that the PBHCI
10 Program would have taken care of it. We need
11 integration conversation with our colleagues that are
12 running some of these programs that are out there in the
13 communities working, because while I agree with you
14 around PBHCI, I'm going to guess, and it's a loaded
15 guess -- informed guess, I should say -- that many, if
16 not most, of the substance abuse prevention providers
17 programs never heard of PBHCI. And people in SAMHSA on
18 the fourth floor don't always necessarily know what the
19 sixth floor is doing, so we have our own issues of
20 language alignment and programing alignment as well.

21 MS. REYNOLDS: Yes, because I know that -- and,
22 again, I don't mean to talk in acronyms because I know

1 for our audience that's really challenging. That's
2 Primary and Behavioral Health Care Integration Project,
3 which I think is in its fifth round of cohorts. And I
4 know that a portion of all the grant's funds need to go
5 into prevention and wellness. So absolutely, I think as
6 I mentioned, that's been -- as someone who works in a
7 part of that TA center helping to make those linkages
8 and bringing that information in, I think, is critical
9 because a portion of the grant does go for prevention
10 and wellness. And we could absolutely use CSAP's
11 knowledge and support in helping grantees with that
12 aspect of the project.

13 MS. HARDING: I agree with you, and I think that
14 we've done a very good job over the last couple of years
15 with our language. We have not yet gotten to the level
16 of really looking at the different programming efforts
17 that are out there and how we can complement with one
18 another. That's why I like where all three of you chose
19 27.

20 One of the reasons why I like it, and thank you,
21 Steven, for putting it down to a decade rather than
22 three. But the -- it focuses -- I mean it could. It

1 could if you agree -- could focus on more of the
2 workforce issues of the strengths because it's the
3 workforce that Dianne mentioned equally around knowledge
4 base and increasing the skill sets. But it's also when
5 I look at workforce and common language, I think of the
6 programmings that are out there, and that you could be
7 sitting in a community that's getting sources of grants
8 from and integration grants from CDC that work very
9 beautifully with what the programming you're doing, but
10 one doesn't necessarily -- the workforce is overwhelmed
11 as it is. And I think it's up to us to figure out how
12 do we make that integration at that level as well.

13 MR. GREEN: Yes, Fran, this is Steven. I just
14 want to make one more plug for 27. As you know, my
15 heart is in Indian country, and it's often very
16 difficult to develop continuums of services. But
17 prevention is one of the easiest ones to develop in
18 Indian country because you just don't need brick and
19 mortar dollars and cents to do that.

20 So when I look at item number -- priority number
21 six, "look closer at successes in Indian country,
22 develop an appropriate model, and develop the capacity,"

1 I think 27 gets us there. So I'm going to put in an
2 extra vote for 27.

3 MS. HARDING: Okay. And would all that are on the
4 phone, can we agree that 27 is one of the priorities,
5 and then we can decide -- if we could come up with three
6 or four priorities and then we'll rank them as a list.
7 But could we agree 27 is definitely one that you all
8 agree would be a worthwhile kind of first step?

9 MS. REYNOLDS: Yes.

10 MR. GREEN: Yes.

11 MS. HARNAD: Yes.

12 MS. HARDING: And can I also get you to agree to
13 bringing number six and sort of attaching that one to
14 this one, and we'll kind of meld the two together and
15 then we'll have others?

16 MR. GREEN: Yes, I support that.

17 MS. REYNOLDS: Yes.

18 MS. HARNAD: Yes. I think there are a few other
19 ones, too, Fran, that would work. For instance, number
20 15, "Identifying state and local models to showcase."
21 That would be, like, the TA or sort of a training. I
22 think somebody even said guidance toolkits. I think all

1 of that would -- some of these will enter workforce
2 development. We just have to go through the list again
3 and put them in that box.

4 MS. HARDING: Okay. Okay. That's good. So we're
5 almost making -- the overarching header will be the
6 actual putting together the business plan, but six, 15,
7 and, as we mentioned, there are several others we can
8 look through and see which ones kind of fit underneath
9 that. That helps narrow it down.

10 That's such a behavioral health thing to do, by
11 the way. Only behavioral health professionals would
12 find a way to make three or five priorities. I just
13 wanted to throw that out there, not that I think it's
14 wrong.

15 MS. HARNAD: But I was going to suggest that we
16 have another one in there that part of the business plan
17 include all the work that has already been done with the
18 community coalition, so I don't know if that's a
19 separate one or included in the business plan.

20 MS. HARDING: Okay. And that's actually a couple
21 of them. Twelve is definitely one, and I know there's a
22 couple more, and I won't waste our time looking for

1 them. But good idea. Good idea.

2 Okay. So we have 20 minutes left. We have from
3 what -- I'm going to keep this pure. We have so far
4 agreed to one priority, and just sliding others
5 underneath it. So can we go back to Matthew's list
6 here?

7 MR. AUMEN: So we had seven, 11, and 14 were ones
8 that all the members who responded had agreed upon.

9 MS. HARDING: So let's look at seven, 11, and 14,
10 if that's agreeable. If Matthew can show them so you
11 can see them. Seven is at the bottom of your screen.

12 MS. REYNOLDS: And I think seven is the one that I
13 was referring to that I don't know if it's part of the
14 business plan or if it's a separate priority.

15 MS. HARDING: That's a good question. What do
16 people think?

17 MS. HARNAD: Providing support.

18 MS. HARDING: Because we don't want to lose the
19 focus of the purpose of the business plan. So we could
20 -- I don't know. I think it kind of stands -- it can
21 stand alone. I think it's strong enough.

22 MS. HARNAD: Well, it could stand alone. We could

1 look at it as part of the current workforce strength,
2 that we have coalitions in states, communities, little
3 entities all over the Nation.

4 MS. HARDING: Okay. All right. Can we show them
5 11 to remind them of what 11 is?

6 MR. AUMEN: Sure. And just quickly, folks, we do
7 have other Council members who are trying to dial in. I
8 believe Michael Compton has logged in, and we're trying
9 to get him on the line as well as -- Michael Montgomery
10 has some thunderstorms in the area, so he is losing
11 power. So we're trying to get him as well. Ruth is
12 also on phone only from what I can tell, so we'll try to
13 get in touch with her so that she can connect with us as
14 well.

15 MS. REYNOLDS: I just was wondering, Ruth, if you
16 had anything to add to what Steve, and Dianne, and the
17 group have been saying.

18 MS. SATTERFIELD: I'm totally in support of what
19 we've been saying about doing seven and 14. I do feel
20 like number seven could still stand alone. I think it's
21 extremely important that we focus on helping those
22 coordinating coalitions throughout the state know how to

1 integrate with primary care. So I feel like that has to
2 be a focus, so I like it being separate. I feel
3 comfortable with the seven, 11, 14, and 27 being our top
4 four.

5 MS. HARDING: Something I remembered about seven
6 which may help when we go to actually selecting in the
7 next few minutes is it up brings up very clearly the
8 whole notion of primary care, and the fact that primary
9 prevention, which is mostly done in coalitions, how does
10 that interact with primary care, because that is really
11 the -- that actually is the reason why we began this
12 conversation in the first place because many of our
13 grantees were having trouble trying to figure out how do
14 they fit into the ACA and in funding. So that's what I
15 like about that particular one, but I'm reading into it,
16 so I don't want to sway.

17 Could we look at number 11, just have a little
18 discussion? We just heard Ruth is good with that to
19 stay on as a priority. What do you think about focusing
20 on the leadership? Oh, that's our leadership.

21 MS. REYNOLDS: Well, that was my top priority, to
22 be honest with you, number 11.

1 MS. HARDING: Okay.

2 MS. SATTERFIELD: I kind of agree with that. This
3 is Ruth. I feel like it really has to be top down in
4 SAMHSA to take that strong leadership and pushing it,
5 and showing and modeling how to do that for the states.

6 MS. HARDING: Steven, Kathy, are you okay with
7 that?

8 (No audible response.)

9 MS. HARDING: Okay. Are we --

10 MS. SATTERFIELD: And then also in addition to
11 that, number 14 fits nicely, I think, with number 11.

12 MS. HARDING: Yes. Kathy --

13 MS. REYNOLDS: No, I was just going to respond. I
14 think number 11, I think the public health approach,
15 that's something that we talked about a lot in terms of
16 behavioral health, mental health, and addiction, and
17 starting to look more at a public health approach to
18 some of the services. So I like number 11 a lot.

19 MS. HARDING: Was 14, Kathy, the one that you were
20 thinking of when you were talking about things like the
21 PBHCI Program and others?

22 MS. REYNOLDS: If I can apologize again. If we

1 can pop down to the next slide so I can see 14.

2 MS. HARDING: Sorry. Our mistake.

3 MS. REYNOLDS: Yes. I think that could be a part
4 of that, absolutely, and I think, Fran -- this Kathy
5 Reynolds. And I think, Fran, you were talking about
6 that in terms of making sure that the projects that are
7 out there, like the coalitions, and the PBHCI grants,
8 and other projects -- excuse me -- get a line on this
9 project. So, yes, it could fit there under 14.

10 MS. HARDING: Yes. So I'm going to say what I
11 think we just agreed to, and please correct me if I'm
12 wrong. Number 11 seems to rise to the top; that is,
13 it's important not to be forgotten. Number seven, which
14 is "Provide support to statewide coordinating coalitions
15 to accomplish in primary care coordination." I don't
16 know if we'd want to flip these.

17 Number 14, which is right on the board right now,
18 and number 27 with the additions -- it's not in the
19 order -- priority order. But number six, number 15, and
20 number 12, which we can scroll slowly to so that -- in
21 case there's -- and we're changing it, thankfully,
22 Steven, to one decade.

1 (Laughter.)

2 MS. HARDING: It's enough of a reach as far as I'm
3 concerned.

4 MR. GREEN: Yes, and I certainly support your
5 recommendation. I like seven as a standalone, 11 as a
6 standalone. So I agree with you.

7 MS. HARDING: Fourteen and seven.

8 MR. GREEN: Yes. Yes, absolutely.

9 MS. HARDING: Is everyone good with that? I mean,
10 it's not a quorum, so you're committing with your
11 friends until we get a quorum, but we can at least use
12 this as our guiding principle going forward because then
13 we'll be able to put some work together between now and
14 next April so that we can have -- actually show you both
15 what our integrated group is.

16 MS. HARNAD: Yes, and I would say that I think
17 that we said under 27 also to add 13 as a piece of that
18 with the toolkits and divide it into pieces.

19 MS. HARDING: Okay. We can do that, absolutely.

20 MS. SATTERFIELD: Oh, I'm sorry.

21 MS. HARDING: I think we're just one shy of a
22 quorum, so just letting you know. I don't want to be

1 the only one with the good news.

2 (Laughter.)

3 MS. SATTERFIELD: Fran, I had one more thing to
4 add to number seven.

5 MS. HARDING: Okay.

6 MS. SATTERFIELD: Number 20 -- the priority 21,
7 "Increase SAMHSA's capacity to assist coalitions by
8 sharing knowledge of effective programs, and tools, and
9 resources." That would align, I think, nicely with
10 number seven if it was a part of that.

11 MS. HARDING: You're right. Okay. I told you.
12 That's what we do. We combine things.

13 MS. SATTERFIELD: I was going to say by the end of
14 the meeting we'll have all of them down to six.

15 (Laughter.)

16 MS. HARDING: That's the goal. That's my fear,
17 but that's where the clock works within our favor. We
18 only have so many.

19 MS. HARNAD: I'm just wondering. I see Michael --
20 Dr. Compton is on this. Do we have him on audio so we
21 can see what he thinks of our -- of our choices?

22 MS. HARDING: Michael, are you able to speak to

1 us?

2 DR. COMPTON: Can you hear me?

3 MS. HARDING: I can.

4 DR. COMPTON: So I have been listening. I do want
5 to chime in and say that I really like number 13 related
6 to toolkits and also number 15 pertaining to identifying
7 best practice models because those seem like really
8 concrete steps that could help people who want to go
9 about -- with integration.

10 MS. HARDING: Michael, we had discussed folding
11 that into the business plan, which looks at the
12 workforce. Are you comfortable with that, or are you
13 saying that possibly number 13 could stand on its own?

14 DR. COMPTON: I'm fine with that. I just wanted
15 to chime in to say that I really like those two very
16 concrete things that could be done.

17 MS. HARDING: Okay. I like that, too, because
18 then we show some deliverables. One of the things I
19 didn't say about our new Secretary is that's what her
20 main focus is. She wants to make a difference in the
21 two years, four months, and so many days that she has
22 left, and one of the things is outcomes. What did she

1 call it?

2 SPEAKERS: Impact.

3 MS. HARDING: Impact, impact, impact. And so that
4 will help us. Thank you.

5 MS. HARNAD: And I think number 13 is another
6 place. HRSA, Health Resources Services Administration,
7 already has a number of tools out in the primary care
8 setting for screening, so assistance and review of those
9 could be very valuable.

10 MS. HARDING: I agree. You know, in a side
11 conversation -- I had a conversation with a couple
12 people from HRSA in a meeting recently. And we actually
13 got to talking and speaking about prevention, in
14 particular the full continuum of prevention from
15 promotion right straight through indicated. And we're
16 hopefully in the near future going to be setting up a
17 meeting to do more discussion about that, because it was
18 an area they really aren't that familiar with.

19 And I'm not going to say that they didn't know we
20 had a huge workforce that focused on this, but they were
21 more -- they were very intrigued about what the
22 workforce actually does in the community versus a

1 community health center. So I was very encouraged about
2 that, and we can fold that into this very easily.

3 That being said, would any of you be interested
4 when we have some of these exploratory meetings with
5 some of our partners from the other Federal agencies in
6 calling in and being online for these conversations?
7 Would that be something that you would be interested in,
8 depending obviously who it is that we're speaking with?

9 MS. REYNOLDS: This is Kathy Reynolds. I'd be
10 very interested in the work of HRSA. We do a fair
11 amount of interfacing with that and with the SQHC, and
12 then the screening. And we've been doing a lot of work
13 out on the ground getting primary care, behavioral
14 health, particularly addiction, screening as prevention
15 for physical health problems and helping them with their
16 chronic health problems.

17 MS. HARDING: I think --

18 MS. HARNAD: And, Fran, it's Dianne. I would be
19 interested if it was related to workforce development
20 working with the existing workforce, the MPNs and
21 coalition.

22 MR. GREEN: Yes, Fran, Steven. Anything you think

1 that would be helpful to Indian country, I'd certainly
2 be interested in participating.

3 MS. HARDING: Great. Thank you. Okay. I am
4 going to turn this -- thank you very much. Any last
5 words on this particular topic? Obviously you can
6 always write in to Matthew anything that you think of
7 later as we -- or respond to what we give out to you.

8 MR. AUMEN: Can we just run down real quick what
9 we have finally decided on?

10 MS. HARDING: Okay. So who wants to know?

11 (Laughter.)

12 MS. HARDING: Who wants to do this?

13 MS. REYNOLDS: While you're preparing that -- this
14 is Kathy Reynolds -- could I ask Dr. Compton a question
15 from the primary care M.D. perspective about screening
16 time and the primary care session for screening?

17 DR. COMPTON: Sure. I am not a primary care doc,
18 I'm a psychiatrist. But I'm happy to try.

19 MS. REYNOLDS: I don't know, Michael. I'm not
20 hearing you. I don't know if anyone else is having that
21 problem.

22 MR. GREEN: Yes, I'm not hearing Michael either.

1 MS. HARDING: Sorry. We're multitasking here.
2 Does anybody have an answer? Clarese? We couldn't
3 hear you either. Is this Michael Compton?

4 SPEAKER: Right.

5 MS. HARDING: Michael, I'm sorry. We're having
6 difficulty hearing you.

7 DR. COMPTON: Can you hear me now?

8 MR. GREEN: Yes.

9 MS. HARDING: Yes. Whatever you did worked.

10 DR. COMPTON: Okay. I was just saying that I'm
11 not a primary care doc, I'm a psychiatrist. But I'm
12 happy to help.

13 MS. HARDING: Okay. Thank you.

14 DR. COMPTON: Kathleen, did you have a question?

15 MS. REYNOLDS: My question was just in the work
16 that you've done on screening for addictions and those
17 sorts of things. In doing that in the primary care
18 setting, have you done work and talked about where and
19 how to make that practical?

20 DR. COMPTON: I haven't specifically done work in
21 that area, but I think that in general, primary care
22 docs are open to this type of screening, especially for

1 the most prevalent behavioral disorders like problematic
2 alcohol use, and major depressive disorder, and the
3 anxiety disorders.

4 I think they're open to the screening because they
5 know so many of their patients have either overt or
6 hidden behavioral disorders. What they need help with
7 is exactly how to do it and how to do it in a very
8 efficient way. And that's why I like the idea of a
9 toolkit and pointing out best practices.

10 MS. HARDING: Thank you.

11 MR. AUMEN: Okay. So I'll do a rundown of what I
12 understand that the group has decided on. I have number
13 27 with six, 15, and of course I didn't number these in
14 order -- 12 and 13. And then I have number 11, and then
15 I have number seven along with number 21, and then I
16 have number 14. Those four. Okay.

17 So if we get Michael on -- Michael Montgomery here
18 in a little bit, we could have the Council vote. As far
19 as these being your recommendations to CSAP, we will
20 wait on that, but thank you very much for your feedback.

21 MS. HARDING: Okay. Is everyone comfortable with
22 moving onto a discussion on the Strategic Initiative

1 Number 1?

2 MR. GREEN: Yes, Frank, this is Steven. I'd just
3 like to make a comment before we move onto Kathy that
4 here at Gila River Health Care, we have a healthcare
5 system, Kathy. And I agree with Dr. Compton that our
6 primary care actually screens for substance abuse
7 violence. And it took some time before it took off, but
8 we're having hypersensitive screenings, and we have
9 electronic records where people are referred from
10 primary care over to our behavioral health program. So
11 it is working over here.

12 MS. REYNOLDS: Excellent. Thanks. I just was
13 wondering how that was going. Thanks, Steve.

14 MR. GREEN: Sure.

15 MS. HARDING: Okay. Thank you. And, Steven, I'll
16 make a public statement and then it will make it real.
17 We are trying to reschedule the trip that I couldn't
18 take because of the furlough, because I so very much am
19 interested in seeing the services that you all have
20 discussed. You basically have the full continuum of
21 services in one location, and I'm very excited to
22 continue to be excited to see that, so I will --

1 MR. GREEN: We can't wait.

2 MS. HARDING: I know. I know. And I don't think
3 there's any furloughs in my future, so we --

4 MR. GREEN: Okay. Well, that's great news, and
5 you're always welcome, and we'll look forward to the
6 announcement Sunday, okay?

7 MS. HARDING: Thank you. Thank you. Okay. So
8 we're now going to move on and discuss the changes that
9 have been made and some of the responses to the
10 Strategic Initiative Number 1 in the new 2.0 document,
11 is that correct?

12 MR. AUMEN: Yes.

13 MS. HARDING: Okay. And I'm asking Rich Lucey to
14 guide us through this conversation because he has been
15 the primary source of gathering the information for --
16 which went out to you in the whole strategic initiative
17 document from our Administrator, Pam Hyde.

18 MR. LUCEY: Okay. Hello, folks. This is kind of
19 a two-part conversation regarding the strategic
20 initiative. We have the current Strategic Initiative
21 Number 1, and then we have, of course, our Proposed
22 Revised Strategic Initiative Number 1.

1 Let me let you know that another document that
2 SAMHSA is currently working on is an accomplishments
3 report of all of the various things that have been
4 achieved under all eight of the strategic initiatives.
5 And we are all diligently working on tightening that up
6 so that it can be reviewed/approved internally and then
7 released, so that's something that's in the works.

8 As it pertains to our revised Strategic Initiative
9 Number 1, you'll recall that the first ready for prime
10 time draft of the document was provided to you that
11 first week in April both at our NAC meeting and then
12 also at the joint NAC meeting. And it was in those two
13 venues that you actually had two bites at the apple, so
14 to speak, of providing your input on the goals and
15 objectives that were drafted for the Strategy Initiative
16 Number 1.

17 So let me quickly walk you through where we
18 incorporated your comments and your input both at our
19 NAC meeting that was on April 1st, as well as the joint
20 NAC meeting a little bit later that week. So what
21 Matthew sent out to you is something I provided to him,
22 which was more or less kind of a road map or a color

1 coded key of some type to show you where strategic
2 planning included your input.

3 One of the common things you'll notice across all
4 four goals is that we went beyond just reducing certain
5 behaviors like smoking or suicide or underage drinking.

6 We actually are in the business of preventing and
7 reducing those types of behaviors, and that came
8 directly from you. So you will see that specifically in
9 goal one, we're talking about helping to prevent and
10 reduce tobacco use. Same thing in goal two with prevent
11 and reduce underage drinking, and then the same is true
12 for suicide prevention as well as for prescription drug
13 misuse.

14 Another area that we used your input and
15 incorporated it was in goal number one. And this is one
16 of our newer areas, and it has to do with emerging
17 behavioral health issues. We initially simply said we
18 were going to identify emerging behavioral health
19 issues, but thanks to your input, which we've
20 incorporated it, we're proposing to identify and respond
21 to emerging behavioral health issues. So certainly
22 identifying them is one thing, but it also is helpful to

1 respond to them, and that's something that we've
2 incorporated.

3 If you look at goal two, which is underage
4 drinking, this is where we had the most change based on
5 your input. First of all, we have a brand new objective
6 that we didn't have that first week of April, and that
7 was to -- that is, I should say, to prevent and reduce
8 underage drinking and its negative consequences among
9 middle and high school students ages 12 to 17.

10 One of the conversations we had with you is that
11 we've been seeing some really good declines among the
12 12- to 17-year-olds in our country as it pertains to
13 underage drinking and not so much among the 18- to 20-
14 population. And we'll talk about that in a moment. But
15 based on your feedback, we have now incorporated the
16 distinct objective to call out the 12- to 17-year-olds.

17 On that point of the 18 -- the young adult
18 population, 18- to 20-year-olds in college, 18- to 25-
19 year-olds who are not in college, we've now collapsed
20 that into one objective. Instead of having two separate
21 objectives like we did before, we've now collapsed that
22 into one. And that's solely based on your feedback, so

1 thank you for that.

2 Moving onto goal three, the only change that we
3 really had in this particular goal is within the first
4 objective, what we call Objective 1.3.1. We have
5 incorporated the phrase "integrated primary care
6 services" apropos of the conversation that we just had
7 around integration and where we're trying to go with
8 integrating behavioral health into primary care. We're
9 now looking at promoting suicide prevention as a core
10 component of healthcare service, which includes
11 integrated primary care. And that came directly out of
12 your conversations with us, so we thank you for that,
13 and we have incorporated that into the goal.

14 And then the last thing I'll mention is in goal
15 four, which is around prescription drug misuse and
16 abuse. This was another simple -- we added the word
17 "prevent and reduce opioid overdose incidence and death"
18 as one of the five objectives that we've drafted.

19 The conversation we want to have with you today is
20 particularly around the metrics. First, let me let you
21 know that as happens at times when you're doing a lot of
22 different drafts and lot of the different moving parts,

1 the version that was released to the public has a couple
2 of typos in it that we've identified and will be
3 corrected in the final draft. And it's in the metric
4 for goal one.

5 In the metric for goal one, it should not address
6 young adults in there at all. Young adults are not part
7 of the 12- to 17-year age range, and so it's "Reduce the
8 percentage of youth ages 12 to 17 reporting past 30-day
9 substance use." And then the next typo is its "major
10 depressive episodes," not "depression episodes." So we
11 caught those after it got released, and it will be
12 certainly corrected in the next go-round.

13 Before we get in depth into the discussion about
14 the metrics, I should also mention -- I'm sure you're
15 aware of this -- the draft document was released last
16 week. It's currently out for public comment. We
17 certainly ask you as well to distribute it to all of
18 your different networks and stakeholders that you come
19 in contact with, and encourage them to comment on it.
20 The comment period closes on August 18th. So we have
21 more or less or so one-month period for public comment
22 on this document.

1 So on the metrics, we stuck to the goal of having
2 only one metric per goal. And, in fact, a couple of
3 them are multi-part, but it still is our goal to keep it
4 to one metric. So you'll see in goal number one, for
5 example, we're not only dealing with substance use as a
6 metric, but also major depressive episodes.

7 When you look at these four goals, you will notice
8 that they are not quantified per se. There is not a
9 specific percentage or number that we've included. For
10 example, let's look at goal two around underage
11 drinking. We're simply saying decrease the percentage
12 of youth and young adults ages 12 to 20 engaged in
13 underage drinking and reporting past 30-day alcohol use
14 or binge drinking. We haven't said by five percent, by
15 10 percent, what have you.

16 A couple of the other metrics in the other five
17 proposed strategic initiatives do go so far as to put a
18 quantified measurable metric in there to that degree.
19 Our question to you is -- a two-part question. One,
20 should we, and if so, which ones, and what should the
21 number be?

22 And so, that's where I'm going to leave it, and

1 punt it to you, and open it up for the discussion. Let
2 me first ask, though, since Fran does lead this
3 initiative if she has anything from her perspective she
4 wants to add or guide us on.

5 MS. HARDING: No, I think that the -- we felt that
6 the actual goals and the objectives, you will have
7 plenty of time to comment on in the next couple of weeks
8 if you've received the document. And if you haven't,
9 please let Matthew know, and he'll send it right out to
10 you. That's number one.

11 Number two, it's the metric we struggle with. I
12 told you recently the directive that our Secretary has
13 given us and the importance that she puts on impact. So
14 the -- in one respect, it shouldn't even be up for
15 question that we do have numbers on our metrics. On the
16 other hand, we're talking about prevention, and we don't
17 want to set ourselves up for a metric that our
18 communities and our states do not have the ability to
19 collect data for, and to give us the numbers that we
20 would need to justify percentage of a particular number
21 or percentage in the metric.

22 So we kind of have to weigh out the differences in

1 there, and can we word this metric -- have we worded the
2 metric strongly enough, or is there is another way to be
3 able to get to the actual goal and show that we've moved
4 the needle on these particular four goals?

5 MR. LUCEY: So, we'll open it up to all of you
6 that are on the phone, our Council members, and get your
7 input on our metric.

8 OPERATOR: At this time, if you would like to make
9 a comment, please press star, then the number one on
10 your telephone keypad. Again, to make a comment, please
11 press star, then the number one on your telephone
12 keypad.

13 MR. AUMEN: For the -- for the operator, we're
14 going to leave this one for the Council to discuss.

15 MS. HARDING: Okay. So are there any Council
16 members that have comments? Is Kathy trying to get in?
17 Is someone trying to get in? Yes. We're not hearing.
18 We're not hearing the Council members, Operator.

19 MS. HARNAD: Fran, I guess I could add to this
20 one. When you had -- when I thought about this
21 initially, I thought -- I was thinking back to the
22 Partnership for Success Grant. And there was an

1 incentive if, I think, you reached a three percent
2 reduction.

3 And then when you had, well, we don't want to set
4 up prevention folks in that meeting, those quantifiable
5 measures, it sort of was an aha moment for me because it
6 took maybe five years to get a one or two percent
7 decrease in a state that was really well structured to
8 do the prevention work. So I sort of agree with you
9 around the quantifying it, that may be a little bit
10 difficult.

11 MS. HARDING: Thank you.

12 OPERATOR: And we did have a comment from Amy
13 Hiller. Is she a Council member?

14 MR. AUMEN: No. So, we'll leave this, Operator,
15 for the Council discussion. And at the end at 2:50,
16 we'll open the lines up for the public to provide their
17 comments and questions.

18 OPERATOR: Certainly.

19 MR. AUMEN: Thank you.

20 MS. REYNOLDS: Yes, this is Kathy. I lean towards
21 quantifying the metrics just to -- always in terms of
22 trying to do that so that we have something to shoot for

1 and we know if we got there or not. But that then gets
2 into how at the Federal level do you do that and
3 collecting the data to make sure that it happens. So I
4 think these are really good questions, but I would log
5 in on if it was possible to quantify them.

6 MR. LUCEY: And also, let me just say thank you so
7 much both to Dianne and to Kathy for chiming in. Our
8 goal doesn't also have to be to quantify all four if we
9 decide to do that. So the question is, again, if we
10 decide to quantify any of them, it's which one, and what
11 would then be the quantified number to include, or
12 percentage, I should say, in the metric. So we don't
13 have to feel bound to do it with all four of them.

14 MS. HARDING: Do you want to see other two so that
15 you have the full four if you can't see them in front of
16 you? Do you want us to show them to you?

17 (Cross talking.)

18 MS. HARDING: I'm going to say -- I'm going to say
19 yes.

20 (Laughter.)

21 MS. HARDING: I think that was a yes. Okay. So
22 here's the first strategic initiative metric.

1 MS. REYNOLDS: But you'd have to choose some
2 metric to start with, right --

3 MR. LUCEY: Right.

4 MS. REYNOLDS: -- to know if we reduced it. So
5 then you get into the issue of whose metric and which
6 one.

7 MR. LUCEY: Right. So this is one of those
8 metrics where we more or less collapsed two thoughts
9 into one. So it's not only looking at reducing youth
10 30-day substance use, but also from the mental health
11 side, youth major depressive episodes in the past year.

12 So if we were going to quantify this one, we could
13 decide to quantify just the substance abuse one, just
14 the depressive episodes one.

15 But, Kathy, to your point, it's, you know, by
16 what. Do we want to reduce, say, substance abuse use by
17 five percent, or depressive episodes by 15 percent,
18 whatever?

19 MS. SATTERFIELD: Well, the other issue, too, is
20 if the metric is dealing with 12- to 17-year-olds, then
21 in the goal we just -- are we targeting 12- to 17-year-
22 olds only?

1 MR. LUCEY: Yes. No. Actually I'm sorry. I'm
2 jumping on two different thoughts. The metric itself is
3 only focusing on 12- to 17-year-olds. That does not
4 mean or correlate that the goal only focuses on 12- to
5 17-year-olds.

6 MS. SATTERFIELD: Right.

7 MR. LUCEY: That's important. Thank you. That's
8 a very important clarification to make. And the reason
9 we picked the 12- to 17-year-olds in this particular
10 instance, because that was part of the discussion, was
11 because that's one of the age cohorts specifically
12 called out within the NSDA, which is where we get our
13 information from.

14 MS. SATTERFIELD: And we have a lot of
15 longitudinal data with that age cohort also.

16 MR. LUCEY: Right.

17 MS. SATTERFIELD: Yeah.

18 MS. REYNOLDS: But then you get into the challenge
19 of how do you know that you impacted that with what you
20 did versus what someone else did.

21 MR. LUCEY: Right.

22 MS. HARDING: Yes, that is the challenge. You're

1 absolutely right.

2 MR. LUCEY: Yes. Yes, and so actually Mirtha is
3 the one who just raised the issue here at the table
4 around the table of a baseline. We haven't established
5 a baseline per se. I mean, the first time we -- if we
6 quantify it, we're sort of doing that here, but we will
7 prepare over the last X number of years going into the
8 next few years. I mean, that's just the challenge that
9 we'll be faced with.

10 But I think as you said, the NSDA has given us a
11 lot of rich data over the years, so we've got that
12 longitudinal data to drop on and other sources.

13 MS. REYNOLDS: The reason that I like thinking
14 about quantifying and deciding on the baseline and
15 tackling this is that one of the things that's missing
16 for us in behavioral health and in addiction are the
17 numbers. You know, primary care can tell us how many
18 more folks are obese. I have great slides on the
19 increase in obesity across the country, and I have great
20 slides on reducing hemoglobin A1Cs. I don't have good
21 data slides in the way that you're talking about the
22 data now, so that's why I am interested in that.

1 MS. HARDING: We agree with you, and I think that
2 this is something that, not for this discussion, but
3 maybe in April we can talk about whether or not we want
4 to take this to another level. We have had this problem
5 in prevention for a while, and I think that we're
6 getting much better at knowing how to collect the right
7 data to support it.

8 The problem is that for substance abuse
9 prevention, it's mostly at the community level, and how
10 can we take that rich data, which we have a lot of, but
11 sometimes it's like apples and oranges because each
12 community is looking at different things. That's the
13 way our science has told us how to select the right
14 program.

15 So we are getting tremendous data and good stats
16 on lowering certain things in the substance abuse world.

17 But it doesn't always resonate and trickle up to the
18 states, because like Dianne was saying, now, she could
19 have 20 communities getting great change, but yet 20
20 communities in a state like the size of Connecticut is
21 only a small portion.

22 So what we're working on with the community data

1 platform here in SAMHSA is to, hopefully Admiral Delaney
2 will be able to show how we use the rich data at the
3 community level to begin to tell our story of success,
4 which will then convince people that what they're doing
5 in the investment of a dollar is a wise one.

6 So that doesn't really help our metric
7 conversation, but it is -- you just touched with me one
8 of the challenges that we are working on in here in
9 SAMHSA that we may want to explore next year.

10 Do you want to go to the other -- so that we
11 remember what the metrics are so that -- there might be
12 one that jumps off the page that you say this one we
13 know we could quantify, or maybe not.

14 MS. REYNOLDS: Well, Fran, this is Kathy. I think
15 if there was some way that CSAP could help us pick out
16 some of those core measures that everybody collects in
17 addition to their unique data, it would be very
18 incredible data that we need to put up with the physical
19 health data. It would be the corollary to that.

20 MS. HARDING: That's a good suggestion. We'll
21 take that -- we'll take that challenge and send that
22 out. We'll have a conversation, because there are some

1 that we have seen across the country that have worked
2 out quite well.

3 MR. AUMEN: Kathy, can you repeat it real quick?

4 MS. REYNOLDS: No, I think what I hear the field
5 asking, and I get a lot of requests for it, if I can
6 only collect five or six things, what should they be.
7 So if there are key prevention elements like this one
8 here, the percentage of youth 12 to 17 from the future
9 study or something like that, that we could disseminate,
10 or CSAP could put out, or SAMHSA could put out and say,
11 if you can only collect a certain set of things, please
12 make this one of them so that we can have national data
13 to go along with the national public health data and
14 primary care data that is out there.

15 MS. HARDING: Kathy, not to belabor this
16 conversation totally on the data, but the common data
17 platform is doing just that.

18 MS. REYNOLDS: Great.

19 MS. HARDING: One of the challenges of developing
20 the common data platform is we collect -- we have so
21 many measures, and Pete is -- it's his personal job to
22 narrow those down to three to five measures. And that's

1 been very difficult for him because we, the programs --
2 the "we" -- we don't want to give it up. It's just like
3 we couldn't come up with three or four priorities. We
4 tacked on more priorities under the one to get to the
5 goal. He's not allowed to do that. So we've made a
6 selection of five measures. Actually I think there
7 might be four, and not everyone is happy with that.

8 So by April at the end of the meeting, we'll ask
9 you -- maybe we have Pete or one of his staff come to
10 our meeting to talk about the measures, and how to
11 accommodate a platform, and what measures were chosen,
12 and why.

13 MS. REYNOLDS: Great. Thanks.

14 MS. HARDING: Yes. Let's look at the other --

15 MR. LUCEY: Sure. If we can advance this. I'd
16 just wanted to point something out to you, a unique
17 thing about goal two and the metric. One of the
18 challenges in this metric admittedly is the issue of the
19 age cohort of 12- to 20-year-olds.

20 As Dianne has cited in many of her speeches, as
21 Steve Wang has said in many of his presentations, as I
22 have said in many of mine, whether it's the Partnerships

1 for Success grantees or MAI grantees, college
2 conferences, we have seen measurable and a really good
3 decline in underage drinking over the last decade, but
4 it's been primarily driven in the 12- to 17-year-old
5 cohort. Where we have not seen those types of really
6 good measurable declines are in the 18- to 20- cohort,
7 and that's primarily driven by our college students and
8 the amount of drinking that takes places on college
9 campuses.

10 So within this type of a -- you know, the
11 challenge I think to quantifying here is the offset
12 between declines we'll see in the 12- to 17-year-olds
13 and a plateau, and if not, sometimes an increase in the
14 18- to 20-. So that's just something I wanted to point
15 out to you there.

16 And in the interest of time, I do want to just --
17 if we quickly go to numbers three and four. They're
18 pretty basic, and that's not to minimize obviously the
19 magnitude of the issues we're dealing with. But as far
20 as a metric goes, it's simply reduced the number of
21 suicide attempts and deaths by suicide. There's no age
22 cohort identified here. There's no ethnicity or racial

1 population group that we're looking at, no setting.

2 You'll see the parenthetical or the asterisk that
3 we have listed there. In the draft we have identified
4 some very specific populations that are at high risk
5 based on what the data are showing us, primarily among
6 working-aged adults, men in mid-life, as well as some
7 other very specific populations like we've done in the
8 past. "Military," which we're rephrasing that, by the
9 way, to be service members, veterans, and their
10 families, as well as American Indian and Alaska natives
11 remains a high priority population for us, as well as
12 our lesbian, gay, bisexual, transgender, and questioning
13 youth.

14 But we did not include any of that strategic
15 planning in the metric. It's simply a reduction in the
16 number of suicide attempts and deaths by suicide. And,
17 Fran, I guess I can take the luxury of saying this is
18 one of the areas that Pam focuses on a lot because of so
19 much we've done around suicide. And yet we don't seem
20 to be making a big dent in this area in the number of
21 suicide attempts and deaths by suicide. And so, that's
22 why we've put that in there as a metric because that's

1 where we're going to have a lot of attention.

2 And then lastly, I'll mention goal four. Same
3 situation. It's a very straightforward metric: reduce
4 the number of opioid overdoses. We have not identified
5 any particular age group, any particular population, and
6 it's not opioid overdose deaths you will notice, and
7 maybe that's a comment that we'll get within the public
8 comment period. It is simply reducing the number of
9 opioid overdoses. And we certainly have the data
10 through our own survey instruments as well as through
11 the CDC that we have this information. So I just wanted
12 to point those out to you.

13 MS. SATTERFIELD: Rich, I had a question about
14 that. Is there some reason why we didn't have reduced
15 opioid use in that objective?

16 MR. LUCEY: I will guess, but I then want to defer
17 to Fran just because prescription drug abuse has been a
18 lot of our focus over the last year or two or three.
19 But whether you talk about prescription drug misuse --
20 lots of people call it epidemic, other people don't --
21 the primary issue is in the number of opioid overdoses,
22 death. That's what's skyrocketed over the last years,

1 as well as the number of emergency room, emergency
2 department visits as a result of opioid overdoses.

3 Obviously the toolkit that we released last
4 August, which has received tens of thousands of
5 downloads in just now over a year, the focus has been
6 primarily on overdoses rather than the use itself.
7 That's not to say it's not part of the goal, and also
8 would be included, you know, within these objectives.
9 It's just that the metric would be focusing on the
10 overdose part.

11 MS. SATTERFIELD: Okay.

12 MR. LUCEY: Does that help some?

13 MS. SATTERFIELD: Yes.

14 MR. LUCEY: Okay.

15 MS. HARDING: And we're not focusing on deaths
16 because CDC focuses -- they have aligned their
17 programming for prescription drugs around mortality.
18 And so, we're -- and Dr. Frieden has spent a lot of time
19 looking at intervening on overdose deaths. So that's
20 where a lot of work is being done in the CDC.

21 So Pam Hyde is very aligned with her thinking that
22 one of the areas that we feel, especially in the

1 prevention realm, that we can have the most impact on
2 and with the huge success of the toolkit and using --
3 and having more states and, just recently, the Federal
4 government, developing legislation to have NLETs
5 available with first responders, has had an incredible
6 impact on reducing opiate overdoses.

7 So that's one of the reasons why this metric is
8 there because we're seeing an impact. The question is,
9 is this the one where we put a percentage and an actual
10 number is up for question. If I were -- when I look at
11 this, I think it's a little bit easier to classify this
12 one than it is some of the others. Kathy, are you
13 trying to call in?

14 MS. REYNOLDS: No, when I can't hear people well,
15 I have to bring my phone up from speaker to my ear. So,
16 no, I'm fine.

17 MS. HARDING: Okay. Thank you.

18 MR. LUCEY: So to bring this back to our charge
19 for you, it was a two-part thing that we hoped to either
20 get your recommendation or input on. Part one is should
21 any of these metrics be quantified, and that's probably
22 the easier of the two questions to answer at this point

1 in time. And then the second part is if so, then what
2 should the metric be. How should it be quantified?

3 So I'm looking at Matthew and seeing if that's
4 kind of the direction we should go with them right now
5 as to, one, just have the discussion about get their
6 input on should they be quantified.

7 MR. AUMEN: I would recommend that now. What are
8 we looking at as far as a timeline for wanting to have
9 something in place?

10 MR. LUCEY: Yes. So I'm just guessing. So we
11 know that the public comment period is August 18th. As
12 this has been on a relatively fast track to get
13 developed and get out, I'm guessing that October 1 is --
14 because it is the 2015 strategic plan through '18,
15 October 1 is probably the target date to get it
16 released. So we would want, just like the rest of the
17 public, any of your other further comments by the 18th.

18 And I think that's the period of time you could be able
19 to mull over the issue of how to quantify.

20 But I think the easier part for here is to just
21 decide should they be. And I'm looking at Matthew to
22 see if that would work as part of the Council

1 recommendation or what have you.

2 MR. AUMEN: Yes. I'd say go with that, with 40
3 minutes remaining or -- 40 minutes -- 20 minutes
4 remaining before --

5 MR. LUCEY: Public comment.

6 MR. AUMEN: Yes. So I don't think that we will be
7 able to get to specific Council recommendations. We'd
8 also need a quorum. There is a possibility that if we
9 are looking to have something by October 1st, possibly a
10 teleconference with the members perhaps late September,
11 we could work with the members between now and then to
12 further develop those recommendations before any would
13 be voted on. And then we could have -- we could have a
14 teleconference for a vote if that's what the Council
15 wants to do.

16 MR. LUCEY: Yes. So the challenge in that is once
17 this gets put in its final form, I mean, it then becomes
18 SAMHSAs's strategic plan. And I don't think late
19 September is going to work because basically I'm saying
20 by the time, you know, we review and do all of that, so.

21 You know, as Fran is saying, they certainly can
22 write in just like anybody else. But I don't know if we

1 collectively have him write in to us as well. Maybe by
2 the latest the end of August.

3 MS. HARDING: Yes. I think that we did both in
4 one respect. My proposal is to have you write to
5 Matthew what you suggest the metric would be for any of
6 these, your data, quantifiable data. And then we will -
7 - and have it into us before the 18th. And then we will
8 try to find the time where we can get a quorum to do a
9 quick 30-minute conversation with all of you before the
10 end of August.

11 I know it's tight, but we can try. And if it
12 doesn't work then we will -- hopefully if you send your
13 suggestions in and then circle if there's more than one
14 -- it depends on how ambitious you are -- let us know
15 which one is your priority, because if you all come back
16 with a strong priority, we can do this, I think, online,
17 and we might not even need the call to begin with. So
18 let us try to figure out what we can do. But we won't
19 be able to do anything unless we hear from you.

20 So, and if you wouldn't mind sending a note to
21 Matthew, even if you don't have anything so we'll know
22 when we have all the responses back.

1 MR. AUMEN: Yes. So basically how that would work
2 is if the Council were to decide on a collective
3 recommendation that it would want to vote on, we would
4 have to discuss that before making any final
5 recommendation in a public forum. And that's not
6 difficult to set up. It would just be a time issue.

7 MR. LUCEY: Yes.

8 MS. HARDING: Okay. Great.

9 MS. HARNAD: Fran, it's Dianne. I was just
10 thinking many of the core measures that are currently in
11 place could have probably -- I would suggest that we use
12 some of the core measures that are already in place that
13 would align or that are feasible with the strategic
14 initiatives.

15 MS. HARDING: Are you talking about the NOM?

16 MS. HARNAD: Yes.

17 MS. HARDING: Yes. Okay.

18 MS. HARNAD: I don't know if that's okay, but I'm
19 just thinking rather than reinvent the wheel. It's hard
20 to go through a whole new, you know, process of getting
21 things approved. If we can use some of what's in place,
22 that may be a good start, and it wouldn't be that much

1 of a burden to state to everyone else.

2 MS. HARDING: Okay. Thank you. That's a good
3 idea. We'll look at that. Yes, we'll look at that.
4 Thank you. We have a question from Mary.

5 MR. AUMEN: Yes. She's unable to call in. She's
6 having connectivity issues from American Samoa. But she
7 wrote in and asked if there's any data on the Pacific
8 Islands that are included in the initiative, the
9 strategic initiative.

10 MR. LUCEY: So, Mary, this is Rich. I certainly
11 know that in the various presentations that Fran and I
12 have collectively done primarily around the underage
13 drinking prevention piece, there definitely, and there's
14 been a couple of slides we especially have used that
15 have pointed out the significant differences around not
16 only underage drinking, but then also rates of binge
17 drinking and then heavy drinking among various racial
18 and ethnic groups, including American Indian, Alaska
19 native, the Pacific jurisdictions, Pacific Islanders,
20 typical white, black, and then Asian-Americans. So
21 those are the five that typically show up on the chart.
22 So we do have the access to that data, and I'm

1 sure that will hold true for the other areas as well,
2 goal one as well as goals three and four.

3 MS. HARDING: So any last words, comments, advice,
4 anything about this segment of the Strategic Initiative
5 Number 1, 2.0?

6 (No response.)

7 MS. HARDING: Hearing none, I think what we'll do
8 now is go to the next -- we locked somebody out.

9 (Laughter.)

10 MS. HARDING: We'll go onto the next level. Thank
11 you very much. This is -- we have learned for the first
12 Strategic Initiative 1.0, at first when we first came
13 out with them the first year, it was like we were --
14 every presentation, every conversation, every opening to
15 every meeting we talked about this, and it just didn't
16 seem real. We weren't real sure if this was going to go
17 anywhere.

18 We have -- we have since learned over the last
19 four years it has really been a good road map, and we've
20 really been able to look at the activities, add to them,
21 tweak them a little bit, but to know that this was
22 direction has been incredibly helpful. So we're hoping

1 that the extra time that we're spending now with 2.0
2 will give us the same level of guidance and security
3 moving forward.

4 And we talked about this in April, but number one
5 -- excusing the pun -- strategically worded so that we
6 could have some room to add, God forbid, another
7 disaster, tragedy or issue between now and 2018 so that
8 you could fit it in without worrying about, well, we
9 can't focus on marijuana because marijuana, but there is
10 no place in Strategic Initiative Number 1. Now we can
11 focus on the different emerging issues both on the
12 mental health side as well as the substance abuse side.

13 So when you do get this, please do, and the reason
14 for me telling you this is because it is worth your time
15 and your colleagues' time that you share this with to be
16 incredibly, critically poignant in your comments of what
17 needs to be changed, what you like, what you don't like,
18 what's missing. Did we miss the boat? Are we on track?

19 You know, all of that. We look at every single
20 comment, and it's really been helpful. So I thank you.

21 MR. AUMEN: We do not have a quorum. Michael
22 Montgomery is still experiencing the thunderstorms. I

1 think he said he was trying to get a hold of a
2 generator, but --

3 (Laughter.)

4 MR. AUMEN: The lengths people will go to.

5 MS. HARDING: Okay. So now there's a visual, a
6 visual of Michael looking for a generator, going to his
7 neighbors.

8 MR. AUMEN: But we'll hold off. We are going to
9 have a teleconference call at the end of the month. We
10 go over the minutes there. We do not per se have to
11 vote on the minutes this morning, right now.

12 MS. HARDING: Okay.

13 MR. AUMEN: We can make that happen at our next
14 meeting.

15 MS. HARDING: So then that means we'll go to
16 public comments, and then right after that, closing
17 remarks, and then we'll adjourn. Is that correct? Just
18 so you know what the plan is.

19 MR. AUMEN: And we have 105 folks who are on the
20 webcast portion. We'll have to assume that there's even
21 more on the telephone. So great turnout. Very happy to
22 see all these folks join us, so hopefully they will have

1 some good, vibrant comments for us. So, Operator, you
2 can queue the folks up who may want to provide public
3 comment. Depending -- let us know if there's a large
4 queue so that we can at least stop by around 2:55 I'd
5 say. And we can let folks know if there's a large queue
6 to try to keep their comments to a few minutes.

7 OPERATOR: At this time, if you would like to make
8 a comment, please press star, then the number one on
9 your telephone keypad. Again, that is star, then the
10 number one on your telephone keypad.

11 At this time we do have two questioners in queue.

12 The first comment comes from James Gallant.

13 MR. GALANT: Hello. Yes, I have a comment and a
14 question, and it concerns the Strategic Initiative
15 Number 3 by reducing suicide. And I'd ask you folks to
16 please consider to recommend to the administration of
17 SAMHSA that providers must identify the court-ordered
18 parenting rights of their clients that they serve and
19 assess the needs or legal services, and then refer them
20 back to the court, the court that issued the court
21 orders for enforcement if necessary, because two-thirds
22 of your suicides are children from single parent homes,

1 and a vast majority of them have custody and parenting
2 rights through divorce and separation.

3 And this would be a way to get them prevention
4 services to make sure they're not being alienated from
5 the families and a parent that they don't live with --
6 and a parent that they don't live with. And the adults
7 that are in substance abuse treatment, now they would
8 spend more time out of the bar if they had more time
9 with their children usually.

10 And so to actually officially refer them back to
11 the court would help all of these populations, you know,
12 all over -- across the board of everybody in divorce and
13 separation, family needs, and the people that you serve.

14 And also I have a question, is it doesn't have any
15 definitions, and rules, and guidelines for the
16 establishment of coalitions because you're talking about
17 getting recommendations from coalitions. And like
18 interagency agreements, and governance, and represents
19 patients on the coalitions by agencies.

20 We have -- at Michigan here, we have a North Care
21 Network is our substance abuse coordinating agency, and
22 they've provided funding to establish a prevention

1 coalition, and there's no agreed upon mission or goals,
2 no bylaws, no voting, no public meetings. They're just
3 winging it and calling it a coalition, and this is the
4 decision. And we're wondering how -- you know, there's
5 a lot of bullying going on and out of these meetings
6 I've noticed over the years. And without a set of rules
7 that people have to follow, some people just kind of
8 take over the decision making process, and everybody
9 just falls in line.

10 So you have some sort of, you know, requirements.

11 To say you're going to establish a coalition, you have
12 to -- I mean, these people just kind of show up and say
13 I represent, you know, Marquette General Hospital just
14 because they work there. Well, they were never
15 appointed to represent the opinion of the agency there
16 or our community health agencies. They'll just send
17 every next person that's available to go to these
18 meetings, and then they say they represent the agency.

19 And I would hope you would consider tightening up
20 the decision making process. You know, people at least
21 vote. I mean, you've got 24 people in a coalition and
22 agencies. Nobody voted, but then you've got one person

1 saying this is the decision. But that's kind of like
2 decisions by acclimation, which, you know, in America
3 that's a little inappropriate.

4 So, but thank you for your commitment and your
5 time on this subject. It's very important these days.
6 So good luck to you.

7 MS. HARDING: Thank you. Thank you very much.
8 And I will share your comments around suicide, and
9 parents, and home with our suicide lead here in SAMHSA
10 is Dr. Richard McKeon. And as far as the coalition, I
11 think this falls directly under our conversation, if you
12 were listening, to number 27, priority area of --
13 suggestion of what SAMHSA focuses on, because this is a
14 straight workforce issue of integrating substance abuse
15 and mental health practices together. And we do indeed
16 have structure around coalitions.

17 And you've just underscored our conversation that
18 this really needs to go forward, and begin to share the
19 differences and the strengths of them. So thank you
20 very much for your comment and listening in.

21 MR. GALLANT: Sure. Thank you. And could you
22 have somebody send me those requirements at my email

1 address?

2 MS. HARDING: We'll follow up on what -- we'll
3 have to get back to you on that.

4 MR. GALLANT: For the coalition, thank you.

5 MS. HARDING: Yes.

6 MR. AUMEN: And we spoke over the phone before the
7 meeting, so just --

8 OPERATOR: Again --

9 MR. AUMEN: -- email me your comment and request.

10 MR. GALLANT: All right. Thank you.

11 OPERATOR: Again, if you would like to comment,
12 please press star, then the number one on your telephone
13 keypad. Our next comment comes from the line of Amy
14 Hiller.

15 MS. HILLER: Hi. Thank you so much for allowing
16 me to comment. I was hoping that the Council would
17 address the question of mandatory student drug testing.

18 I come in from a community in northern New Jersey that
19 just spent a year debating this instead of doing
20 anything positive in the form of evidence-based
21 substance abuse prevention. Eventually it was taken off
22 the table in our community fortunately.

1 There's been recent research in 2013 and 2014
2 which has made it very clear that this policy is neither
3 effective, deterrent, responsible, or safe. And given
4 the recent studies from Dan Romer at the Annenberg
5 Center, Lynn Goldberg in Oregon, and Lloyd Johnson and
6 his team in Michigan, I think it's worth -- would be
7 wonderful if SAMHSA would actually get -- make an actual
8 statement, a recommendation against it.

9 I think that the other problem for me with student
10 drug testing is that it doesn't prepare students for
11 college. I have a son who's going to college in one
12 week, and testing would've done nothing to actually
13 prepare him for the challenges of higher alcohol use in
14 college. I have done what I could do to prepare him,
15 but the school, instead of wasting time debating this
16 ineffective policy, could have actually been spending
17 the time and energy to educate the community and the
18 students.

19 MS. HARDING: Thank you for your comment. We
20 certainly hear the energy and feeling behind that
21 statement. And if you send your email address to
22 Matthew as he's instructed, we will send you what we

1 have on mandatory drug testing -- a lot of what you have
2 already quoted, but we'll send it to you and see if
3 that's helpful, and take the rest of the conversation
4 under advisement. And good luck.

5 MS. HILLER: Okay. Well, we succeeded, but I'm
6 concerned about all the other communities that are
7 citing this policy. And I was hoping that perhaps your
8 leadership could steer other communities in a better
9 direction.

10 MS. HARDING: And we will certainly take that
11 under advisement. Thank you.

12 MS. HILLER: Thank you very much. I really
13 appreciate it.

14 MS. HARDING: Okay. Thank you.

15 MS. HILLER: Bye.

16 MR. AUMEN: Operator, do we have any more in the
17 queue?

18 OPERATOR: There are no further questions or
19 comments in the queue.

20 MR. AUMEN: Okay. We do have four minutes left to
21 go to any closing remarks that you have, Fran.

22 MS. HARDING: No. My only closing remark is to

1 once again say thank you for those of you listening in.

2 MR. MONTGOMERY: Hey, I'm on. This is Michael
3 Montgomery. I'm on the line now if you need to vote.

4 SPEAKERS: Yay.

5 MS. HARDING: Hang on --

6 (Laughter.)

7 MS. HARDING: -- because now I have no time, so
8 just thank you. I just wanted the public to know that
9 the work of the Council members is both exciting and
10 also a lot of work. They advise -- they're both
11 ambassadors to SAMHSA and they advise CSAP directly in
12 our programming. So keep that in mind when and if any
13 of you there who would like to help and join us, there
14 is a process of nomination, which Matthew can certainly
15 help you with.

16 So we thank you for being on the call. We thank
17 you for your questions and advisement. And I always
18 thank the Council. But I think we are -- I'm going to
19 turn this over to Matthew, but before I do that, to let
20 the Council members know and our public online, our next
21 meeting will be a face-to-face in SAMHSA -- at SAMHSA on
22 April 8th and 9th. These are somewhat tentative. I

1 would say they're like Jell-O. We pretty much are sure
2 that's going to happen, but then again you just never
3 know.

4 So hopefully we'll see you in April on the 8th or
5 the 9th, and I officially -- I'm closing the public
6 period and sending this over to Matthew for further
7 instructions.

8 MR. AUMEN: Right. And so, that will be the April
9 8th and 9th of next year will be the next time that the
10 Council is scheduled to meet on its own for the public
11 period. Obviously if we go with a session as we
12 discussed earlier, we can do that.

13 But we will do a closed grant review -- glad that
14 we now have a quorum -- at the conclusion of this open
15 portion. Then on August 27th, the Council will meet in
16 joint session with the other SAMHSA council. So that we
17 call the joint meeting, and there -- we have plans to do
18 a closed session grant review on that date as well. So
19 those are the things that we have in the meantime, but
20 our next official open CSAP only Council meeting, we're
21 looking April 8th to 9th.

22 So if there are no further comments or questions -

1 - is there anything that the Council has last minute?

2 MS. HARNAD: Could I move the approval of the
3 April 2014 meeting minutes since we have a quorum now?

4 MR. AUMEN: Okay. We can do that fast.

5 SPEAKER: Yes, we can do that.

6 MR. AUMEN: Well, let's go ahead and do that. So
7 we have a quorum. We needed seven folks on the line out
8 of our 12.

9 Is there a motion to approve the minutes from the
10 April 2nd open meeting that we had in 2014? Now, the
11 Council members have already reviewed and commented on
12 that. Our chair, Fran Harding, signed those minutes,
13 and this is for just the public record as a formality to
14 approve those minutes.

15 MS. SATTERFIELD: So moved. Ruth Satterfield.

16 MR. AUMEN: Okay, Ruth. Do we have a second?

17 MR. GREEN: Second. Steven Green.

18 MR. AUMEN: All right. So we have Ruth, who
19 provided the motion, and Steven with the second to move
20 the meeting minutes for approval.

21 Are there any objections?

22 (No response.)

1 MR. AUMEN: Hearing none, as noted by the
2 transcriber, the April 2nd, 2014 Substance Abuse
3 Prevention National Advisory Council meeting minutes has
4 now been approved for the public record.

5 So this -- if there are no further comments or
6 questions by the Council members, I will officially
7 adjourn the meeting. Any last minute words?

8 (No response.)

9 MR. AUMEN: Hearing none, the meeting is now
10 adjourned, and the Council will move into closed session
11 for grant review in about 15 minutes. Thank you.

12 OPERATOR: Thank you. This concludes today's
13 conference call. You may now disconnect.

14 (Whereupon, at 3:02 p.m., the open session was
15 adjourned, to reconvene at 3:27 p.m. in closed session.)

16 MS. HARDING: So, okay. Are we ready? Are you
17 ready? Okay. We're ready.

18 MR. AUMEN: Okay. So what I'll do is I'll go
19 through a roll call just to make sure everyone is on the
20 line and make sure that we have a quorum, so I'll just
21 go through the list. So John Clapp?

22 (No response.)

1 MR. AUMEN: No. Michael Compton?
2 DR. COMPTON: I'm here.
3 MR. AUMEN: Steven Green?
4 MR. GREEN: Present.
5 MR. AUMEN: Dianne Harnad?
6 (No response.)
7 MR. AUMEN: Dianne?
8 MS. HARNAD: I'm sorry. Present.
9 MR. AUMEN: Okay. Steve Keel is not here.
10 Michael Montgomery?
11 MR. MONTGOMERY: I'm here.
12 MR. AUMEN: Kathy Reynolds?
13 MS. REYNOLDS: Here.
14 MR. AUMEN: Ruth Satterfield?
15 MS. SATTERFIELD: Here.
16 MR. AUMEN: Khiree Smith, not here. Mary Ann
17 Tulafono?
18 MS. TULAFONO: Here.
19 MR. AUMEN: Patricia Whitefoot, not here. And Joe
20 Wiese, not here.
21 Okay. So we do have a quorum, and so now we will
22 proceed with the grant review. So I'll read the

1 instructions for you, which you have received
2 previously by email. And that's just to make sure that
3 you're knowledgeable and informed of the
4 responsibilities and the procedures during the review.

5 If you have any questions after I am done reading
6 them, feel free to chime in. After that we'll give you
7 a short, brief overview of the program, the SPF
8 Partnerships for Success, the State and Tribal
9 Initiative. Then we will go into the review, comments,
10 questions, and vote. So it'll take me just a couple of
11 minutes to read through the instructions, a few pages.

12 So here we go.

13 So SAMHSA uses a dual review system, which
14 includes technical review of grant applications and
15 cooperative agreements by an initial review group, in
16 addition to a secondary policy review by the
17 appropriate national advisory council. All competing
18 application are subject to initial review, group
19 review. The NAC will review all competing
20 applications, which, one, exceed \$150,000, and, two,
21 are in the competitive range, which are usually scores
22 of 60 to 100. Recommendations from the two review

1 bodies advisory to SAMHSA.

2 So the IRG review -- the central purpose of review
3 at the IRG level is to provide a competent and
4 objective evaluation of the technical merit of each
5 application based on the evaluation criteria published
6 in the request for application, or the RFA, and to
7 assign a numerical rating to each application for
8 program officials to have a sound basis for making
9 funding decisions.

10 The IRG review follows a thorough, deliberate,
11 well thought out, and carefully implemented process,
12 which involves a selection of reviewers with expertise
13 relevant to the unique requirements of the assigned
14 applications. The IRG review identifies the highest
15 quality applications to be considered for an award by
16 Center officials. The IRG review is conducted in
17 accordance with the public health service laws and
18 SAMHSA policies.

19 So the National Advisory Council review is the
20 second level review, and the Council is to provide
21 oversight of the IRG process rather than evaluate
22 individual applications. So this function is carried

1 out by using the summary statements developed by the
2 IRGs. The NAC also has a mandate to provide policy
3 advice on these Center's programs in making
4 recommendations. The NAC, unlike the IRG, considers
5 policy issues and provides advice on, one, the
6 expenditure of federal funds, and, two, the policies
7 and programs of the Center.

8 Regarding confidentiality, review information is
9 strictly confidential and may not be shared with
10 anyone. The summary statements include information
11 regarding the activities and careers of other people.
12 This information is privileged and must be kept
13 confidential. If you have a question about an
14 application or Council's review, please refer them to
15 the Council chair or designated federal officer, which
16 is Fran and myself.

17 Conflicts of interest. Council members as
18 reviewers of grant applications are subject to the
19 provisions of Title 18, U.S. Code, that relate to
20 criminal activity and the standards of ethical conduct
21 for employees of the executive branch. As special
22 government employees serving as members of this

1 advisory council, you must avoid real or apparent
2 conflicts of interest. Should you, your spouse, minor
3 child, organization where you serve as an officer,
4 director, trustee, general partner, employee, or
5 organization, which you are seeking employment, have a
6 financial interest, you will be recused from the review
7 of such applications for that particular announcement.

8 So examples of a conflict of interest may include,
9 but aren't limited to, the following: you are the
10 spouse of the chief executive for an organization that
11 submitted an application to SAMHSA; you are the
12 director of the substance abuse and mental division in
13 your state that submitted an application to SAMHSA; or
14 you are a consultant/evaluator contracted by the
15 applicant organization that submitted an application to
16 SAMHSA.

17 If at any time during the Council review you
18 discover that a conflict of interest not identified
19 prior to the meeting exists, please make it known so
20 that you may be recused from the review of those
21 corresponding applications. So for the audio meeting,
22 we are pretty much going with the honor system. If you

1 do have a conflict, make sure you let me know, and then
2 we will disconnect you, and then I can call you back to
3 get you back on the line when we do the en bloc voting.

4 So the voting options are a quorum has to exist,
5 which is half plus one of the authorized voting
6 membership, needs to be established when the meeting is
7 called to order. Programs will be reviewed and voted
8 on en bloc, which means as a group, as a whole. If you
9 wish to single out a particular summary statement for
10 discussion or if you have questions, please identify
11 the summary statement number, then it will get put back
12 into the block for final vote.

13 So the Council decision is by a majority vote of
14 the members present, which would be four out of the
15 seven. Council members may concur with the IRG's
16 recommendation. The Council members may non-concur
17 with the IRG's recommendations. And if the Council
18 disagrees with the IRG recommendations, the Council may
19 defer one or more applications for a second merit
20 review.

21 The scores -- regarding the priority scores
22 assigned by the IRG, they're based on a range from zero

1 to 100, 100 being the best score. The Council may not
2 change the numerical score. Council's recommendations
3 on applications are advisory. However, an award may
4 not be made for a project unless the application has
5 been recommended by the Council. So at the discretion
6 of the Administrator and under exceptional
7 circumstances, the Council review may be waived.

8 And that is my long speech. So I'll catch my
9 breath here for a second.

10 MS. HARDING: No time.

11 MR. AUMEN: But the Council members have filled
12 out a conflict of interest form. We do have Ruth, who
13 has a conflict with the Ohio application, so if that
14 one particular application comes up for specific review
15 or questions, we'll ask Ruth to log off the phone, and
16 we will call her back once that discussion is
17 completed.

18 So I'll ask again real quick, do any of you need
19 to be recused due to a real or perceived conflict of
20 interest with any application before we begin the grant
21 discussions?

22 (No response.)

1 MR. AUMEN: Hearing none, Flo Dwek, who is our
2 Project Officer with the Division of State Programs,
3 will give us a very brief overview of the Strategic
4 Prevention Framework Partnerships for Success State and
5 Tribal Initiative grant. If you have any questions
6 afterward, then you can ask them once she is finished.

7 MS. DWEK: Thank you. I'd like to just tell you a
8 little bit about the Partnerships for Success grant
9 opportunity. Basically as in all of these partnerships
10 for success, it is to provide funding to eligible
11 states, territories, and tribal entities to address two
12 of the Nation's top substance abuse prevention
13 priorities. I believe you are familiar with those.
14 The first one is underage drinking among persons aged
15 12 to 20, and the second is prescription misuse and
16 abuse among persons aged 12 to 25.

17 Like all of the others, we are calling for the
18 implementation of a data-driven process that grantees
19 must use and take those funds to target these two
20 priorities and possibly an additional data-driven
21 priority at their own behest in communities of high
22 need within those states and tribes. That's basically

1 it in a nutshell. And as with all the PFS grants, this
2 program is based on the premise that changes at the
3 community level will eventually lead to measurable
4 changes at the state or tribal level.

5 MR. AUMEN: Okay. So that was Flo, and Ilene
6 Bemureds is here from the Office of Financial
7 Resources.

8 MS. BEMUREDS: Grants Management.

9 MR. AUMEN: Say it again?

10 MS. BEMUREDS: Grants Management.

11 MR. AUMEN: Grants Management. So she will be
12 able to answer questions that come up about the grants
13 piece. So let me look at my notes.

14 So you have all reviewed, members, the summary
15 statements for the SPF PFS grant. Are there any
16 comments or questions that you have in reference to
17 your secondary review of the summary statement before
18 our vote?

19 MS. TULAFONO: No, just (inaudible). I was just
20 -- I reviewed part of the -- there seemed to be a
21 continuing comment towards the -- towards describing
22 how (inaudible) SAMHSA in a timely fashion or manner.

1 I was just -- that appeared a few times at the end --
2 at the end of the document.

3 So here, I just need to understand,
4 notwithstanding (inaudible), you know, and move forward
5 with the (inaudible). Is there any particular, you
6 know, addendum for us as to how we would recommend any
7 changes to, you know, to be -- to be added in here?

8 MS. HARDING: Mary Ann, I'm sorry that --

9 MS. TULAFONO: I'm sure I'm articulating my, you
10 know, my thoughts properly here. But just basically
11 I'm just trying to say that this -- it's showed up in
12 quite a few of, you know, of the summaries. And I'm
13 just needing to know if there's a concern about that,
14 because I know that we -- it was brought up in the last
15 discussion.

16 MS. HARDING: I'm sorry, but the last part of your
17 question we heard very clearly. But the essence of the
18 first part of your question we couldn't really hear and
19 understand. So could you repeat what summary statement
20 art you -- what are you referring to? You don't have
21 to go through the whole thing, but the -- you
22 articulated, I'm sure. We just couldn't hear it.

1 MS. TULAFONO: Yes. Fran, I'm sorry if I'm
2 speaking over you. Just it's a very delayed, you know,
3 connection. But all I'm saying is that I have no
4 problems with the overall review of the grant. I just
5 noticed that that there was a comment stating that does
6 not describe how information will be submitted to
7 SAMHSA, you know, accurately and in a timely fashion.
8 I'm just saying that that appeared a few times.

9 If you want me to -- I can go back and I can look
10 at all of the -- but I'm just wondering if that is a
11 concern of the Council now that everyone is moving
12 forward and approving, you know, the grant.

13 MS. HARDING: Understood.

14 MR. AUMEN: And so, those are generally -- if I
15 understand correctly, it's the IRG's comments inside
16 some of the sections of the application, timeliness and
17 sections were --

18 MS. TULAFONO: I believe it's down -- if you go to
19 the bottom of (inaudible). And at the very end where
20 it says -- where it comes up (inaudible) budget, you
21 know, (inaudible) the budget or -- so just the section
22 just around that area. I'm trying to find it.

1 MR. AUMEN: Okay. So I think in general --

2 MS. TULAFONO: Yes. If you guys -- it sounds like
3 you guys like this one better. Yes, that's fine. I
4 just wanted to understand because I've seen the process
5 a few times, maybe two or three, or even more.

6 MS. BEMUREDS: Hi. This is Ilene from Grants
7 Management. Oftentimes when we review the actual
8 application, if we see that there are any budget
9 concerns or any budget comments on the summary statement
10 while we're reviewing the application, we'll go back to
11 the applicant and say these -- the committee has certain
12 comments, can you please respond to whatever the concern
13 might be. And we get a response from them before we
14 issue the award. So it's part of our review of the
15 application as far as Grants Management is concerned.
16 And that's, of course, with the budget comment.

17 MS. TULAFONO: All right. Thank you.

18 MS. HARDING: Thank you.

19 MS. REYNOLDS: I think it's not just funded data,
20 but it came up again in the last call is that there's
21 concern in the reviews about people's ability to
22 actually get the data back to CSAP.

1 MS. HARDING: Right.

2 MS. REYNOLDS: But if you have the TA things in
3 place, then that's not an issue. I think what I hear
4 you saying is that you have the TA in place, and you're
5 not concerned about that.

6 MS. HARDING: Well, do you have a comment?

7 MS. DWEK: Yes. In addition to allay your
8 concerns, if there is a participant protection issue or
9 something that has to do with a particular programmatic
10 condition or term of award, they have a period of time
11 following their grant notification, about a month, to
12 respond adequately.

13 MS. TULAFONO: Very good.

14 MS. HARNAD: Yes. I sort of go with them -- it's
15 Dianne -- what everyone else has said is that, you
16 know, we're in each -- when each -- especially it would
17 be where there was some, you know, issues of concerns
18 that the IRG had that -- as long as the states and the
19 territories have given TA to get through those issues,
20 I'm fine with all the grants, too.

21 MS. HARDING: Thank you.

22 MR. AUMEN: Okay. Are there any other questions

1 or comments before we move to a vote?

2 (No response.)

3 MS. TULAFONO: Motion to approve.

4 MR. AUMEN: I will ask in just one second.

5 (Laughter.)

6 MS. HARDING: She wants her name on this. I get
7 it. I get it. She wants her name for the record.

8 MR. AUMEN: All right. So, folks, at this time
9 then, may we have a motion to move en bloc on Grant
10 Announcement Number SP 14-005?

11 MS. HARDING: Four.

12 MS. TULAFONO: Which would be en bloc.

13 MS. HARDING: Who said that?

14 MS. HARDING: Michael Compton, was that you or
15 Michael Montgomery?

16 MS. TULAFONO: I believe, Fran, that was me. I'm
17 sorry.

18 MS. HARDING: Oh. No. No, you can't imagine what
19 you sounded like.

20 (Laughter.)

21 MS. HARDING: So thank you. It's not you. It's
22 Mary Ann from the Islands. Thank you. That was very

1 weird.

2 MR. AUMEN: There are times you come through very
3 clear. There are times that you don't.

4 MS. HARDING: You have a good spirit.

5 MS. TULAFONO: Yes, that was me. That was a
6 motion to vote en bloc.

7 MS. HARDING: Thank you.

8 MR. AUMEN: Does anyone second --

9 MR. MONTGOMERY: And I'll second the motion.

10 MR. AUMEN: That is Michael Compton?

11 MR. MONTGOMERY: Montgomery.

12 MR. AUMEN: Montgomery. Okay. So for the record,
13 then please respond with your vote when your name is
14 called. And again, you may concur, non-concur, or
15 abstain. So we have Michael Compton?

16 DR. COMPTON: Concur.

17 MR. AUMEN: Steven Green?

18 MR. GREEN: Concur.

19 MR. AUMEN: Dianne Harnad?

20 MS. HARNAD: Concur.

21 MR. AUMEN: Michael Montgomery?

22 MR. MONTGOMERY: Concur.

1 MR. AUMEN: Kathy Reynolds?

2 MS. REYNOLDS: Concur.

3 MR. AUMEN: Ruth Satterfield?

4 MS. SATTERFIELD: Concur.

5 MS. HARDING: Mary Ann Tulafono?

6 MS. TULAFONO: Concur.

7 MR. AUMEN: And that'll do it.

8 MS. WHITEFOOT: This is Patricia Whitefoot on the
9 call.

10 MR. AUMEN: Hey, Patricia.

11 MS. WHITEFOOT: I concur.

12 (Laughter.)

13 MS. HARDING: Sorry, Patricia. We didn't know you
14 were on.

15 MS. WHITEFOOT: Yeah. I'm in the process of
16 office relocation, so I've had trouble getting on.

17 MS. HARDING: Oh, my goodness.

18 MS. WHITEFOOT: Yes, I'm right in the middle of
19 it, going on for a while.

20 MS. HARDING: Well then, thank you very much for
21 coming on. And you did not hear the couple of times
22 we've said this, but now that you're on, you can hear

1 it personally, which is our thanks for sitting on the
2 Council. We know this is your last meeting, and we
3 have talked about this. And we just wanted to say
4 thank you very much to both you and Mary Ann.

5 We gave a round of applause before. I'd like to
6 do it again now that you both actually are there for
7 all the work that you've done. It's the only way we
8 can show appreciation because we can't give you hugs
9 over the phone. So thank you.

10 (Applause.)

11 MS. HARDING: And also, I am also telling that if
12 we -- you know, sometimes government works slowly. And
13 if we don't get approval of your replacements on the
14 Council, we may be calling you and asking you to join
15 us in April so that we can have a full quorum. So you
16 can make that decision when we get closer to April.

17 MS. WHITEFOOT: Okay. Thank you.

18 MS. HARDING: Thank you very much.

19 MR. AUMEN: And so, just for the record --

20 MS. TULAFONO: Thank you.

21 MR. AUMEN: Just for the record, I just wanted to
22 let it be known that the CSAP NAC concurs with the

1 IRG's recommendation for Grant Announcement Number SP
2 14-004. Got it right this time. So, Fran, any other
3 closing remarks?

4 MS. HARDING: I don't think so.

5 MR. AUMEN: We do have the joint meeting coming up
6 on the 27th with the closed grant review. Please do
7 let me know now if you're on the phone if you won't be
8 able to make it.

9 MR. GREEN: Yes, Matt, this is Steven. I'll be
10 flying on the 27th, so I can't make it.

11 MR. AUMEN: Okay.

12 MS. HARNAD: What time are you planning the call?

13 MR. AUMEN: 11:00 a.m. Eastern. And I know that's
14 so early for Mary Ann. I didn't pick it.

15 MS. SATTERFIELD: And that may be a problem for
16 Ruth.

17 MS. HARDING: Okay.

18 MS. TULAFONO: That's fine. Thank you.

19 MS. SATTERFIELD: So 11:00 a.m. Eastern time?

20 MR. AUMEN: Yes. The Joint Council is from 1:00
21 to 5:00.

22 SPEAKER: 1:00 to what, 5:00?

1 MR. AUMEN: Right.

2 MS. HARDING: You can hop on, hop off, have lunch
3 or breakfast, hop back on.

4 SPEAKER: Oh, that's deadly. Okay. Who gives
5 permission to do that?

6 MS. HARDING: SAMHSA.

7 (Laughter.)

8 MS. HARDING: We're being taped.

9 MR. AUMEN: I may have cut Fran off, but any
10 other --

11 MS. HARDING: Oh, that's okay. No, I've said
12 everything. Just thank you. Enjoy the rest of the
13 summer. For those of you who will be on the 27th, that
14 will be great. If not, then we'll be in touch with
15 you, especially if we try to have a call on the
16 priorities, which we'll send out to you. So those of
17 you who missed that part of the conversation, we're
18 going to write it all up, send it out to you so you'll
19 be able to weigh in. But thank you.

20 Okay. Thanks. Unless anybody has another word,
21 we're done.

22 MR. MONTGOMERY: This is Michael. I apologize for

1 the stress I caused Matthew with getting on.

2 (Laughter.)

3 MS. HARDING: Well, we were just most concerned
4 about you. So I'm glad you're safe. Stay inside and
5 preserve your generator for later tonight. Thank you
6 again.

7 MR. AUMEN: Okay. That officially adjourns the
8 meeting. Thanks.

9 SPEAKER: Okay. Thank you. Bye bye.

10 (Whereupon, at 3:51 p.m., the meeting was
11 adjourned.)

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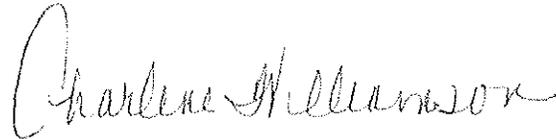
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I, Charlene Williamson, hereby certify that the foregoing is a true and correct transcript, without alterations, from the electronic sound recording and information provided to me of the proceedings in the above-entitled matter.

8/18/2014

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CHARLENE WILLIAMSON
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