

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

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

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PROCEEDINGS

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

LCDR HOLLY BERILLA: Good morning, everyone. My name is Lieutenant Commander Holly Berilla. Welcome to SAMHSA's Joint National Advisory Council meeting.

I just wanted to go over a couple logistics before we open the meeting. In the back, there's a table that has plenty of materials on it, but there are also some sign-up sheets for the breakout groups. And you can certainly self-assign to whichever group you're interested in participating in for today's breakout meetings.

We'll also have signage around so that you know where you'll be headed, and we're here to actually direct you and help you.

The other issue is the microphones. Push to talk, and when you're done talking, push it again, and that will keep pretty much everyone in queue on being able to use the microphone. When you do speak into the microphone, please announce yourself so that we can get you on record for your comments.

And if you have any questions on where the bathrooms are or the café, we have a small café that offers snacks, different types of food, and so forth. And that's available to you. And that's pretty much it for the logistics. So if you have questions, I mean, just see one of us. We'll be glad to help you.

So, Operator? Keith, are you on the line?

OPERATOR: Yes, I am on the line.

LCDR HOLLY BERILLA: Oh, hi, we are ready to begin. You may open the line.

OPERATOR: Yes, ma'am. Yes, you have been placed into the call, and it is being recorded.

Thank you.

LCDR HOLLY BERILLA: We're having problems hearing.

OPERATOR: Okay, ma'am. You are live.

LCDR HOLLY BERILLA: Okay. Thank you.

Again, good morning. This is Lieutenant Commander Holly Berilla. I'm the committee management officer for SAMHSA's National Advisory Council. I am calling the joint meeting of SAMHSA's National Advisory Committees to order, and Administrator Hyde is presiding.

MS. PAMELA S. HYDE: Good morning, everyone. It's great to see all of you.

Forgive us for our little confusion up here. We've got, as usual, a few things going on.

So I, first of all, just want to thank Holly. You all met her at the last time I think you -- the advisory councils were in, and we were switching over at that point. You've heard a lot from her with emails and other kinds of things, but I want to thank her for taking on this role of helping to manage the advisory councils and Joint Council, and then also the National Council that meets tomorrow.

We also have other staff -- I don't know if they're in the room -- who support each of the center and the other councils. Are any of those staff in the room? Matthew and other -- yeah, back there. Great. So thank you to all of them who have supported you all in the last day or day and a half that you've been doing the various councils that you are on.

I'm going to have us introduce ourselves up here, and I'd like all of you to do a quick run-through because we've got some new people in the room. We love to say hello to all of you.

And as you're thinking about that, I also just want to remind you that tomorrow we have a couple of special guests at 11:00 a.m. tomorrow at the National Advisory Council meeting. And we encourage you to either be on the phone with us or stay around if you have a chance to do that and listen to Karen DeSalvo and Patrick Conway.

They are two of the major leaders in our department, HHS, and they are coming to talk to us about something we call delivery system reform. So I think you'll find that a very interesting presentation and discussion. So if you'd like to stay for that, please do.

The advisory council, the National Advisory Council tomorrow is also going to talk about SAMHSA's ecological model of behavioral health that we've been talking about and thinking about. So please join us. You're all welcome if you want to participate in tomorrow's event, either through the electronic process or if you want to come, you're welcome.

And there is -- if you don't know how to get on tomorrow, you can see Holly at the

break, and she'll tell you how to -- where to find or how to get on the call tomorrow, or is it a webinar or is it -- I mean, is it webcast, or what is it?

LCDR HOLLY BERILLA: It'll be through Adobe Connect. So you will have slides live.

MS. PAMELA S. HYDE: Okay, great.

LCDR HOLLY BERILLA: And a telephonic connection.

MS. PAMELA S. HYDE: All right. So let me start up here with our wonderful leadership and have them introduce themselves. Fran?

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

MS. PAMELA S. HYDE: And is anyone here representing Pete? Anyone from CBHSQ? Al, do you want to come up and be Pete today? No? There might be a question. All right.

Pete is out in California doing some health information technology stuff. So we'll get a representative for him there tomorrow.

I'm Pam Hyde, obviously, the Administrator at SAMHSA.

MS. KANA ENOMOTO: Kana Enomoto, Principal Deputy. Good morning.

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

MS. DEEPA AVULA: Good morning. I'm Deepa Avula, the Acting Director for the Office of Financial Resources.

MS. MARY FLEMING: Good morning. I'm Mary Fleming, Director of the Office of Policy, Planning, and Innovation.

MS. PAMELA S. HYDE: Oh, Daryl is on her way. Is that right? Is that what we hear? Okay.

So we're going to do a quick set of introductions. If you would just say your name and say which of the councils you're on, and that's really kind of about all the time we have to get through all the introductions, but we want to at least know who you are and see especially for those of you who are here for the first time.

So, Kathy, you want to start?

MS. KATHY REYNOLDS: Kathy Reynolds, the Center for Substance Abuse Prevention.

DR. JEREMY LAZARUS: Jerry Lazarus, CMHS.

MR. ADRIAN SPOTTEDHORSECHIEF: Adrian SpottedHorsechief, TTAC.

DR. GAIL W. STUART: Gail Stuart, National Advisory Council, new member.

MS. SADE ALI: Sade Ali, CSAT.

MR. JEROME BIG JOHN: Brooks Big John, TTAC.

MR. VICTOR JOSEPH: Victor Joseph, National Advisory Council.

DR. ERIC B. BRODERICK: Ric Broderick, National Advisory Council.

MR. GILBERTO ROMERO: Gilberto Romero, Center for Mental Health Services, National Advisory.

DR. LORI SIMON: Lori Simon, CSAT.

DR. ALAN SOKOLOW: Alan Sokolow, CMHS.

DR. KENNETH J. MARTINEZ: Ken Martinez, SAMHSA National Advisory Council.

DR. DAN LUSTIG: Dan Lustig, Advisory Committee for Women's Services.

MR. WES AYLES: Wes Ayles, TTAC.

MR. MICHAEL MONTGOMERY: Michael Montgomery, CSAP.

MS. LACY KENDRICK BURK: Lacy Kendrick Burk, CMHS.

MS. LISA WADE: Good morning. Lisa Wade, TTAC.

MS. MEGAN GREGORY: Megan Gregory, SAMHSA NAC.

MR. KEITH MASSAWAY: Keith Massaway, TTAC.

MR. ANDY JOSEPH JR.: [Speaking Native language] Good morning. My name is Andy Joseph Jr. I'm from SAMHSA's TTAC committee.

DR. LEIGHTON Y. HUEY: Leighton Huey, CSAT.

MR. CHRISTOPHER R. WILKINS: Chris Wilkins, National Advisory Council.

MS. CHRISTINE WENDEL: Chris Wendel, CSAT.

MS. ELIZABETH A. PATTULLO: Betsy Pattullo, National Advisory Council.

MS. JEANNETTE PAI-ESPINOSA: Jeannette Pai-Espinosa, Advisory Committee for Women's Services.

MR. ARTHUR SCHUT: Arthur Schut, CSAT.

MS. THERESA GALVAN: Theresa Galvan, TTAC.

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

MS. RUTH SATTERFIELD: Ruth Satterfield, CSAP.

MS. ALESIA REED: Alesia Reed, TTAC.

MR. PAUL GIONFRIDDO: Paul Gionfriddo, CMHS.

DR. JUNIUS GONZALES: Junius Gonzales, SAMHSA.

DR. LORI ASHCRAFT: Lori Ashcraft, SAMHSA NAC.

MR. JOE GARCIA: Joe Garcia, TTAC.

MR. ANDRE JOHNSON: Andre Johnson, CSAT.

DR. VIJAY K. GANJU: Vijay Ganju, CMHS.

MR. STEVEN GREEN: Steven Green, CSAP.

DR. CAROLE WARSHAW: Carole Warshaw, ACWS.

DR. INDIRA PAHARIA: Indira Pahlaria, CSAT.

MS. CASSANDRA L. PRICE: Cassandra Price, National Advisory Council.

DR. JEANNE MIRANDA: Jeanne Miranda, CSAT.

MR. JEREMIAH D. SIMMONS: Jeremiah Simmons, CMHS.

MS. PAMELA S. HYDE: Okay. Did we miss anybody back there? All right. I really appreciate it, all of you being here. And let me just remind everyone if you

have one of these devices, which all of us do, that make some noise, could you try to mute them or make the noise low so that if it goes off, we're not disrupting in the middle.

We do have lots of folks listening throughout the day. People come on and off, and we will from time to time check in to see how many people have joined us electronically. So you'll have a sense of that. But it is really important to talk right into the microphone when it's on so that people on the phone and all over the country can hear you.

And I want to just recognize we have a lot of staff in the back room and -- back of the room and a few folks from the public listening, and we have folks, as I said, listening on the phone. And we also have some great contractors that I just want to acknowledge that are both making pictures and managing all the electronics over here and all of that. So thanks to all of them for doing that.

I want to start this morning by just saying a big thank you for all of your time and the fact that you come here and give us your time voluntarily. I know many of you have heard me say this. I will continue to say it is that these days are always very, very special to us. We enjoy you being here. We enjoy the conversations. We get a lot out of your advice and your challenge and your thinking and your ability to help us with challenges that we are facing, and we're going to certainly ask you some of those today.

And part of what's the value of this is we get to step back for 2 or 3 days from our everyday work and actually talk with all of you, who we consider to be hugely smart people and big helpers and really knowledgeable in the field. And so, having you here to really just think with us and ask us questions and push us and help us think through things is very important. I often say and I will continue to say that I think of advice as a product. So you are giving us a product, and we take that seriously.

You may say "you really should do X," and we may not actually be able to do X immediately in a way that you would recognize it. But believe me, the way that you provide your input and get us to think differently and challenge us in the ways that we have been thinking in the past are all incredibly important and helpful parts of our work. So thank you for making us better and for giving all of us your thoughts and your time, et cetera.

So we have a really full and interesting day today, I think. We have designed this a little bit differently because we want to focus and we've tried to focus the 3 days on treatment issues, and the way that healthcare is designed and the way that behavioral health is provided and what SAMHSA should be doing in that space.

I got a chance to meet with each of the five, six, however many there were yesterday -- I lose track -- five yesterday. Each of you for a few minutes, and just

to talk a little bit about the context in which we are having this conversation. I think all of you know that SAMHSA's strategic initiatives start with prevention, and prevention is our number-one strategic initiative, and we feel very strongly about that. And then the outcome and the goal of all of our work is people being in recovery.

So either prevention or recovery have been our top priorities. We have, as a consequence, I think, not articulated well enough what we do in the area of treatment, and we have probably not talked enough about how our influence on treatment may be slightly different than our influence on prevention and recovery.

We tend to be the loudest voices and the -- in some cases the only voices around substance use prevention and around emotional health development and those kinds of issues with some other partners, but we tend to be a big voice there. We are often the major funder or voice for recovery services from the Government perspective. With regard to treatment, most of you heard me say this yesterday, we're actually a very small player in terms of payment. Not in terms of influence, but in terms of payment.

So, as a consequence, we aren't Medicaid. We aren't Medicare. We aren't private insurance, and those are the three biggest sources of payment for treatment services for both substance use and for mental health or mental illness services and treatment. And in fact, it's a growing, those three resources are growing resources, especially Medicaid and private insurance on the substance use side.

That said, we do have, obviously, a lot of ways in which we influence, test, pay for, provide infrastructure for, and do other things with regard to treatment for these -- the disorders that people experience in this space. So what we wanted to do this time is have a lot of time with you and your advice about how we can think about, talk about, support, influence, and otherwise be a force in the treatment world.

We don't want to exclude prevention and recovery because they all sort of go around in a circle, and they touch each other and overlap. But we are focusing this time on treatment. As a consequence, we're doing our day a little bit differently in two ways. One is normally I would do some very quick updates, maybe pull out three or four things to tell you we're working on.

This time we're going to do speed dating of updates. So we're going to tell you a whole bunch of things we're doing in a variety of roles. So folks often think about SAMHSA's role as a funder, a grant maker, and that is clearly one of our six roles, but it's only one of our six roles.

So we're going to go through some updates very quickly between Kana and myself about just some highlights. This is not in any way, shape, or form

everything that SAMHSA does in these six areas, but we want to give you some highlights in those areas to get your heads wrapped around a little bit that we have different roles. And I think that will help your giving us advice.

So a lot of times we ask people for advice, and they say, well, you ought to fund a grant like X. Or you ought to fund a grant like Y. Well, we're going to have to go tell Congress that, and they get to make those decisions.

But we have other resources, and part of those resources are our expertise, our staff, who know what they're doing and who can work with folks and who can bring issues to bear. So that's an important role or that's an important resource as well as our grants. So we want to show you a little bit about some of what we're doing in these different roles or these different areas, and that will, hopefully, again stimulate your thinking throughout the day.

The other thing we're going to do that we think will be kind of fun is we're going to have some breakout groups with you this time based on however you want to consider yourself in terms of clinical types or in some cases not clinical because some of us, me included, are not a clinician. But we might be policymakers or advocates or whatever it is that you want to ask -- or put yourself into whatever group you want. So we'll say a little bit more about that when we get to the break or right before the break and tell you where those breakout groups will be.

You can choose the one you want to be in, whether you want to be a physician or a social worker/counselor or a psychologist or a preventionist or peer practitioner. You can see the list there. You get to choose which group you go in.

Ric, we didn't figure out one for dentists. So you'll have to figure out where you want to go. But there are some outliers, and I know a lot of our tribal leaders are here as tribal leaders, not so much as clinical folks or people in the behavioral health world. So you'll want to think about where you want to participate as well. So you can either participate in one of the groups as an affinity group because that is your type of work in this area, or you can pick a group because you want to hear what that group has to say or talk about.

So we'll say a little bit more about that when we get to it. Before we start with the updates, let me just acknowledge one thing. I don't know if Ellie is in the room. Ellie, are you here? I haven't seen her yet this morning.

Ellie McCance-Katz, who is our chief medical officer, has indicated to us that she's leaving us in June. We are very sorry about that. She will have been with us for 2 full years, and that's a lot for one of our special people and special experts that we have. Ellie's husband followed her here from California, and he has now gotten a job in Rhode Island. So she is next following him to Rhode Island.

So we're very sorry that she's leaving us, but she has done an incredible job of helping us establish this role as the chief medical officer. That is not a role that we had before. It was something that we felt very strongly about needing and wanting. And if any of you have ever gone into an organization and had to sort of create an office or a function that wasn't there before, you know how hard that can be sometimes.

So all of us were really pleased to have her in the office. She's been on our executive leadership team. She has brought incredible experience and wealth to us both in addiction psychiatry and in serving people with serious mental illness and other mental health conditions. So she's been just a terrific add, and we're really going to be sorry to lose her.

As she kind of winds down over the next couple of months, she's going to help us think through an idea we have about growing that Office of the Chief Medical Officer. We have realized with her being with us in the organization how important that sort of clinical voice across all of our programs. We have other clinicians and other physicians in our organization, but they are in particular program areas. So Ellie has been able to provide that kind of clinical perspective across all of our programs, and it's been just incredibly important.

But it's more than one person can do. So we're thinking about that, and we haven't come to any final resolutions about that. If any of you have any thoughts about that, and I'm looking at you, Gail. You may have some thoughts about that. Maybe we can talk about it at breaks or otherwise because we are just starting to think about if we wanted to make that office more than one person, more than one psychiatrist, how would we put it together? So, and what would be its function?

So anybody who has an interest in chatting with us about that find either me or Kana at the breaks, or if you see Ellie around, please give her that input as well. Mary is somebody else you can talk to about that. The chief medical officer sits administratively in the Office of Policy, Planning, and Innovation. So you can talk with Mary about that as well.

So I think that's it at the moment with regard to sort of SAMHSA issues. Let me just say just one other issue, which is perhaps obvious, but I'll say it out loud, and that some of you asked me about this yesterday as I went around to the different advisory committees. It's like what's the context? Why did we choose to do this discussion about treatment now?

I think what I already said is part of it, which is that we recognize that we have been dealing primarily or a lot with prevention and with recovery and not so much out front or publicly about treatment. A lot of the work that we do around treatment, because we don't fund it all, has been influencing payers of treatment. So, as a consequence, it tends to be behind the scenes.

So part of it is that we wanted to get what we do a little bit more out front. That's one of the reasons we wanted to have this conversation. The other reason is just to acknowledge we've had some criticism about this. We've had some critical input that we aren't messaging right on our work around treatment and that by focusing so much on prevention and recovery, we are not letting the country know and people know what the importance of treatment for disorders that we are concerned about are and what we do or what we can do about it.

So we want to acknowledge that. Criticism often comes from a place of as some people say, if you're not doing -- if you're not getting criticized, that means you're not doing anything. So, as a consequence, I'd say SAMHSA is doing a whole lot right now because we are getting some criticism. That's cool.

We're trying to take that in and be responsive to that criticism, and so trying to have much more of a public conversation about SAMHSA's role in the treatment space. So that's part of why we're doing this as well.

So let me continue, if I can, we're going to start this speed dating of updates because I'm going to do a lot more than the three or four that we normally do, and there's going to be slides up here that you can watch and go through. And before I'm done here, I'm going to turn it over to Kana to finish up some of these updates as well.

Agenda Item: Update on SAMHSA's Priorities Budget: "Leading Change 2.0"

MS. PAMELA S. HYDE: So I don't have a click -- oh, here it is. Does this -- will this do it? All right. So we're going to do, I want to be very clear that as I do these, these are not everything SAMHSA does in these areas. They are simply things that are happening right now to help you understand some of the different ways in which SAMHSA has an influence or works to make a difference in the area of behavioral health.

I think you all know we have strategic initiatives. We have a new 4-year plan that has six strategic initiatives. Oftentimes, I will do discussions with people and with groups like this about what's going on in our strategic initiatives. I'm not going to do it in that frame right now, but we did want you to know that we have a new 4-year plan. Here's the initiatives, and they range from prevention to healthcare and health systems integration, trauma and justice, recovery support, and health information technology, and workforce.

We've taken on workforce as a new one, workforce development. And our health reform initiative, which was the last 4 years, has moved into the healthcare and health systems integration initiative, which is really where a lot of the treatment

work that we do sits. And we work with Medicaid and Medicare and a lot of other payers and other issues in there.

This slide also shows you that our strategic initiatives are undergirded right now by some internal work we're doing on internal operating strategies. Again, we are not going to spend time talking to you about those, but we want you to know we're doing an awful lot of work within SAMHSA, all of the executive team is, to try to improve SAMHSA's work, whether that ranges from doing new policies and procedures to some talent management work to some training and business operations work and other kinds of things.

If you have questions about any of that, we'd be happy to talk to you about it at a break or at any other time. All right. So SAMHSA's roles. We play what we think of as six completely different roles, but they all interrelate.

One is a major role is our leadership and our voice. We sit at tables on behalf of the behavioral health community and on behalf of behavioral health issues when other players are making decisions and other players are doing programs. We work with DOJ. We work with Department of Justice. We work with the Department of Defense, with VA on military/veterans issues. We work with Department of Education on issues around young people.

We work with any number of other departments on data and efforts in ways that you wouldn't even -- you wouldn't even think of without knowing why we might work with the Food and Drug Administration, for example, or the Agriculture Department or somebody else that might seem a little odd on some of these things.

But leadership and voice is a lot of what we do. We also work with a lot of health surveillance and data issues, and then we do a lot of work around practice improvement, helping the folks in the country improve their practice to deliver treatment and prevention and recovery services.

We also do tons of work around public education and awareness, and then we have some regulatory work and standard-setting work, and then we also do our strategic grant and contract work. So, again, very high level in our leadership and voice area. Some of the things that we're working on right now is our behavioral health and delivery system reform. That's what you're going to hear about tomorrow, if you stick around with us, from Patrick Conway and Karen DeSalvo.

We are working on a paper called the Ecological Model of Health. Mary and her staff have been working on that. It has to do with bringing behavioral health into the entire community health prevention, health delivery, and community services area.

MHPAEA, which is the parity law, the national parity law that passed in 2008, we've been working with the Department of Labor and Treasury on implementation issues all around the country. Medicaid parity regulation was just produced or just put into the Federal Register for public comment last week. We had a lot to do behind the scenes with helping to make sure that regulation was as forward thinking as it could possibly be.

So that one actually is a perfect example maybe, as is MHPAEA implementation, where you wouldn't see our work. You wouldn't see SAMHSA's name or footprint on it particularly anywhere, but we have spent lots of time and effort, and our colleagues call on us to be the experts in these areas. So it's an area where we've done a lot of work, but it's not ours, our fingerprint. We're not the leads on it.

Medicare parity analysis. We are starting an analysis of the Medicare program on things that they are either by law or by regulation not able to provide in the behavioral health space. So we're starting to analyze that and work with our Medicare partners on that issue.

There's an interagency task force on military mental health that the President started that I actually represent the Secretary of HHS on with Department of Development and -- I'm sorry, Department of Defense and the VA. They're doing a lot of work around research and suicide, around quality measures for programs delivered across programs, et cetera.

Workforce data and issues. We have been working with HRSA for some time because they are the leads on workforce development. But we've been working with them and with ASPE -- and forgive me if I'm doing acronyms that people don't know. You can kind of wave your hands, and I'll try to deal with that. But we're trying to figure out how would we actually get national data that would tell us where we sit and where we need to be in terms of workforce development.

Because we know it's a problem. We just don't have really good sense of, well, how many psychiatrists do we need? Well, how many nurses do we need? Well, how many social workers are we going to need? Et cetera. So we're working on that.

We also have the next acronym is a Behavioral Health Coordinating Council. We actually co-chair that. And we have a lot of subcommittees that happen within HHS working on all kinds of behavioral health issues. We have a new one on -- a relatively new one in the last year on marijuana. It's an emerging issue in our field. And on serious mental illness, which just started a couple of months ago.

Fran works and Tom Coderre work on the marijuana one, and Paolo helps to staff and co-chair the serious mental illness subcommittee. We're also about to kick off work on developing a serious mental illness or a framework around

serious mental illness with our colleagues at ASPE, which Paolo's shop will work with.

I don't know if many of you know about the IMD issue. This is Institutes for Mental Disease. It's what prevents Medicaid from paying for a lot of inpatient and residential care. We've been working with CMS and with ASPE on what to do about that going forward. There's lots of policy issues in that.

We also work on historical trauma issues and a lot of trauma issues, and we actually did a presentation yesterday at the TTAC about those issues. So we have been working on those with our tribal colleagues at the Secretary's level.

And we also have a National Tribal Behavioral Health Agenda that we are starting to work on with IHS and with Bureau of Indian Affairs and others, going around the country doing work with tribes and folks on that issue.

On October 4th, there's going to be the first-ever recovery rally on the Mall. Tom Coderre is our liaison to that work. That's actually a private effort, but nevertheless one that we support in terms of presence and being a liaison. So that's just our leadership and voice areas.

In the surveillance and data area, we have a series of behavioral health barometers, which I'm sure many of you have seen that are online. We started them last year. So we've only done two of them, 2 years' worth of them. They are by State and by the Nation. But we're also now working on -- we'll be doing those every year and releasing them sometime in December or January. We're also working on a behavioral health disparities barometer, pulling out the issues affecting ethnic and racial minorities and other folks out of our data.

We have a set of work going on around developing a common data platform for our grantees, which pulls data together from all of our grantees in one place, and then we've been working with States around client-level data development for our block grant programs. We also have, I think you know, a National Registry of Evidence-Based Programs and Practices, and we are making changes to that to try to make it more rigorous and to try to be more inclusive about what goes into NREPP. So lots of work there. We get lots of questions about that.

CBHSQ is our Center for Behavioral Health Statistics and Quality that Pete leads. We have developed an economic analysis unit that Al back there, who wouldn't come forward, is leading. I have to tease him a little bit. It's a new unit, and we're trying to think about what our role is there. We have also been trying to expand our treatment dataset to areas that it's not in at the moment.

Our NSDUH, another acronym, which is our major National Survey on Drug Use and Health, and also includes mental health. We are now beginning each fall to release mental health and substance abuse data together. We are testing

LGBTQ issues in that -- in that dataset. We are developing a recovery module or measure, and we are developing a trauma module for that dataset.

These are all humongous issues in our data work that take years to get developed. Pete would be glad to hear me say that I acknowledge it takes years to do this because I usually ask him for it the next month, and he says, no, that can't be done. At any rate, we're doing a lot of that work.

And we're also trying to move from being primarily a State-based dataset or a State-level dataset to try to look at bringing in more local and community data so we can say what the difference is between Albuquerque and Santa Fe or -- to use New Mexico as an example, or Boston and the rest of Massachusetts or whatever.

And finally, in this area, we have developed some significant work in our evaluation capacity because we have gotten clear that we don't have enough money to do all the evaluations we'd like to, and so we're trying to make better decisions about that and be more specific and scientific and rigorous about our evaluation efforts.

In practice improvement areas, I just got back from something called the National Network for Elimination of Disparities, and they produce every year a learning conference for providers all across the country, which is quite helpful in helping people understand how to address disparities in our world. Medication-assisted treatment is definitely an area that we are doing a lot of planning work in. Kana is leading that effort, along with our Center for Substance Abuse Treatment. We also have some area that Fran is leading on part of this.

We have a training program on opioid prescribing and treating that we do a lot of work in, and we have a number of policy academies. I listed a few up here just as examples.

So we've done recently some policy academies on juvenile justice with the MacArthur Foundation. We've done policy academies with tribes, and we've got one coming up with tribes about how to do alternatives to programs, especially for juvenile substance users and mental health -- young people with mental health issues. And we have a prescription drugs and opioid policy academy that we did last August and supported or expanded on the Secretary's 50-State policy academy that she is doing a second one of this year.

We also have expert panels that we pull together sometime. A year or so ago or a couple years, we did an expert panel on adolescent substance abuse treatment. Gosh, I guess that's been almost 3 years ago now. But we pulled that expert panel together, and out of that came an information bulletin that CMS issued to the States about how to address substance abuse treatment for adolescents. So that kind of work is in collaboration with our colleagues.

We also did, Larke Huang and Kana and others did some work in a Screening, Brief Intervention for Trauma, bringing together some experts around that issue, and we're about to kick off an expert panel on conversion therapy for looking at this issue of the science that isn't there behind that and the harm that actually that can do to young people. So conversion therapy is something the White House has just taken a position on, and we're pulling together an expert panel to try to help the field know how to deal with that issue.

As I said, we've done information bulletins with CMS for children with significant behavioral health needs and for adolescents with substance abuse needs. And then we are doing what some of you may be aware of, the Section 223 demonstration, which is a demonstration to help States change the way they both fund and bring quality to community behavioral health services, and that will be kicking off this May, we hope, with an RFA that we're doing with both CMS and ASPE.

And then, finally, we have continued -- actually, I guess this isn't finally. I told you this was speed dating of updates. We are doing -- continuing to do measures development for the National Behavioral Health Quality Framework. So you all have seen that two or three times. The measures in that area within NQF have just continued to grow, and we've had a major role in that.

We also provide a lot of technical assistance. So through various and sundry centers we have, some of which are done with other partners, I'll let you read them up here. You can see those. We just released not too long ago a TIP, which is a treatment improvement protocol document, on trauma-informed care. We have released hypertension guidelines for people who have mental health/substance abuse issues as part of the Million Hearts campaign that you may have heard about in the country. We're doing hypertension guidelines in our context in that effort.

We've also done some work on mandatory community treatment and are working with ASPE. Both of us are doing different kinds of complementary reports on assisted outpatient treatment, which is a big issue in our field at the moment. We've also done some dialogues on patient engagement and some self-directed care decision materials, which are on our Web site, and as I told you before, working on a workforce data strategy with HRSA.

We're also about to release, if we haven't quite yet, competencies for consumer and family peer services. So you'll be able to make public comment on that. So those are examples of things we do directly trying to impact the treatment space but may not be directly funding treatment.

Next is regulation. So we have some upcoming 42 CFR Part 2. If you all know what that is, that's the regulation that prevents the release of substance abuse

treatment data without special consent. We are making some revisions in that regulation, which is about 25, 30 years old now, and that should be coming out for public comment soon.

We're also about to release some new workplace drug testing mandatory guidelines about both urine specimens and a new use of oral fluids. And then doing some work in the area of hair samples.

We also have standards for electronic health records that we have worked with with the Office of National Coordinator, and we've done some data segmentation pilots actually in the electronic health record space to try to get at this issue of segmenting substance abuse, mental health, and other kinds of data that shouldn't be released.

We are considering whether to add e-cigarettes to the Synar provisions that we oversee about underage smoking, sales of cigarettes to minors. And we also have some updates that are in process about our opioid treatment program regulation, and a block grant application for 2016 and '17 is about to come out.

So if you're not tired yet, this has nothing to do with our grant programs so far. We'll get to those. Public education. So we've -- actually, I'm going to turn this one over to Kana. She is going to tell you a little bit about our public education work and about our grant work and then tell you a little bit about our budgets.

MS. KANA ENOMOTO: So we're very pleased to be working with the Office of the Surgeon General, new Surgeon General, Dr. Vivek Murthy, who has agreed to work with SAMHSA, NIDA, NIAAA, FDA, CDC, and others on a Surgeon General's report on alcohol, drugs, and health. So that is something that is in development, and we are on a very fast track working with our partners to get done.

We have an initiative that's included in our FY '15 and '16 budgets called the Science -- '14, '15, and '16 budgets called the Science of Changing Social Norms, which is an effort for SAMHSA to develop the kind of research base on how to do its public messaging to best effect.

While organizations like the CDC and FDA have a significant investment in collecting data, doing research, understanding the market on how people receive messages best, how to influence to achieve the kind of behavior change that you want around issues like tobacco cessation, SAMHSA has not had that type of investment to date, and we really understand that if we are going to shift the way society views substance abuse and mental health as public health priorities, we're going to need to get a better grasp of the science of how that's done best.

And for now, we have a project with the Institute of Medicine National Academy of Sciences trying to gather what's being done both within behavioral health and,

more broadly, in public health. And it's a very exciting proposal as we keep moving forward.

We recently issued a naloxone toolkit, as well as a toolkit on injectable naltrexone, long-acting injectable naltrexone. So we're moving on educating the public about medication-assisted treatment and reversal of overdose.

Children's Mental Health Awareness Day, it's a longstanding tradition of ours. We're very excited to be doing that on May 7th. Secretary Burwell will be joining us.

The Voice Awards in August 12th -- on August 12th is one of those social norms changing efforts where we're trying to recognize those in Hollywood who are doing responsible portrayals of prevention, treatment, and recovery of substance use -- substance use disorders, mental illnesses, and mental health.

Project Evolve is a brain child of Administrator Hyde. She brought it to us. She said you have -- SAMHSA has 90 different Web sites. You probably only need one. And so, we have been in an effort, multiyear effort to bring together all of that content into a single platform, and it's been -- it's been quite a journey.

We have an incredible SAMHSA team. It's been a partnership of -- with the leadership of Marla Hendriksson, our Office of Communications, in partnership with our Office of Management Technology and the three or four programmatic centers, which have really been contributing all the content. We hope that our Web presence is more robust, is more user-friendly, searchable, and accessible to the public.

We've had under OC's leadership an incredible growth in our blogs, our social media, and our e-blasts. SAMHSA in the last 18 months has seen a 600 percent increase in its number of Twitter followers. So we're now up to 52,000. Again, more than doubling of the number of people and organizations who've liked our Facebook page. We're at 50,000. Our e-blasts are reaching a quarter million people every time we send them out.

Our blog posts are regularly viewed by tens of thousands of people, and we're making a number of efforts to use technology to reach a wider audience. One of the latest is a Suicide Safe mobile app, which has already been downloaded over 16,000 times in the last month. So, obviously, a great need and interest and a utility there for the mobile applications. And we're projecting higher figures than standard industry benchmarks for this app, given the level of interest and need.

Three top social media engagement topics, just for your information, it's what people are tweeting, retweeting, posting, liking are underage drinking prevention, suicide prevention, and opioid treatment. So those are where our audiences seem to be focusing and paying attention. So go, Fran.

And we've also recently hired an internal communications expert, and SAMHSA is redoubling our efforts to foster communication within the organization because it's a small place, but a very busy one and difficult sometimes to get information from bottom to top, top to bottom, around and sideways, and we recognize the importance of our employees, you know, knowing what the direction is. Us knowing what they're thinking, what they're seeing and hearing. So we're trying to foster better internal communication.

Strategic grant making is a role that we've identified for ourselves, and it's strategic because we don't have enough money to fund everything that needs to be done. So every dollar that we put out by grant has to be serving multiple purposes.

Not only is there immediately purpose to do the program or the practice or the service that's getting funded, but that we're learning something, that we're leveraging other dollars. We're leveraging other investments. We're getting States, counties, communities, providers, consumers, family members to pay attention to something that they weren't paying to before or that we're bringing other Federal or local partners to the table who weren't addressing our issues.

So we are trying to be very strategic in our grant making. We're also trying to be practical and efficient. So this year, for the first time in a very long time, we got all of our planning done by December 31st, which was pretty daunting, considering, you know, we always get continuing resolutions for a couple of weeks. But this year, we were able to get all of our planning done, signed off, and agreed to by December 31st, and then all of the grant announcements that we had planned to get out by March 31st we actually got out by March 31st.

And so, thank you to leadership from our Office of Policy, Planning, and Innovation, Office of Financial Resources, and the SAMHSA centers and the staff there who really pulled together to get very good products out so that our communities would have -- our applicants would have at least 60 days for every application, which is also a great benchmark for us.

And so, we're making progress towards a theory of change. I think I've talked about that with the councils before. But one of the things we've noticed, just as an example, we've had a great conversation at the CSAT and ACWS councils yesterday. We had a -- opened the doors and had a joint conversation about the Pregnant and Postpartum Women program.

It's a program that's been around since 1993. We have had 100 grants between 2003 and 2014. And it's a lovely program to address the needs of pregnant and postpartum women who are struggling with addiction and in need of residential substance abuse treatment.

While those 100 grants have done wonderful work, and we've seen many, many health babies born, we have not yet seen a State adopt that model State wide. We haven't yet thought through how do we finance and sustain these programs through public -- a combination of public and private financing? And we haven't seen the kind of multiplier effect that one would like to see. So what is that 10-year, 12-year investment doing?

And so, we're engaging in a conversation about what do we need to do to, for example, leverage the substance abuse block grant set-aside for women? How do we give guidance? It's not a mandate. It's not an unfunded mandate. But what are the tools that people need? What is the guidance that they need, the technical assistance they need to take a best practices to ensure that most healthy babies are born, that the most women who are pregnant and struggling with addiction get the treatment that they need?

And so, this is the kind of work that we're doing with our grant making to say, well, do we need to adjust our mechanism slightly? Do we need to take slightly different approaches? Do we need to add an evaluation? Do we need to add some collateral materials? And so forth.

And we've done this with the Children's Mental Health Initiative very successfully. You know, Safe Schools/Healthy Students, which got a boost from the President's Now is the Time initiative in 2014 where for Safe Schools/Healthy Students, we'd had over \$2 billion invested, grants in every single State, and yet no State had adopted that model State wide.

And so, in 2014, with Project AWARE, we said -- or actually in a pilot in 2013, we said we really need to start looking at what -- how can we help States understand the value of this model in preventing substance abuse and promoting mental health and reducing bullying, reducing school violence, increasing perceptions of safety by students and teachers and improving educational outcomes? We have a tool that does that. People don't know about it. States don't know about it.

They don't know how to implement it, and we need to adjust our grant making to try to move that ball down the field. And that's how we're looking at our whole portfolio.

In addition, we're really paying attention to the rigor and the consistency with which we are managing Federal dollars and ensuring -- ensuring the responsible expenditure of funds. We have wonderful Government project officers here. They've been -- they have great expertise, and they have incredible dedication.

We're now trying to help them standardize some of the practices that they are doing with the new policy and procedures effort and handbook, and we've been doing some talent management pilots. We've been looking at how we are allocating our staff resources at SAMHSA, how can we make things consistent,

how can we help create predictable expectations for different jobs at different levels so that you don't have inequities, and you don't have people being surprised, and we can create career ladders and opportunities for growth across the board for our staff.

We're also investing in training our managers so that they can understand and implement consistent approaches to hiring, assigning work responsibilities, evaluating performance, and getting the work done. We have an incredibly dedicated, passionate, expert workforce, and we recognize and appreciate that. What we're trying to do with these efforts is put in some more standard business practices so that talented workforce can do their jobs and express their passions in more consistent and efficient ways.

So that, I think, is the -- that's it for the updates, and then I'm going straight into budget priorities.

Actually, do you want to take any questions on the updates?

MS. PAMELA S. HYDE: Kana is asking if we want to take any questions on this? The idea of these updates was not so much to have you understand every single thing. What we were trying to help you understand is there are many different ways that SAMHSA does its work, and we are really just hoping that that will help you give us good advice about when we get down into the what are we trying to do in the treatment angle.

So we'll take one or two questions and then go on to the budget. Jerome?

MR. JEROME BIG JOHN: Good morning. Wow, what a team. You two really go together real well. Yeah, I mean that. I compliment you both.

MS. PAMELA S. HYDE: Thank you.

MR. JEROME BIG JOHN: Listen, my name is Jerome "Brooks" Big John. I'm from Lac du Flambeau, Wisconsin, a little bitty reservation way up in the northern part of Wisconsin, up in God's country. We have a little reservation that's 12-by-12 with about 160 lakes on there.

So in this treaty where they set these Indians up there secluded, they put us in the wrong place. They put us in God's country, I'm telling you. But let me say thank you, okay, for allowing the tribes to participate in your family that you guys have here, and I mean that.

When I had the opportunity to get involved as a TTAC member, I could smell the opportunities not only for my tribe, but for my brother and sister tribes in Wisconsin and really, basically, all of Indian Country. The -- you know, I think that listening allows for learning, a great forum, and I think that's for true

partnerships that eventually lead to friendships, then require collaboration, of course, sharing, and eventually, you get to this trust, okay?

In order for SAMHSA to know the tribal nations -- I think you may have heard some of this yesterday -- it's important, it's vital that you and your staff know that the tribes have a lot of commonalities, especially in our sovereignty issues, different other things. But it's vital that you understand we have -- we are vastly different. You know, the -- we have different traditions, culture, and needs.

So let me take this opportunity here, Madam Administrator, and Ms. Enomoto, to invite you and your staff, your team, your family to come out to Indian Country, like I mentioned yesterday. Come and see our needs that I described to you yesterday a little bit about my little reservation back home. Come and feel your needs from your heart. Get to know our people. We'll put the key people in front of your people. We talk, and I'll tell you what, then you have a true partnership, and you'll get things done.

Just let me close this by saying that an action item that I would certainly like to see, okay, and after listening to you yesterday, Madam Administrator, you said that in your strategic grant writing, it's what I call grant writing, and your approach to Congress, you try to be very vague. You know what I mean? And it's kind of - - it's smart in a way. That way, you can kind of lean this way and lean that way. Pretty cool. Smart.

MS. PAMELA S. HYDE: I don't remember saying that, Jerome.

[Laughter.]

MR. JEROME BIG JOHN: But here's kind of -- well, maybe I read between the lines.

MS. PAMELA S. HYDE: You probably did, yeah.

MR. JEROME BIG JOHN: I can do that. Congress wants more details. They want the specifics. They want the evidence-based practices. So I'm thinking, as a grant writer, in my grant writer days, that I'm going to call these guys and see exactly what they want. You know, I have this here. How does that fit? How does that sound? You know, they'll kind of let you know.

You know what Congress wants, okay? We talked about these evidence-based practices yesterday, and I think over time, we can get these from the tribes with your help, with this partnership.

If we put some time into helping the tribes learn how to prioritize to, first of all, create a list, prioritize this list with these new tribal evidence-based practices/initiatives that we would like to add to the National Registry of Effective

Programs and Practices. If we work on them together and if we show them like we talked about yesterday the traditional healing that we're working on, if we show them with your help, if we show Congress that, hey, this is something that we believe will work. This is an evidence-based practice.

We've used these healers and these traditional people for hundreds and hundreds of years, and they're at the same level as this medical doctor, if not even higher in our eyes. That's when you start respecting us as a sovereign, really true government-to-government relations come out, and that, you know, the policy for collaboration and the consultation really hits home then.

So I just want to share that much with you this morning. I want to say [speaking Native language]. That means "thank you" in my language for letting me smell that opportunity here.

MS. PAMELA S. HYDE: Great. Thank you so much.

We're going to take another one or two, and then we're going to have to move on. Yeah?

MR. JOE GARCIA: Thank you. This is Joe Garcia. I'm from Ohkay Owingeh, New Mexico, and I represent the tribes from Southwest, mostly New Mexico, Colorado, and Texas.

My question or statement, maybe a recommendation, is has to do with the grant making, and it's on the bullet point, you wrote down that we're using theory change approach. And so, when you talk about a grant, the granting process has to start from the beginning of who writes the grant. So the grant, the people that draw out the guidelines for the grant must be in tune with what changes are we talking about?

They send out the notice. The people that respond to the grants are going to include what they know, as my brother has said, things that have worked over hundreds and hundreds of years. And so if that's what they write up, and the next thing is that the submittal comes in, and then there are grant reviewers. If the grant reviewers don't know about new ways or other ways of providing support for the people in need, then there's a big X already.

So we've already struck out on one sense. And then next comes the people that justify the -- or provide the services for overseeing the grants. Those are the contractors or grant contractors, whatever they're called. If they don't know about the new changes, then there's strike two. So they're going to -- they're going to criticize and say, well, the tribes or the recipient of the grant is not doing justice to the grant. So all these conditions.

So if you're looking at the change, the grant making process and the grant

providing process, the entire thing has to change. But the root cause, as you said yesterday, was who approves what the grant looks like? Well, it goes all the way back to, from what I understand, Congress. If the Congress is not going to provide the funding to allow these kinds of grants to move forward, then there's strike three. So we're back to square one.

So I believe that in that sense, then the change approach is a good approach. It's just that we all got to be on the same -- at the same ballgame, if you will. We don't want to be in 10 or 12 different ballgames, and then we're talking about change. We all got to be in the same game. So I provide that as recommendation, but if you have a response, appreciate it.

MS. PAMELA S. HYDE: Yeah, thanks so much, Joe.

I appreciate the comment because part of what we are going to be asking of you all day long is what advice do you have about us doing our work? So telling us sort of how we should do our grants better is, frankly, a better piece of advice than "do more grants." Because "do more grants" is really up to Congress. We can think about how we do our grants differently with your input and advice.

So thanks, Joe. I appreciate that. Jeremy?

DR. JEREMY LAZARUS: Thanks. Jerry Lazarus from CMHS.

Thanks to both of you for that overview. That's very comprehensive. It's a lot of information to take in. And actually, it would be helpful to actually get that pushed out to us so that we can see that list.

What's missing for me is, and perhaps even structure it this way, is to connect the dots between all of the programs that you both talked about and the strategic initiatives. Sometimes I could see it there, but sometimes I couldn't. And then to the degree it's reasonable, to let us know how the budget priorities are attached to those also.

But I'd just suggest that for the next round that we can sort of see how those fit, and then the second part of the question is when you're doing all those programs and you have these priorities, what are you not doing? Is there anything you're stopping doing? And to the degree it's appropriate, to let us know what you're not doing in order to achieve these priorities.

MS. PAMELA S. HYDE: Great. Thanks.

That's great information or great input. And in fact, it's a great segue to let me have Kana do the next piece about budget priorities, and then I think throughout the day we can help try to connect some of those dots. But your point is really well taken.

Thank you.

So, Kana, you want to do the budget?

MS. KANA ENOMOTO: Sure. I will say to Jerome I'd love to see your 100 lakes. And please speak with President Joseph about how we shared moose stew in Tanana Village and rode on a van in a kitchen chair in the back of a van through the -- through the dirt roads. So we have been out to Indian Country and to Alaska to try to understand some of it, but there is always more to learn. So I appreciate it.

Thank you.

So I am -- so a little bit of what you're saying, talking about what are our budget priorities? I can't tell you what we're not doing because there is a lot that we're -- we're unable to do because \$3.6 billion is a lot, but it's not enough. So we have focused -- in 2016, we had four key priorities.

One, given the number of newly insured or people with expanded insurance, thanks to MHPAEA and ACA, about 62 million people have expanded access to mental health and substance use benefits, and so we know that that has implications for the behavioral health workforce. We need to train more professionals, para-professionals, and peers. So we have that as one of our key priorities.

Crisis systems. Given everything that's happened in our country, we understand that there are some shortcomings in our ability to deal with crisis. Not just the immediate crisis response. We know there are evidence-based practices for that. We know many States, communities have adopted those. But in fact, how all the systems are working together, both to prevent crises, to de-escalate crises, and to make sure that we can mitigate the effects by connecting people who experience crises with the needed services and supports in their community so that they don't run into the next one. And so, we have prioritized crisis systems in both CMHS and CSAT.

Prescription drug and opioid use disorders and prevention, incredibly important platform for the President, platform for the Secretary and the Administrator. And we've done -- we've continued to increase our efforts and our resources there.

And tribal programs. As you've just heard where it's something that's very important to us, something we've been paying a lot of attention to. Last year, the President went out to Standing Rock, reaffirmed the administration's commitment to Indian Country, and SAMHSA continues on that with our tribal behavioral health programs and the way that we are trying to increase the cultural awareness, the awareness of the legal and the political relationships that we

have with tribes that are different than with States and communities and other organizations. So we can tell you a little bit more about what we're doing there in a bit.

So we are at \$3.7 billion in 2016's President's budget. So it's not real money yet, but we're hoping for it. It's \$44.6 million above what we have currently in 2015. Like I said, our priorities are crisis systems with \$10 million new. That's \$5 million and \$5 million in mental health and treatment.

Prescription drug and opioid use/misuse, we've got \$35 million new there. That includes \$25 million for MAT, \$12 million for preventing opioid overdose-related deaths, allowing States to do education and training, as well as purchase naloxone. Strategic prevention framework for prescription drugs, we call it SPF-Rx, which would be \$10 million new in substance abuse prevention.

Behavioral health workforce, we have in 2014 saw an infusion through Now is the Time. We're requesting an additional \$31 million. That would be \$10 million for peers and \$21 million for the work that we're doing in conjunction with HRSA to train professionals and para-professionals.

For tribal behavioral health, we're requesting an increase of \$25 million. That would be \$15 million in mental health, \$15 million in prevention. That would be for a program that does substance abuse prevention, suicide prevention, as well as addressing trauma and behavioral health issues for young people that affect their learning.

And we would do that in partnership with our colleagues at IHS and BIE, and it would be very tribally driven so that tribes would be able to propose the interventions, the programs, the activities, the evaluation measures that they think would work for them, and we would be able to provide that support to address these really critical needs in Indian Country.

Sorry. Some other key proposals that we have in the 2016 budget include Mental Health First Aid for veterans. That would be \$4 million new in mental health. We've had an investment in Mental Health First Aid for local educational agencies. So working with youth and those adults who work with youth.

We this year have a new announcement for Mental Health First Aid for community organizations as well as schools, again focused on youth, and then in 2016 proposing to expand this work to address the needs of military families and service members.

We have -- we continue to propose our primary care and addiction services integration. Based on the work that we've done in primary behavioral healthcare integration with community mental health centers focused on people with serious mental illness, we recognize that the healthcare needs of people with addictions

are equal or even greater, and work needs to be done in that area.

We are continuing our support and our request for grants to address adult trauma screening and brief response, \$2.9 million, which would be in mental health. There is -- we've had some robust conversations about the zeal with which people are trying to address trauma, and some of this zeal has led to kind of misled efforts to screen in potentially inappropriate settings and responding in potentially harmful ways. Even a nonresponse is harmful. And so, we think that it's important that we do some services research on how to best screen and respond to trauma in primary and other healthcare settings.

And National Strategy for Suicide Prevention. Again, trying to bring -- if we want to move the needle on the numbers of suicides in this country now reaching over 40,000 per year, we need to look at populations where those numbers are the highest. And so, the NSSP allows States to do that.

We are going to see some reductions. This is the answer of what are we not doing to allow us to do the things that are most critical at the moment. We are going to have -- we are requesting \$28 million for PBHCI, which is a consistent amount for the President's budget from prior requests. But that is \$24 million less than what we have currently.

SBIRT is at \$30 million, a \$17 million reduction. Criminal justice activities in substance abuse treatment would be reduced by \$16.1 million. In, I think, all of these cases, it wouldn't produce any grant terminations. In some of these cases, we would still be doing new grants. It would just be fewer new grants.

In Addiction Technology Transfer Centers, we would have a \$1 million reduction, and Access to Recovery would be eliminated, a reduction of \$38 million from what we have in 2015.

To illustrate how our funds are allocated and how we've been doing over time, you see that the \$3.66 billion -- \$3.66 billion in 2016 is our highest request yet, and that in 2014, 2015, we did relatively well. We had the growing red bar there in the middle that shows different types of funding. The green is prevention and public health funding. The red funding is Public Health Service evaluation funds, and the blue is our budget authority. So you see we have an increase in our PHS evaluation funding, a slight decrease in our budget authority.

And sorry, just for those of you who don't remember, the little blip that you see there for 2013, which is a dip, that's sequester. So let's hope we don't see sequester rise its ugly head again.

So here's a comparison to where we are in 2015 across if you look down sort of the bottom row there. Mental health services is going up by \$7 million. Substance abuse prevention is going up by \$36 million. Substance use

treatment is going down by \$41 million. Health surveillance and program support is going up by \$43 million, for a total increase of \$45 million between '15 and '16.

So, with that, I can take any questions, or we can move on.

MS. PAMELA S. HYDE: Anybody have questions on the budget at the moment? Yeah, Lori?

DR. LORI ASHCRAFT: I'm noticing the money you have in integrating substance use with primary care, and I'm wondering how that fits with the overall plans to integrate primary care, mental health, and addiction services, especially since addiction services and mental health services really aren't integrated to begin with.

MS. PAMELA S. HYDE: How is the integration of -- I think your point about integration is a good one. When we talk about -- we've tried to decide whether the word "integration" is really something we should keep using, or if we should use something different.

So in this larger look we've been trying to take at where does behavioral health fit in the larger scheme of things, we've tried to think of it more as the ecological model. You'll hear more about this if you're with us tomorrow. Those of you who are able to participate or listen tomorrow, we're going to do a little bit of work on the paper that we've been working on about that, that Mary has been leading.

But when we talk about integration, per se, which is just one piece of this larger ecological model, a lot of people will say that integrating substance use and mental health is one of the first things we need to do, and it's not -- integration doesn't mean that the identity of either one of those goes away. It means that we have to understand what the relationships are and what the co-occurring situations are, what the competencies are that translate from one to the other, et cetera.

So we've got work to do in both of those areas, Lori. And the field has work to do in both of those areas. So even within mental health, you don't treat depression the same way you treat schizophrenia. They're different diagnoses and different diseases and different processes. Same thing in substance use, you don't treat methamphetamines the same way you treat opioid dependence and alcohol dependence. Those are all different.

And yet there is something about the competencies and the skills and the capacities and, frankly, the infrastructure to deliver those that are -- that have some commonality. Fran has probably been one of our best strugglers and thinkers on this because it is not an easy thing to think through.

So that kind of integration, not losing identity, but understanding the

relationships, is important. Same thing is true with primary care and behavioral health, but then we're also trying to go beyond primary care. We're trying to go into specialty care and other kinds of ways that we look at how physical health and behavioral health or physical health and mental health or physical health and substance use disorders all fit together.

So I don't know if that answers your question, but we're very cognizant of all of those issues and trying to struggle through them.

DR. LORI ASHCRAFT: That helps.

MS. PAMELA S. HYDE: Yeah. Dan?

DR. DAN LUSTIG: Good morning. Just a quick clarity. What is the thinking behind the \$41 million loss for substance abuse treatment that's in the budget?

MS. PAMELA S. HYDE: Do you want to take that?

DR. DAN LUSTIG: I mean, I don't know if I'm reading it correctly. I just want to -- what is -- is that because other systems are picking up those dollars and that's --

MS. KANA ENOMOTO: I think we see the greatest opportunity to cover substance abuse treatment costs coming from MHPAEA and the ACA. So we are also investing in business operations and other opportunities to help providers do more third-party billing. And the largest part of the reduction comes from the elimination of ATR, which as we have -- and we've talked about this.

As we have encouraged the block grant to cover more recovery support services, as well as services that aren't covered by insurance, then the need for ATR was seen as less and the need for this work on the intersection between addiction services and healthcare was seen as greater.

DR. DAN LUSTIG: The only comment that I want to kind of make on that is we discussed yesterday in our committee meetings is a lot of addiction providers across the country begin to have challenges when working with private payers, managed care organizations. And there needs to be a period of time of transition as managed care entities are trying to contract with addiction providers because, currently, it is a profound problem that is restricting treatment to many individuals who are in most need of it.

So I just wanted to make a comment on that.

MS. PAMELA S. HYDE: That's an excellent comment, and let me just underscore that any time we tell you that we have reduced programs, it is not necessarily because we wanted to. It's every time we do budgeting now, the first question is what will you cut? And then the second question is what would you

like to do new or different, and where are you going to take the money from out of your budget or somebody else's budget?

We do get opportunities to propose new things on top of flat budgets, but you've seen what Congress is going through. So it's always this struggle between what we are seeing, and Kana mentioned it. But we have another set of pie charts -- I can't remember if we sent them out to you or not -- that shows over time how much the changes are happening with other coverage for things like substance abuse treatment.

But you're absolutely right. There is also this sort of profound shift going on in the provider network. The larger entities are recognizing that this is now a cost center. It's no longer a losing proposition. They can actually bill somebody. So they're starting to take it up, but not necessarily always the way we would like, and we don't want to lose that capacity.

So we've been working with some of the provider organizations, Kana mentioned it, on something called BHbusiness to try to help them understand how to do some of that better.

MS. KANA ENOMOTO: I would also note that the net reduction to substance abuse is slightly -- is not quite that number because in our HSPS appropriation, that's where the workforce piece is. So money that is for both the substance abuse and mental health workforce has moved over to HSPS, which is not in the treatment appropriation, but obviously funds towards a treatment purpose.

DR. DAN LUSTIG: My last question is when -- the clarity around the workforce. I know that there has been discussions around licensed individuals -- doctors, nurses, and the expansion of that. But has there been any discussion about how to improve the workforce for certified addiction counselors that provide a bulk of in community-based organizations the services for addictions treatment?

MS. KANA ENOMOTO: So the \$21 million that we're requesting includes -- includes both master's level professionals, Ph.D., psych interns, and para-professionals like addiction counselors. So that group is included, and then we also have a new MFP, Minority Fellowship Program, for counselors.

DR. DAN LUSTIG: Thank you very much.

MS. PAMELA S. HYDE: Okay. We're going to take one or two more questions, and then we're going to again have to move on. So there's never enough time to have these conversations.

MR. ANDY JOSEPH JR.: [Speaking Native language] My name is Badger. I'm Andy Joseph Jr., and you know, kind of dealing with the funding, you know, we want to make sure that the funding that we receive gets stretched out and

actually is more effective.

And Joe, both Joe and our other tribal leader talked about our traditional practices and healing methods being a best practice that works. And you know, I don't know if any of you have seen the Band of Brothers, but one of those soldiers actually comes from my reservation. And our tribes, we have our different warrior societies and different ways of bringing healing to our veterans that come home.

We have a lot of veterans that are coming back from Afghanistan, and they're young parents and they're suicidal, and their children have to deal with them kind of similar to the effect that the Vietnam vets had with their post traumatic distress. You know, part of the way that we work with our veterans is utilizing our traditional healers and practices.

If you go to Spokane's VA, there is a sweat house right behind the hospital there, and you know, our practices not only help our tribal people, but you know, like the Band of Brothers, they become a big family, and we treat our brothers the same as we would treat anybody else.

And we've had some nontribal people come to us and thanking us because without the services that we're providing, they wouldn't be alive today. They wouldn't be parents to their children. They wouldn't stop drinking or using drugs and alcohol. But these traditional practices need to be acknowledged by someone, and they need to be known that they're doing good.

The VA at the National Indian Health Board meeting, a big national meeting we had, acknowledged that they're saving hundreds of millions of dollars on treatment because of utilizing traditional healers, and it really needs to be looked at as a way to provide the services. And the people, like Joe said, that look at our grants and look at our compliance need to understand, you know, that they're actually -- sometimes they put a mark against us because we want to like provide some food or something.

Well, if you go to American Legion meetings, they start off a lot of times with a dinner, and that brings the veterans, you know, there. It's the same way with the tribal nations. You know, we start off with a meal, and that brings the young families there, the ones that are addicted to these alcohol and drugs. And you know, we have talking circles and things like that that actually work.

And, but some of the grants and the people that we have to deal with say, well, you can't do this and you can't do that. So, you know, we get dinged on grants. And to me, I think it needs to be really looked at.

And you know, it was mentioned that we have to go to Congress to get their approval on this stuff, but I would say we need to go there in a partnership with

the leadership here and go to Congress. And you know, if you need the doctors that we have people that are highly educated that could go in and help with the numbers and testify on our people's behalf.

But that's all I have to say for now. Thank you.

MS. PAMELA S. HYDE: Thanks, Andy. Appreciate that.

Your comment might be a good place for me to underscore -- because we're going to move into the next area unless there's another question -- that one of the things SAMHSA can't do and we don't do a lot of, we don't do any of, is we don't lobby. You can lobby, but we can't. We are prohibited by law from doing that.

We can educate congressional leaders, and we do a lot of that. We can respond to questions if they ask us. But if they don't ask, we can't respond. And so, it's not that we don't have a relationship with Congress. We definitely do. But there is in all of Federal Government, it's not just SAMHSA, in all of Federal Government, we are -- have a relationship between the executive and the legislative branch that has some limitations on what SAMHSA can do.

So one of the things that we talk about, I think, in these kinds of constructs is we propose a budget, but we propose it through HHS and the White House, and the White House proposes a budget to Congress. That's the way the law is. And once that budget is proposed, that's what we present to Congress.

So we don't get to go over and say here's all the needs. Would that it were so, but it's not quite that. It's not quite the way it works. So as we talk together about these things, if you think we need more money for data, health surveillance, for example, then that would be something somebody else would have to tell them, except in the context of our grants -- I mean in our budget.

Now why do I tell you that there is because we often get questions, even from Congress, who knows this relationship, that, "Well, why didn't you ask for X, Y, and Z?" Well, we're asked to cut our budget, or we're asked to keep our budget increase in less than a percent or whatever it is.

So there are those kind of constraints, but that doesn't mean that we don't have a lot of ability to make some implications here or to educate the public or to educate tribes or to educate anybody else who wants to go talk to Congress about what should or should not happen in behavioral health not just in SAMHSA, but in the country as a whole.

So let me take one more question and then we -- do I see any other hands about the budget or any of the things we've talked about so far? Then we're going to move into our panel. Okay, Victor?

MR. VICTOR JOSEPH: Hi. Thank you. Victor Joseph, National Advisory Council member.

I got a couple questions here. Your behavioral health workforce, I'm glad to see that you're looking at that, and you're having increases. But at the same time, I'm wondering during this and looking at this, are you thinking about those support systems that can assist long distance delivery services? That would be one question.

The second question, as I'm looking at your primary care -- I'll just run them down, and then you can answer them, if that would be the best way to do it. As you're looking at your adult trauma screening and brief response, it's also really good that we're seeing this because we know a lot of people going to primary care facilities have been traumatized. And a lot of people won't go to those providers because they're traumatized. So how do we mitigate that?

But at the same time as you looked at your SBIRT programs, and we're seeing a decrease now, I start getting concerned with sustainability, and a lot gets put onto the programs for that. With all that being said, you're also working with CMS for the IMD's inclusion, but how are you going to be working with CMS for parity when we're looking at pay schedules for like sustainability with SBIRT programs or with your trauma-informed care so that you just won't have an initiative that dies in a couple, 3 years?

MS. KANA ENOMOTO: So I think the issues you brought up about looking at how to provide, whether it's by telehealth or something like the ECHO program, where we're addressing -- using technology to increase the capacity of professionals to provide services in rural and remote areas, that's something we're definitely thinking about for '17.

This -- this proposal that we have now in the current program is fairly flexible in terms of allowing training programs to pay for practicum experiences for students in different types of places. So I think the current proposal, the current program does allow and provide support and opportunity to pay for clinical internships and clinical practicum in rural and remote areas and to provide the kind of support -- for example, para-professionals out in the region -- so that the clinical professional who's doing the telepsychiatry, for example, has the support out there.

So that's the kind of model that would be -- that could be supported by those current grants, and then we are looking in '17 about what we might do to further that use of technology in different ways.

MS. PAMELA S. HYDE: I'm not sure how much this adds to it, but we're also working with HRSA, who is the primary player in workforce, and they are trying to

think about how to help other behavioral health provider locations become places of training for practitioners because part of the problem is you have to have an organization that will take responsibility for supervising and training and stuff, and that has been somewhat limited in the behavioral health arena.

And so, HRSA has been hugely big supporter because we don't have either the authority or the money to do some of this. They have the authority, and they've been very supportive of trying to think about ways to bring more opportunities for people to get training out in different areas.

And Mary Wakefield, who was the head of HRSA until recently, she's just actually moved into the Acting Deputy Secretary role. But she comes out of nursing, and she comes out of rural America, and so she has a very strong commitment. She comes out of North Dakota. So she has a very strong commitment to trying to increase capacity in those rural areas or in areas or with practitioners that aren't always the usual groups that we think of.

So we got a good partner there. So I don't know if that totally answers everything that you're asking, but some comments anyway.

MR. VICTOR JOSEPH: I got a lot of feedback.

MS. PAMELA S. HYDE: Okay, great. All right. Any other final questions before I move into the panel?

[No response.]

Agenda Item: SAMHSA's Role in Influencing the Provision of Treatment for Mental Health and Substance Use Disorders: Types of Investments That Can Best Leverage SAMHSA's Limited Resources

MS. PAMELA S. HYDE: Okay. Why don't we do this? We're going to get a -- we're going to have a little bit of shift out of the technology because some of it is not working as well as we'd like. So Selby is going to do some work. Forgive him for moving around while we're doing this.

But I want to take the opportunity because I see Ellie in the audience now. Ellie, I said wonderful things about you while you weren't here. So would you stand up and wave? This is our chief medical officer, who is leaving us in a couple of months, and we just really want to give her a lot of credit for all that she's done.

I said the speech earlier. So we're going to give you the round of applause at the moment.

[Applause.]

MS. PAMELA S. HYDE: So thanks, thanks, Ellie, for your work.

And then I want to also acknowledge Marla back there. She's another one of our executive leaders, and Kana mentioned Marla many times and some of the work she's doing in public education. So thanks to Marla for all of her work with the Office of Communications.

So I don't know who all else I'm missing back there, but I wanted to acknowledge those folks.

Okay. So what we're going to do next is I put these roles up because we want to keep our heads wrapped around the different things SAMHSA can do, some of which, again, is producing products, harassing people. I sometimes say we do leadership by harassment or nuisance, leadership by nuisance. Or we can educate the public or we can change our regulations to the extent that we have those kinds of requirements or set standards or do things to try to train people, improve practice, et cetera.

So I want to keep all those in your mind as we have this next panel discussion and then also as we do the breakout groups. So those of you who are representing each of the center advisory committees, if you'll come forward, we'll make that shift, and we'll get into conversation about what you all talked about in your advisory committees.

So come on down. Yeah, so if those of you up here want to just provide a little space for the folks to come up. Yeah, take your tags with you. Take your nametags with you.

[Pause.]

MS. PAMELA S. HYDE: All right. Can you all hear me on this mike? Is this working? It needs to be a little higher, Selby. This guy is a magician back here with the technology. So I'll have to keep moving back and forth here probably to be heard.

All right. Good. So you can all hear me now?

All right. So what we wanted to do with this panel is not do a lot of talking heads. So we're not trying to just have a bunch of report-outs. I think I'll have you guys just remind us who you are and which council you represent, and then we asked each of you to look at some similar questions, and we're going to talk about those questions just a little bit as a way, again, to stimulate our conversation just a little bit more.

So you want to start by telling us which one you represent and who you are.

DR. LEIGHTON Y. HUEY: I'm Leighton Huey, Center for Substance Abuse Treatment.

MS. KATHY REYNOLDS: Kathy Reynolds, Center for Substance Abuse Prevention.

MR. ANDY JOSEPH JR.: [Speaking Native language] My name is Badger. I'm Andy Joseph Jr. I am representing the Tribal Technical Advisory Committee.

MS. PAMELA S. HYDE: Okay.

DR. CAROLE WARSHAW: Carole Warshaw from ACWS.

MS. JEANNETTE PAI-ESPINOSA: Jeannette Pai-Espinosa, also from ACWS.

MR. JEREMIAH D. SIMMONS: Jeremiah Simmons with CMHS.

DR. LORI ASHCRAFT: Lori Ashcraft, CMHS.

MS. PAMELA S. HYDE: All right. Are we -- we'll get them all. So some people can't always follow directions. So that's why we have two.

[Laughter.]

FEMALE SPEAKER: You can't always get a volunteer until --

MS. PAMELA S. HYDE: Yeah, right. Exactly. So, Kathy, I apologize because you had a partner, too, that I told you you should only come, have one person. So if you want your partner up here, you can do that as well.

All right. So we asked you two or three questions, and one of them had to do with culture and gender issues. We haven't talked about that too much today, but we have talked about that at other times, and one of the things that we always try to do -- could you put the roles back up there?

Here, I might be able to do it with this. Well, maybe I can't do it with this.

So at other of our meetings, we've talked a little bit about what SAMHSA's role should be in this, and I told you we have something called the National Network to Eliminate Disparities. We have a lot of work we've been doing in not only disparities data, but also in just trying to make sure that we are paying attention to the unique cultural needs of primarily we look at African American, Asian American, Latina American, and Native Americans and LGBT populations, and to some extent, we put the issue of women in that role. So I don't know if I listed all

those out.

But nevertheless, there's a ton of different cultural groups in that, but what did you guys talk about in terms of the roles that we play and as we try to address the treatment issue that we should be really paying attention to in the gender and ethnicity and disparities issues? You guys want to tell us, the women's group?

MS. JEANNETTE PAI-ESPINOSA: Sure, sure. And I think a lot of our -- a lot of our comments really focused on kind of finding its root and encouraging SAMHSA to shift its frame a little. We asked Kana, I think, during our meeting do you consider yourself a thought leader? And she said, well, we'd like to think of ourselves that way.

And I think our suggestions are really to kind of seize that role because certainly at least our advisory committee sees you in that role, and in that position, you really can kind of leverage your role as convener and a bridge builder, but also as a practice expert and someone who can connect the dots and is, from our observation, far ahead, particularly as it relates to gender and culturally responsive, trauma informed. Far ahead of at least most of the Federal agencies that we're aware of.

And specific ways to do that, we talked about really were providing some -- and a lot of these things you're already doing, but continue to and/or to build on them really is to identify what the obstacles are for organizations to transitioning to or providing gender and culturally responsive, trauma-informed approaches. So, you know, what's the rub? What's stopping them from doing that? And then providing some support in that area.

And also education materials. We often assume that people know basic things when they don't. Because we work in that sphere, we kind of forget that.

DR. CAROLE WARSHAW: And a couple other things that came up were around there was a recent group that developed guidelines on providing gender-responsive substance abuse treatment in mixed-gender settings. But there's already a lot of guidelines on what gender-responsive treatment should be, even though there are very few places that actually provide it.

There's not the same thing on the mental health side. So we need to be thinking about what that might mean or what that would look like and beginning to have those conversations. And the other thing that we talked about -- so creating some guidelines on, you know, expert panel guidelines on what would mean and what that would look like.

And the other thing is that a lot of under the rubric of trauma-informed care, it's gender responsive, gender inclusive, culturally responsive, and so it's like doing this kind of care or this kind of care. But so maybe having some umbrella of what

good care looks like when it is actually responsive to the people who are receiving that care or seeking services and thinking about it that way as well.

MS. PAMELA S. HYDE: So gender-responsive care in mental health sort of marrying what is out there in substance abuse. I'll come back to you guys.

I want to do maybe a little bit of a, I don't know what it's called, provocative perhaps conversation for CMHS folks. This issue of gender and culturally responsive care. There's a lot of talk these days about assisted outpatient treatment, and there's only really three main studies. And one of the main studies in New York, which a lot of people talk about, really showed some fairly major disparities in who was subject to assisted outpatient treatment.

Now the argument is that's just the way public systems are, but I'd be interested if you're aware, and if you're not, that's fine. But if you're aware of that study at all or if you know anything about that, do you have any thoughts about this issue of mandated treatment versus voluntary treatment and how it impacts people of different cultural backgrounds?

DR. LORI ASHCRAFT: First, I'm not very familiar with that particular study, but I have a lot of experience with involuntary treatment and how it affects different groups. And I think the more different you are from the norm, the more likely you are to be misunderstood and misdiagnosed when what you could be suffering from is trauma or alienation, and you get diagnosed with a mental illness. And then involuntarily treated, either inpatient or outpatient, because of your differences.

And what I see is a real reluctance to learn about and be sympathetic to those differences. And in a lot of organizations, they'll say, oh, that's the person who deals with the gender issues. So instead of it being something that the whole organization takes on to become more understanding about, it gets isolated in one person, and then the misunderstanding and the misdiagnosing continues because it's not accepted.

We all know -- I'm probably going to aggravate a lot of people in the room by saying this. We all know that stigma is strongest in our own organizations. This has been proven over and over that behavioral health professionals have a stronger sense of stigma than the general public. So I think that stigma carries over into this area as well.

MS. PAMELA S. HYDE: So just so the folks know, I think you've been pretty clear, Lori. You're a member of a tribe, right? So you bring that perspective in addition to your work.

And do you see -- and Andy, you may have a comment about this, too. Do you see some issues around tribes and involuntary treatment, whether it's substance

use or whether it's in juvenile facilities or whether it's in literally assisted outpatient treatment kind of approaches? Is there something particularly about tribes we can be doing in this gender area and the issue of mandated versus voluntary treatment?

DR. LORI ASHCRAFT: Yeah, I have to say I just don't know. I think there's others in the room that might be better equipped to answer that.

MS. PAMELA S. HYDE: Okay. So this may be an area we ought to explore?

DR. LORI ASHCRAFT: Yes. I think so.

MS. PAMELA S. HYDE: We ought to look at a little bit. And I'll come back to you in just a second, but let me ask the tribal question. Andy, do you get this issue of involuntary treatment that comes at you as a tribal person at all?

MR. ANDY JOSEPH JR.: Well, you got to look at the source to begin with. Our tribes have a real deep impacted historical trauma. I could use my family as an example -- or our tribes.

The Colville Tribe was 12 tribes pushed together on the reservation from the north -- or from eastern Washington State. We were pushed away from the places where our food grew. And like I said, our warriors went away to fight in a war and come home, and the dams were put up and the rivers were blocked, and the salmon couldn't make it to feed our people. And you know, so you lose your source of food.

And then, you know, for men, it was a way of providing food for their families. And then, on top of that, you get sent to boarding schools. I was sent to a Catholic boarding school. A lot of my classmates were raped and sexually abused, and if not that, they were physically abused. Go to my tribe and ask anybody what the "black mike" is, that's what the priests used to whip us with.

And then you top that with, you know, I think the statistics for Native American women, one in four get sexually abused in their lifetime, and that's not only -- and it isn't really from our own tribal men. It's from nontribal people.

So you have all of these factors that does cause, you know, the mental abuse. There's post traumatic stress from way back, you know, hundreds of years that's impacting our people, and it carries on from generation to generation.

And you know, a lot of our -- my dad, mom -- or my dad was a fluent speaker of our language and raised in a traditional way. When he went to school, he got beat for speaking his language. And he never taught us until later on in our life because he didn't want us to be beaten, you know, for learning that. So, you know, I was fortunate that he kind of kept that away from me.

So I would say there is that factor. But we had suicides, and we had a public health team come to our reservation because we had a state of emergency. We had a big suicide cluster, and Dr. Hibbeln in his report was saying that the closest thing to what the brain is made of chemically is salmon. Well, we lived on salmon for thousands of years until they took it away, and that's kind of why I crave salmon so much.

But if you take some -- there was another report by a doctor, and she specializes in diabetes. Well, diabetes is high in Indian Country as well, and she talked about, you know, what develops a brain of a young child and the different parts of your body that really help you live longer. So a big part of our diet was impacted. So there's going to be, you know, more problems.

Like Dr. Hibbeln said, a person that -- his prescription was those fish oil pills to try to get that back into our systems. To me, I just think that the thing that works with our people is, I kind of spoke about it earlier, is our traditional practices, being able to go and gather those foods and to bring it back into our diet.

But when you work on grants and stuff and they say you can't do that, it's -- it's something more simpler than going into a room with a provider that's going to scare the hell out of you. I wouldn't want my children to go in a room with any providers because, you know, we don't have that trust anymore. And our tribe got dinged for doing group sessions, and you know, the FBI came and, you know, said, well, you can't do that.

And it's like, to me, it's more of a traditional practice to work with our children in groups. And you know, our parents were sending their children to these group sessions because they were coming home feeling better and being more active in their community. And you know, some of these children see trauma.

I asked my enrollment how many people we've lost in this year, and the numbers are really high. But my son, you know, he's 33 years old now. He had a class of size of 25, and now he's only got -- there's only 5 of them left.

So it's -- it depends on what the Government wants to do, I guess. If they want to save lives or if they want to save money, that's what it comes down to.

MS. PAMELA S. HYDE: Yeah, thanks, Andy.

So I'm hearing several things. The reason I raised the involuntary treatment issue in this context of cultural issues is because we are -- it's a big issue right now is what do we do on involuntary treatment on the mental health side, and I'm going to ask you in a minute, Leighton, whether you guys have had any discussion in Treatment Advisory Committee about this notion that the main place we get referrals is through the courts and coming through systems that you

can argue are involuntary or not, but nevertheless, not necessarily getting people into treatment in the fastest and best ways possible.

And we know there's a big treatment gap. So trying to figure out what SAMHSA needs to do in this area if we're going to do work around involuntary treatment, which we are doing some, and some work around patient engagement, then how do we do that sensitive to the cultural issues? And I think your comments about how women and gender-specific issues in the mental health side, we probably need to do a little bit more work there. And Andy is making the case that we need to do something about tribal practices.

I'll come back to you in a minute. Can I come to Leighton here?

DR. LORI SIMON: Just -- it doesn't have to be now, but I'm actually very knowledgeable about what's going on in New York about this is AOT and the actions and stuff. So at some point -- I mean, I don't have to do it now. I don't want to interrupt. But I can comment on that, or I can --

MS. PAMELA S. HYDE: All right, thanks, Lori.

So I'm interested in where the treatment folks talked about, if you talked at all about this issue of how people come into treatment and whether there's a gender issue or gender differences or cultural differences, about how that happens?

DR. LEIGHTON Y. HUEY: Well, I had anxiety about trying to represent our group.

[Laughter.]

DR. LEIGHTON Y. HUEY: Given the wide-ranging discussion that we had yesterday, and we covered so much, and trying to sort out what seemed relevant and what was not relevant was a huge task. But I -- I go back to the comment that you made earlier about, well, treatment of what? Prevention of what?

And our group collapsed the three questions, as I interpreted them, to really all three questions got blended together. So you were saying yesterday, Pam, that SAMHSA has taken some heat because of its focus on recovery and that the concept of recovery is not well understood for the most part. What is that?

But people in recovery understand what it is quite well, and there was some sense that looking at the recovery community from models of cultural tolerance would be an important place to understand and to learn from, and that that was essential, too.

And then in this concept of treatment and prevention, and I'm glad that prevention is sitting at the table here, we were talking about can SAMHSA get on

the ride with science in terms of what science is telling us? What we have been calling the same disorder is really multiple disorders. Pharmacogenomics is informing all fields that what we previously were viewing as homogeneous is really not.

So there are many different kinds of psychoses and mood disorders and stress disorders and addictions that are highly varied, with differing outcomes. And this gets to the frailty of our existing classification system, which, while it represented improvement over the fly by the seat of our pants from over the last 40 years or so, diagnostic approaches from that era don't fit any longer. And the concept has been if a person fits a criteria, they have the diagnosis. And that's very short-sighted thinking and quite problematic.

So when we're talking about how SAMHSA can leverage itself, it seems to me that taking in the science of what's happening in the larger field and recognizing that there is high variability and treatment-specific and prevention-specific initiatives that will apply to specific component subsets of what we historically have called the same disorder is really quite important because that will represent the essence of patient-centered care ultimately.

MS. PAMELA S. HYDE: Okay. So it sounds like some of what you're saying is really helpful advice about the Surgeon General's report that we're going to be working on. Kana is leading our efforts on that with a lot of other staff and NIDA and NIAAA. But how we think about that sounds like how we portray that in the Surgeon General's report is going to be really important.

And the Surgeon General's report is on alcohol, drugs, and health. We've done a Surgeon General's report 15 years or so ago now. But nevertheless, on mental health. Never done one on substance abuse and drugs. And so, we're calling it alcohol, drugs, and health. So your comments are well taken about that, and it sounds like also both gender issues and cultural issues need to be in there as well.

From a prevention point of view, you can either jump off of this issue about science and the Surgeon General's report, or if you want to go a different place on this?

MS. KATHY REYNOLDS: I think sort of the last to respond, we echo a lot of what the other councils talked about or advisory councils talked about during this. I think the one unique piece that we did talk about is mobilizing and activating communities to address the culture and gender issue. We did talk about peer and folks with lived experience being critical to addressing this issue. But whether it's specialty communities or communities in general, getting the community mobilized, getting the organizations in the communities, the people with the lived experience working together to address this gap.

And I think very similar to what our treatment friends talked about is we talked about one of the best things that we could do to bridge the gap and to do this is to do better prevention. That if we were able to activate the research and science that we know works right now and bring that to bear in our communities, that we could do a substantial job in addressing the gap in services for treatment.

And just would echo that we are really glad for prevention to be at the table talking about treatment with you because sometimes we're siloed off. But we think we're part of treatment. We think we have a lot to offer, and particularly in the science mobilizing communities and coalitions and groups to address the issues. And we would echo the thought leadership recommendation, for SAMHSA to be a role in the thought leadership discussion around this.

MS. PAMELA S. HYDE: So how would that look, Kathy? I mean, we think of ourselves, as you heard, as a thought leader. But when you say that or when your committee talked about that, what did you think about in terms of what SAMHSA should do to position itself as a thought leader, be a thought leader?

MS. KATHY REYNOLDS: We had some recommendations similar, and I'll ask my colleagues on the women's committee to join us about there are already a lot of best practices and strategic initiative planning things out there that are available. Making sure that SAMHSA is viewed and out talking about the things that are available. When organizations think about bringing somebody in to where is the thought, that they think of SAMHSA first in terms of doing that. So developing the expertise, developing the marketing, developing those sorts of things.

And I'll punt to my friends from the Women's Advisory Committee to support that as well.

MS. PAMELA S. HYDE: Okay. So I know you had your hand up and want to say something, but I would like you to take this comment and also talk a little bit about families. Because one of the things we've gotten a lot about is that we pay attention to the person who is in need or whatever, but we don't pay enough attention to the family who's also experiencing the issue.

Can you say however you want to segue into that?

DR. CAROLE WARSHAW: Okay. Well, I'll segue into what we were just talking about. One of the things, and Jeannette, you'll probably want to add more. On the thought leader, I mean, we had also talked about having the big picture framework that brings the science and the complexity and being a leader in that way, to have the big picture of where we are now around mental health and substance abuse. So that's one piece and having it be big, you know, that people can -- like writing it up and presenting it.

But the other is building alliances with other natural allies like the APA and other allied professional groups and with partnerships with funders, private foundations. So that we have a bigger constituency that both share the message that SAMHSA creates a kind of umbrella that people can all be connected to and that become allies in presenting that to Congress and other places where that message needs to get out.

So that's one of the -- do you want to say more about the thought leader because you --

MS. JEANNETTE PAI-ESPINOSA: Yeah, I was just going to say I think -- I just totally forgot what I was going to say, but I'll remember. No, I remember it now.

One of the things that seems like, you know, is the unspoken thing when we talk about gender and culturally responsive services is that really all care should be gender and culturally responsive, trauma-informed, developmentally appropriate, strength-based, you know, the whole litany of them. And that to not acknowledge that the reason we have to talk about the need to be gender and culturally responsive is because practice for a long time was based on what worked for white men, based on research with white men.

So I think SAMHSA could be -- I think the way you frame it is really not about, well, you have these gender and culturally responsive services over here, and then you have all the other services. You really talk about it as all services, though I don't know that I've read it exactly like that. In terms of being a thought leader, that would be huge.

I mean, a lot of organizations are talking about it, but no one is acknowledging that it is a part of the reality of where we are today and kind of builds upon what Leighton Huey was saying in terms of, you know, good individual care. It needs to be based on the reality of a person's life, and that -- I'm segueing now to the family --

MS. PAMELA S. HYDE: Okay, good.

MS. JEANNETTE PAI-ESPINOSA: That includes the family. Because we look at the multiple, you know, the generational patterns of everything that we've talked about. And if we're not looking at where we are helping an individual and their family break a cycle for their family, their lineage back and forward, then we're not really doing our job because we'll be in the same place in another 10 years.

MS. PAMELA S. HYDE: So I want to try to drill down. Because part of what we're trying to get from you is what do you think SAMHSA should do? And obviously, making perfection is what we should be working toward, but that's -- but we have to do it a step at a time. So the reason I say it that way is we have

done some very specific work recently on family for providers, helping families accept their LGBT children.

So how do you -- I grew up Southern Baptist. Believe me, they didn't think LGBT was okay. But I never felt rejected. There was a difference. My mother didn't have to give up her Southern Baptist belief in order to tell me she loved me, even though I wasn't living a lifestyle she would have preferred.

So we've done some practitioner work in that area. Are there some other family things we could do? Because that was a very specific thing, and it was very helpful. It was a product that we could put out there about engaging families in this particular situation. Do you think there's something we can do around families, there is some task or activity we can do in some of these areas --

MS. JEANNETTE PAI-ESPINOSA: Well, I learned at the meeting yesterday that there's a lot that you do that I don't know. And that I'm relatively new, but PPW, which we talked about yesterday, is certainly one.

DR. CAROLE WARSHAW: And I think with the NCTSN, the National Child Traumatic Stress Network, there's a lot of child-parent work that's one of the evidence-based practices. The child-parent psychotherapy, a lot of family-centered services are often not structured financially to work with parents and kids together.

MS. PAMELA S. HYDE: So looking at some of the financing things that preclude families from being in the treatment process?

DR. CAROLE WARSHAW: Right. And to support that kind of family-centered work when it's appropriate and the family isn't abusive. So --

MS. PAMELA S. HYDE: I see Andy's hand up, but I want to come -- you haven't had a chance to talk either. So let me have Andy, and then we'll come to you.

MR. ANDY JOSEPH JR.: I'm glad you're talking about families, and you know, I look at when we have to do Honor Guard for our veterans, and I compare the camaraderie with our tribes and our communities when we provide that service for our veterans. You know, when they move on to the next world, we honor them with the flag and the rifle salute, and we play the Taps. And we actually have part of the ceremony during the funeral service.

But you can't get that kind of healing from -- I guess it's a type of healing that really works. It helps the family cope with their loss, and to me, that's something that's simple. And you know, I could go to anywhere if there's a bunch of veterans pulled together, and I'd have look towards the senior veterans that's been to war and that family feeling that you get, the encouraging words that you get from them. We learned how to pass that on to our veterans that come home,

and you know, it saves lives.

And same way with the boarding school children, they're all my brothers and sisters. When we pull together and, you know, meet with each other, we treat each other like family. Sometimes they have to -- they're having a hard time, and we'll help them cope and live with what they're dealing with. Sometimes, you know, we could share our own feelings with what happened.

The way families are brought up, you know, I pushed on our traditional way of life to my family, my children, and none of them have gone to alcohol and drugs, and they're not having to deal with this other. It's a better prevention tool, you know, overall. I'd rather see all my people kind of living like my family's example.

But we need to, I guess, get more people to be able to train our people because a lot of that was taken away from them in boarding schools. But if we had funding to train some of our young parents to walk this better road in life, you would save the Government thousands and thousands of dollars, and we wouldn't have to bury so many.

MS. PAMELA S. HYDE: Yeah, cool. Thank you. You want to jump in here?

MR. JEREMIAH D. SIMMONS: Yeah. So, so I'd like to talk about, you know, since you mentioned earlier about working with families and specifically, you know, kind of with an LGBT focus. This is something I experienced working with the GLS grant back in Mescalero. We were working with -- and I'm enrolled in the Yankton Sioux Tribe in South Dakota, but I'm also Navajo, but I grew up on the Apache reservation. So I just wanted to let you know that context.

MS. PAMELA S. HYDE: Multicultural.

MR. JEREMIAH D. SIMMONS: That's right. Exactly. So, but we were working with some LGBT youth, and their families were -- you know, the families view this probably as a crisis. So part of it was crisis intervention, you know, but also part of it was how do you build the capacity within families to learn how to talk about these issues also from a culturally specific point of view?

And you know, that wasn't something that was initially built into the actual grant itself, but that was something that we learned. But part of that learning process was really asking the families and working with the cultural leaders and saying, you know, for them to instruct us and saying, you know, well, a lot of the decision-making power does exist within the family units, and they want to be able to manage a lot of their own acuity within the family. But how do you build that capacity back again, especially in the kind of, you know, social, historical, political context of knowing that a lot of those tribal institutions of how to do that have kind of been eroded away? But you're rebuilding those again.

So part of that process is, okay, how do we build that and how do we work with families? And it gets back to that strategic communications piece, too, and how do you learn to build that communication piece within the families that is culturally responsive and appropriate?

And but again, you know, kind of -- it is, again, relearning from the communities, which I think reflects another comment that I think another person made about kind of honoring and acknowledging, you know, indigenous ways of knowing and being, which includes, you know, kind of an emphasis on the theory of change model, which is reflecting that practice-based evidence piece. And collecting additional information about that, which could be more qualitative in nature, but using that to inform the current practices within the grants to help work with families.

MS. PAMELA S. HYDE: Okay.

DR. LORI ASHCRAFT: I'd just like to kind of put an exclamation point behind what you said and kind of what everybody is touching on related to families and culture. And I think the closest SAMHSA gets to this is talking about engagement. But really what we're talking about is relationship.

And I think when I go around consulting and training, the biggest breakdown I see is professionals with either compassion fatigue or a lack of training altogether, and the importance of being with people in a way that's healing. And so, it comes across like I'm doing my -- oh, engagement? Okay. But it never comes across or rarely comes across as a genuine relationship.

And I'm bringing this up in the context of thought leadership because I don't hear anybody talking about this. And for years and years, I mean, this is old, old stuff, but it keeps being revalidated in new research, is relationship is the key to all of this working. Whether we're talking about professionals role modeling that for families or learning it from families or from unique groups of people, if we could just be with people in a genuine, present relationship that honors who they are, we wouldn't have to worry so much about our differences because we could connect. It's the connecting that's not happening.

MS. PAMELA S. HYDE: So let me take this conversation about families and workforce, Leighton, and come back. Because I know you've spent some time over your career working on workforce issues. But I'm also curious how your advisory committee talked about the issue of treatment or, if you did, talked about the issue of engaging families in treatment.

A lot of times people who are in really difficult substance use disorder issues, and they're ending up in court or whatever, they've sometimes disconnected from families. Did you guys talk about that at all, and then this workforce issue about, again, everything is focused on what should SAMHSA be doing in this area, but

do you have comments about that?

DR. LEIGHTON Y. HUEY: Well, I think we touched a little bit obliquely on this in the sense that our discussion about the societal blind spot when it comes to mental health and substance use disorders, that the difficulty and the modeling that should go on in terms of from the provider community about how to engage families and how to engage individuals is -- is an important aspect.

I'm concerned that -- I'm wondering what the selling point is of this? We understand it in this room.

MS. PAMELA S. HYDE: Yeah, exactly. Yeah.

DR. LEIGHTON Y. HUEY: Okay. But what is the selling point of this to the larger society? Because if I'm in Congress, I'm wondering does anybody understand this stuff, what we're talking about? Are they going to glaze over and say, well, here we are again kind of the softies on the block coming forward and, you know, I don't know what the hell you're talking about.

MS. PAMELA S. HYDE: Yeah, people are looking for that hard science. Where's the genome? Where's the --

DR. LEIGHTON Y. HUEY: Well, okay. But so how do you -- how do you translate that into something that is going to be picked up, and we talked about the difference between the war on cancer from 20, 30 years ago --

MS. PAMELA S. HYDE: Right.

DR. LEIGHTON Y. HUEY: -- and do we have the same kind of momentum and capacity and resilience to kind of go forward in the same way? I don't think that we do, which gets back to the whole issue about, well, what is SAMHSA doing? It's trying to leverage itself from a relatively small-funded operation to try to be at the table and to influence, but are you really able to pull it off?

And is SAMHSA trying to do too much and be too many things to all people? And does that, in effect, dilute your effort and your successes?

MS. PAMELA S. HYDE: He sounds like he should be on our executive team, huh, Fran? We have some of these same conversations. Are we trying to do too much? And yet we're called on to be this larger thought leader.

I want to ask Kathy to respond. Then I'm going to ask all of you a different question because you've all talked about communication issues and strategic communication issues, and you kind of raised it in a different way, which is how are we selling this?

So I'm just getting your heads wrapped around. I'll come back to the question in a minute. But, Kathy, do you want to add to this set of conversations?

MS. KATHY REYNOLDS: I do, and it will lead into your next direction that you're taking us is that I think from the prevention aspect, we do a lot of education and a lot of getting knowledge out there and recognizing and acknowledging the strengths and abilities that we all have in terms of doing this. I think what we need to do and talk about, and we talked about moving forward, is making sure that we do education that includes with it how to take that education and result in behavior change or social norm change so that we're not just doing the education, but we're doing what do you do with the education once you have it.

Everybody in this room has education about something that we're supposed to be doing that we're not. So how do we get the leadership to actually turn that education into behavior change or social change and through the communication?

MS. PAMELA S. HYDE: Okay. So let me ask you the communication question in this way. Everybody touches on it a little bit as sort of how is SAMHSA communicating about itself, or how is -- how are we selling these concepts that we all agree with to the public or whatever or Congress?

Marla has done a lot of work at helping us think about we've done a strategic communications plan, and part of what we've looked at is audiences. And you know, pretty soon, the audience list can be this big, and we have had a lot of work within our executive leadership team, and we've tried to take that out to the rest of the staff about SAMHSA's role in advancing -- leading public health efforts to advance the behavioral health of the Nation. That's pretty broad, and yet it does say we think we have some responsibility to be out there as a thought leader.

But we're only \$3.6 billion, and we're only about 650, 6,500, 650 -- let me say that again. We're only about 650 staff. We have a few contractors here and there to add to that, but we're not very big as Federal agencies go. And sometimes I personally ask are we biting off too much, and should we just not do that and say, no, our job really is just to produce materials, put grants out, and you know, provide some good public education, but really not try to be this big thought leader or whatever.

Do you have thoughts about that? And if you think our role should be that broader role, then do you have specific suggestions for us around this communication strategy? And again, we're doing all this in the context of treatment issues right now. Obviously, prevention and recovery are equally important, but today we're focusing on treatment.

So comments about that?

MS. JEANNETTE PAI-ESPINOSA: I have one.

MS. PAMELA S. HYDE: Yes.

MS. JEANNETTE PAI-ESPINOSA: From my perspective, it's not -- I don't think it's about you doing more at all. I think it's about being more effective in communicating what you do and connecting the dots about why you do what you do the way you do it.

MS. PAMELA S. HYDE: Okay.

MS. JEANNETTE PAI-ESPINOSA: If that was clear?

MS. PAMELA S. HYDE: Yeah.

MS. JEANNETTE PAI-ESPINOSA: Because, and I think the other thing is I don't necessarily think that SAMHSA always is the messenger. I think you have how many messengers in this room? You have all of us. So how to think about how do we help you through our variety of roles and our connections out in the world help to position key pieces of information for you? Because we support you, or we wouldn't be here.

So I think that it's a process of building a bigger public will in the broader general public, as well as in the policy and decision-maker arena, and recognizing that you have limitations around what you can and can't do. There are some of us that have affiliates and members in States that might be of importance to get the message about what you're doing, too.

I think the fact that you are a smaller agency, yet you do -- are perceived as a thought leader in many ways needs to be communicated by people like us, not necessarily by you.

MS. PAMELA S. HYDE: Okay. That's helpful. You guys have other thoughts about that? Andy?

MR. ANDY JOSEPH JR.: I actually wish the Secretary of HHS was here to hear some of our comments. In one of our meetings that I had with my Portland board a couple months ago, they had a "Dear Tribal Leader" letter, and it talked about the Government wants us to be specific on what we're going to spend our third-party revenue. We all had to sign up for some kind of insurance.

So some of our tribes that manage our alcohol and mental health programs that's called Self-Governance 638 from the Government, you know, the IHS. So our providers can bill third party. They also bill Medicaid and Medicare for their services. But now the Government wants to kind of have a say on what we're

going to spend our money that we're collecting.

What we need is to have -- I wish you could speak to the Secretary on our behalf to work with CMS or whoever is pushing on us on what we're trying to spend our funds on, that we use it in a way to do more of this prevention and the cultural practices that we're kind of talking about that I believe will save more lives. To me, I think that would be really a benefit.

And if we can spend it more on the younger generation, the children. I know the President went to the Standing Rock Sioux Tribe, and it's not mine --

MS. PAMELA S. HYDE: No, it's mine. I apologize. Somebody trying to get money from me probably.

[Laughter.]

MR. ANDY JOSEPH JR.: He visited the Standing Rock Sioux Tribe's tribal youth, and they weighed in on a lot of issues. And I was really glad that he went there.

But in order to really, I guess, make the biggest impact, we need to have our programs work together, you know, with CMS, with the Department of Education, the VA, different -- different Government groups that pull together to kind of pull these resources and use the science. That if there could be more study on some of these traditional healing practices, I believe it could save lives of all of the people in this big nation of ours.

And to me, that would be -- it would really be affordable healthcare.

MS. PAMELA S. HYDE: Yeah. So I've really gotten in the last couple days that we should do something about the science or the impact of traditional practices. So that's definitely on my list.

We're going to run out of time. So, as always, I want to do a quick round. So let me just give you a thing to think about this. So everything we've talked about probably SAMHSA is doing a little bit of, maybe more or less.

I know just what Andy was just talking about in terms of coordinating with other agencies, we do more of that than you can possibly imagine. And yet we just got dinged by a GAO report that said we weren't doing enough because we weren't doing this cross Federal agency that they wanted us to do or steering committee or whatever that they wanted us to do.

So that, to me, was some combination of, well, dang, aren't they looking at what we're doing? And then some combination of me scratching my head and saying how do we communicate better about all that we are doing? How do we get

people to listen better maybe? It's not even how do we communicate it, but how do we get people to listen better? So that communication question was about that.

But given that we are about done, I just want to remind you that we were asking you three questions, and it sounded like you guys especially went through kind of combining the questions. But what should SAMHSA's role be in influencing the provision of behavioral health treatment? So influencing CMS, influencing other players. We've done a lot of that, but maybe we should or could do more.

Aside from grant funds, because Congress has to give us more of those, what types of investments could best leverage SAMHSA's limited resources? Our staff time, our technical assistance, our policy leadership role, those things up there.

And then how can SAMHSA best influence the cultural/gender-specific provision of behavioral health treatment in healthcare?

So those are the three questions we sort of asked you, and we've had the conversation around each of those issues. But we've kind of had the conversation at about a 30,000-foot level.

So I'm going to ask you now to really struggle down because the next thing we're going to do is get into these small groups, and we want them to be very concrete. So if you had to say one concrete thing, what message would we produce and blast it out to our quarter million people? What tip would we produce? What training would we do? What regulation would we change?

I mean, can you be really specific about what you think you would give us advice to do to influence behavioral health treatment in this country? That's a pretty big question going down to a very specific ask. Do you have one, Lori?

DR. LORI ASHCRAFT: Okay. I do. I don't think you need to do more. I think you need to do what you're doing and get more attention for it.

MS. PAMELA S. HYDE: Okay. So what's the -- what's the task?

DR. LORI ASHCRAFT: Okay. I'm going to give you an example. We just did a draft of a white paper on integration. So what you could have done there is said to everybody that is on your mailing list, hey, we're doing this. We'll be in touch with some of you. If any of you want to chime in, let us know.

And then you could say once you get the draft, hey, everybody, here are some ideas that came up that you all can do right now without any extra money. We learned this from the field. And we're going to keep giving this back to you as we learn more.

So what you're doing in that process is you're a very helpful resource. You're current. You're giving people on the -- at the moment, cutting-edge tips on how to get things done, and you're staying in the spotlight as a resource on what you're doing. So that's just an example of how you could sort of shine the light on what you're doing in a way that you get more credit for it, and people understand what you're doing a little better.

MS. PAMELA S. HYDE: Okay, great. Thanks. Got a specific suggestion?

MR. JEREMIAH D. SIMMONS: I'd probably say specifically related to strategic communications, again, really, you know, because I think part of the issue is getting people to talk about this. And I think which has been kind of on this difference between, you know, are you trying to be right, or do you want the right outcome in terms of treatment, and you know, and kind of prevention and recovery?

You know, and if you're focusing on the right outcome, a lot of that is, you know, also involving the multiple disciplines that work with individuals. Again, that relates to this focus on interprofessional core competencies and where those overlap and how to get people kind of organized maybe around that issue, how to talk about that. New Mexico is trying to do that, for instance, but it's a struggle.

MS. PAMELA S. HYDE: So is that a paper? Is that a training? Is that an expert panel? Is that a dialogue?

MR. JEREMIAH D. SIMMONS: That would be -- that would be a training. I'd say -- I would say a training and a panel. Because the dialogues are happening, but it's really trying to organize it.

DR. LORI ASHCRAFT: And use more fun ways of doing it instead of webinars.

MS. PAMELA S. HYDE: Like what's more fun, Lori?

DR. LORI ASHCRAFT: Well, Zoom is good.

MS. PAMELA S. HYDE: Zoom?

DR. LORI ASHCRAFT: Zoom is like --

MS. PAMELA S. HYDE: I don't even know how to do Twitter yet, and now you want me to go off and Zoom.

DR. LORI ASHCRAFT: Zoom is like hyper Skype.

MS. PAMELA S. HYDE: Okay. Well, I'm sure Marla knows how to do Zoom.

So, great. Thank you.

All right. Concrete?

MS. JEANNETTE PAI-ESPINOSA: Very concrete. We should have all gotten hashtags for the meeting and could have tweeted from here.

MS. PAMELA S. HYDE: Hashtags for the meeting.

MS. JEANNETTE PAI-ESPINOSA: So, as a whole, we should have gotten them, and each of the advisory committees, the NACs should have gotten them specifically for what was going on in their group. And even more, each of the advisory committees could have taken 10 minutes during the meeting to do a Twitter chat.

MS. PAMELA S. HYDE: Interesting. Okay.

MS. JEANNETTE PAI-ESPINOSA: And you need to tweet.

MS. PAMELA S. HYDE: Okay. We do actually that much more as an organization. I personally am almost 65 and behind the social media curve, but Marla is terrific at getting us into that. But that's a great idea just in terms of communicating our work here as committees.

Okay. What --

DR. CAROLE WARSHAW: I have three things. We've kind of distilled a lot of what we said into three things. One was education and training of stakeholders, and one of the -- a number of people on our panel said that a lot of people don't know about how to do addiction treatment, don't know about medication-assisted treatment. So there's lots of gaps in what people know how to do and that SAMHSA already provides guidance and to make sure that you keep producing them and get them out to the right people.

The second is access and finance. And some of the materials you produce for the meeting that I thought were really great about where behavioral health services are being delivered and where they're not and who's financing them. As the public health/mental health agency, I think SAMHSA should provide a picture of like they're doing it around the ACA all the time, who's getting coverage and who isn't and what's happening around what are the needs, what are the gaps, and what should happen to fill them over time?

MS. PAMELA S. HYDE: That's great. We've actually been talking about something called SAMHSA by the Numbers. And again, Marla is starting to help us think about that. So it's a great idea, yeah.

DR. CAROLE WARSHAW: Yeah, and then the third one is the partnerships so you have allies and that the message gets out, too. So people who have much bigger operations and Government affairs and the ability to get things out.

MS. PAMELA S. HYDE: So just one quick follow-up to that because you both said that. If we put out a set of talking points and said here's the talking points about X, whatever X is, would you please get it out to your membership? Would people do that to their groups and stuff? Okay.

MS. JEANNETTE PAI-ESPINOSA: I would. I mean, I think so.

MS. PAMELA S. HYDE: Okay. All right. So, Andy, real quick, specific?

MR. ANDY JOSEPH JR.: I would say what really works at home. I want our children to be "scared straight" from the beginning if they're -- because alcohol and drugs are --

MS. PAMELA S. HYDE: So scaring children? That's what you're proposing that we do?

[Laughter.]

MR. ANDY JOSEPH JR.: I mean with statistics that show, you know, what these drugs and alcohol does to their bodies, and you need to work -- I agree you need to work more with the Education Department to push, push the issue with our children.

MS. PAMELA S. HYDE: Okay.

MR. ANDY JOSEPH JR.: And also educate young parents, and you know, if it's educating them on our traditional values, that would be really good.

MS. PAMELA S. HYDE: Great. Okay. So you are definitely underscoring some of Fran's work here. That's a good thing.

Kathy?

MS. KATHY REYNOLDS: We came up with two specific things we thought would help. One is we spend a lot of time fighting over language when we're actually talking about the same thing. So a language matrix that would help us be able to know that, you know, when we talk secondary, tertiary prevention, we're talking treatment in some ways as well. So having that so that we know and can get past spending hours and years talking about what word we're going to use and know that we're talking about the same thing.

And the second thing that we talked about was an understandable continuum of

care that we can all see ourselves in as we go through this alignment or realignment so that folks don't get scared at the conversations.

MS. PAMELA S. HYDE: Can you say just a tad more about that?

MS. KATHY REYNOLDS: Just what we talked about, I think I actually even recommended it be on one page. But just a diagram that shows the kind of alignment that we're looking at where we can see prevention and treatment on the same continuum, where we can see primary care on that continuum that would allow folks, as we talk about alignment, if we're going to use that rather than integration, whatever the word is that we're going to use so folks can see what our outcome or end goal is, what the continuum looks like.

MS. PAMELA S. HYDE: Okay. All right. So, Mary, wherever you are, that picture we're trying to draw of the ecological model, however we end up --

MS. KATHY REYNOLDS: There you go.

MS. PAMELA S. HYDE: -- getting that out, that might have some relevance here. Okay.

DR. LEIGHTON Y. HUEY: So SAMHSA should position itself to align itself with what is happening in healthcare. So private practice, as we historically have known it, is going to change and dry up. Integrated care is going to become the model. Bundled payment is going to be the coin of the realm. And so, there is an opportunity here with SAMHSA supporting the integration of prevention and treatment across mental health and substance use disorders.

The integration should extend into mainstreaming these disorders into physical health and move away from the political and de facto segregation of behavioral health from the rest of physical health. The continuing separation in its largest sense perpetuates the extrusion of behavioral health from the rest of society so that the issues and problems, which are all too commonly seen in the larger society, for example, violence, remain viewed as a byproduct of the behavioral health system.

And that gets back to the question about families. How do you engage families if there is the stigma associated with the disorders that we work with? And by integrating our disorders into physical health and have that become a mainstream pillar, we'll reduce the stigma.

MS. PAMELA S. HYDE: Okay. So this is really helpful because, again, tomorrow the National Council is going to look at this issue of we're struggling with the words, too, integration, ecological model, alignment. So we're going to talk more about that tomorrow. And again, I encourage any of you who are able to listen in to that, please do so. So that would be helpful.

And then the delivery system reform work we're going to do tomorrow will also get at where do we fit into this value-based purchasing, bundled payments, changes that are going on there? And that is far from settled. So we are -- it's a good conversation tomorrow. So thank you.

Okay. We need to wrap up. One more comment.

DR. CAROLE WARSHAW: One concrete thing about EHRs. I think the work you're doing on data segmentation and privacy is really critical because it's a barrier to care. And there are other segments of people working on those issues who are allies, and I think being able to develop the technology to make that possible is something that SAMHSA, that's great that you're doing.

MS. PAMELA S. HYDE: Great. Yeah, we are doing a lot of work in that area that people don't realize, and it's probably something that we've been really a leader on that doesn't seem like it should fit necessarily. But a lot of good work there. And it comes out of our Center for Substance Abuse Treatment, actually. But it goes beyond that.

So help me thank the panel. This is great. Good conversation.

[Applause.]

MS. PAMELA S. HYDE: I have a whole list of things to do. So we are going to take a break. We're a little bit behind, and we want to move you into these breakout sessions.

Let me just tell you a little bit about how we're going to do this, and then you may decide to sort of do that and start your lunch and do whatever you need to do. Holly, where are you because we're going to need to do some logistics about lunch at the same time.

But the breakouts are physician/psychiatrists are going to go with Ellie. Where's Ellie? Ellie, where are you? There she is. Wave your hand. Big hi. Where are you taking them, Ellie?

DR. ELINORE MCCANCE-KATZ: Right where you are.

MS. PAMELA S. HYDE: Okay. The physician/psychiatrists are up here. Social work/counselors are going to be facilitated by Paolo. Where is --

LCDR HOLLY BERILLA: They will be in the VTC room.

MS. PAMELA S. HYDE: Everybody know where the VTC room is? If you don't, there will be people out there directing you. It's out there. Paolo, wave your

hand. Follow Paolo. He'll get you there.

LCDR HOLLY BERILLA: Before you go, I have something for you, too, also.

MS. PAMELA S. HYDE: Okay. Psychologists, Gary, are you in the room? Gary is way back there. Gary, where are you taking the psychologists?

DR. GARY BLAU: Sugarloaf.

MS. PAMELA S. HYDE: Sugarloaf. So one of our conference rooms.

LCDR HOLLY BERILLA: You're staying right in here.

MS. PAMELA S. HYDE: Oh, right here. This is Sugarloaf. Never mind.

LCDR HOLLY BERILLA: Don't go far.

MS. PAMELA S. HYDE: Preventionists. Fran, where are you taking the preventionists?

MS. FRAN HARDING: Rock Creek.

MS. PAMELA S. HYDE: Rock Creek, which is one of the conference rooms down that way. Peer practitioners, consumers, people in recovery. Tom, are you in the room?

MR. TOM CODERRE: Right here.

MS. PAMELA S. HYDE: Tom Coderre is going to facilitate your group, and so anybody who wants to go with that group goes to Great Falls, which is also one of the conference rooms down there.

Elected officials, policy leaders is going to be facilitated by Mary. Where are you, Mary? Mary Fleming back there. Where are you taking them?

MS. MARY FLEMING: Rock Creek.

MS. PAMELA S. HYDE: That's two people in Rock Creek?

LCDR HOLLY BERILLA: Yep. So we have two per each room.

MS. PAMELA S. HYDE: Two different groups in Rock Creek. Okay. So they're going to Rock Creek.

And then anybody else who doesn't feel like you fit into one of those groups, and you just don't feel comfortable getting in any of those groups, just go to the other

group, which is going to be facilitated by Kim Leonard, who's back there in the black with the red thing on. Where are you taking this group?

DR. KIMBERLY JEFFRIES LEONARD: Holly, where are we going?

MS. PAMELA S. HYDE: Holly, where is this group going?

LCDR HOLLY BERILLA: Okay, for the miscellaneous group, right behind --

MS. PAMELA S. HYDE: Other.

LCDR HOLLY BERILLA: Other, miscellaneous -- right behind you are the sheets that should show where you're going, and I do not have them on my person. I've left them all right there for you, along with signups, which I will bring to you.

MS. PAMELA S. HYDE: Okay. So if you want to go with Kim, just meet her in the back there, and she'll figure out. Kim, if you have people who want to go with Kim, meet her in the back there. She'll figure out where she's taking you. It kind of depends on how big the group is maybe.

All right. So we're a little bit behind. You haven't had a break. You need one. Take a quick break. Get to your rooms, and then you guys can talk about the questions and what we need from you, which is the very specific reactions from your group's perspective about what SAMHSA can be doing to influence and change and develop and get better treatment out there.

LCDR HOLLY BERILLA: I have one thing. If you -- lunches will be delivered, and we have your names that we will bring them to you for the lunch, or we'll have them in here so that you can take them.

Also, if you're new to advisory councils, there is an orientation that we're going to hold for you, and that's going to be in the Rock Creek room from noon until 1:00 p.m. So you need to attend an orientation --

MS. PAMELA S. HYDE: Okay, I'm going to change that on you just a little bit because since we're starting so late, you need to think about when you want to take a break to get your lunch and keep the conversation going, and then let's make the orientation be closer to like 12:15 p.m. because you really need the hour, 45, 50 minutes to have this conversation. So orientation at 12:15 p.m. in the lunchroom?

LCDR HOLLY BERILLA: 12:15 p.m. It'll be in Rock Creek.

MS. PAMELA S. HYDE: In Rock Creek. All right.

LCDR HOLLY BERILLA: Yeah, so if you're new, Rock Creek.

MS. PAMELA S. HYDE: So does everybody got what they're doing? And then we will be back in here at 1:00 p.m. Okay?

Thanks, everyone.

[Off the record at 11:10 a.m.]

[On the record at 1:13 p.m.]

Agenda Item: Report and Discussion from Breakout Sessions

MS. PAMELA S. HYDE: So everybody come join us, and we'll get started again. If there's anybody out in the hallway, if you want to ask them to come in, that'd be great. We'll get going, and Anne is going to take us through this next time.

Everybody know Anne Herron?

MS. ANNE HERRON: Let me -- I'll introduce myself. Good afternoon, everybody. Sound okay? Can you hear me?

All right. Good afternoon, everybody. My name is Anne Herron. I am the Director of the Division of Regional and National Policy Liaison here in SAMHSA. I am also having the pleasure of being the workforce strategic initiative lead for SAMHSA. So this has been a terrific opportunity for me to walk around and eavesdrop on some of your conversations the last couple of hours.

I wanted to start off with kind of laying a context for the discussion for this next hour or so. SAMHSA has -- for years, we've been struggling with looking at how to influence the delivery and the access to effective and appropriate treatment, and we've been looking at it from a variety of perspectives for us. We look at it really from our grants perspective, from that focus, in the sense of improving technologies, looking at how we can impact the effectiveness and the outcomes of the grants that we fund and support.

We look at it from the perspective of financing and organizational structure and how we can improve that process in order to make sure people get the kind of care and support that they need. We also look at improving treatment impact and outcomes by looking at community health, prevention activities or recovery activities. How do we make sure that neighborhoods and communities are prepared to support the kind of services and access that individuals may need?

We look at it also from a State perspective. We look at it from the full continuum of care and how we can support the full continuum of care that may exist in States so that people can access service wherever they need it -- from

prevention to treatment to recovery and all manner in between.

And we also look at it from our technical assistance perspective. So not only how we can focus and improve those kinds of activities, treatment activities and impacts in the behavioral health arena, but how we can influence what happens in general health and other kinds of settings, criminal justice settings, juvenile justice settings, et cetera.

But one of the things we don't often have an opportunity to look at and to focus on is from the perspective of your profession or from the, excuse me, perspective of your area of expertise. And that really is the opportunity for the conversation that you had over the last hour or so before lunch was to talk about kind of what you see from the perspective of your profession that SAMHSA can do to influence and support the delivery and care in our country.

So, with that, what I would like to do is I would like to open up the discussion and really hear from each of those groups from the perspective of your profession. What is a recommendation that you would give to SAMHSA in terms of providing support and leveraging our ability to influence effective and efficient treatment?

What I would remind you to do because we are -- we do have people who are listening and we are recording is when you do speak, if you could identify what profession you are reflecting and your name, and be sure to speak into the microphone. I'd appreciate that.

So let me go ahead and open it up. From the perspective of your profession or your area of expertise, what would you recommend to SAMHSA in terms of influencing and supporting the delivery of care?

DR. LORI SIMON: So my name is Lori Simon, and I'm representing -- I'm a psychiatrist, and I'm representing the physicians and psychiatrists in the room. We had a number of recommendations.

One was to first understand, really truly understand the population on the needs of all the different, the population that we're dealing with in terms of all aspects of substance abuse and other mental health illnesses, other mental illnesses. And to understand that from sort of the ground up and talk to the providers, talk to really truly understand what's going on out there nowadays. Get in on the trenches and understand both from the providers and also the -- the consumers of what's needed.

And then, after understanding all of that, determining what role SAMHSA can play directly, and then what role other agencies can also play. And for those where it makes sense for the other agencies to take on a primary role, to have SAMHSA sort of be the overall coordinator so that the message doesn't get lost, and they become the one who's sort of coordinating it.

So, for example, there may be studies that need to be done. You go to NIMH. There may be housing issues. You go to HRA, for example.

In terms of an add-on to that is right now there are -- we're always looking for evidence-based treatments. Some aspects of treatment, for example, CBT, as a therapy is very well studied. But there are other treatments that may be equally as good that are not studied well and that need to be brought into the toolbox, so to speak, of evidence-based treatments.

And so, for that, again, SAMHSA recognizing what additional studies need to be done and then talk to, for example, whoever does the studies, whether it's NIMH or whoever it is, okay? And playing a role in advocating for those studies to get done.

Let's see. We've talked a lot about -- also there was some talk about categorizing the studies. That in other specialties, that studies are categorized as to whether they're high quality or medium quality, et cetera. And if that could also be done within behavioral health.

Talked -- again, we've talked a lot during the last couple days about better integration with primary care. I think we all feel that that's extremely important. One of the things that's hampering it, though, is the integration of the data. And to sort of play a role in ensuring that those barriers, whether it's 42 -- that was talked about earlier this morning about 42 CFR, you know, changes being made to that. A lot of health information exchanges are unwilling to deal with behavioral health because of the additional issues regarding it.

SAMHSA has been working on the Consent2Share program, which, where patients have the ability to indicate to whom they want certain data to be seen, to, you know, continue to promote that.

There was talk about there are new models of payment out there, bundling ACOs, for example, to see -- right now, behavioral health is not -- is for the most part excluded from a lot of those models. So to take a look and see does it make sense to include and to take a look at including them in some of those new payment models and what would have to be modified to accommodate behavioral health to make it work.

There was talk about a lot of the grants that are being written. There seems to be not much of an emphasis on psychopharmacology. So to make sure that that's included in some of the grants that are written. Talked about better public relations and to let people -- let the public know or the other agencies know what SAMHSA does, to target that or that PR to the specific audience.

Talked about the insurance issues and the barriers to treatment because of

various different types of insurance. One being Medicaid. To take a look and do some studies to show what the differences in behavioral health treatment in those States where there was an expansion of Medicaid versus those where there weren't and see how much of an effect that has made on adequate treatment.

Talking about Medicare and private insurance. Medicare is -- in psychiatry, Medicare has not been a heavy hitter for a number of years. They just -- there are not as many -- not as many practitioners in -- psychiatry practitioners in Medicare as there are maybe other specialties. There has been an added -- now that may have been as a money issue, but there's an additional hit now because CMS is requiring more and more of physicians in general, whether it's PQRS data or it's meaningful use with regard for computers of which so that may be creating another obstacle for psychiatrists to remain in Medicare.

And then, finally, with regard to the private insurance, out of network benefits are going by the wayside. Some insurance companies are limiting the networks, and so the access to behavioral healthcare in private insurance, in commercial insurance is also becoming a problem.

MS. ANNE HERRON: Some of the things that you recommended, is there a different kind of relationship that SAMHSA should have with the guilds to begin to support some of those recommendations or --

DR. LORI SIMON: What do you mean? You said -- mentioned guilds?

MS. ANNE HERRON: Mm-hmm.

DR. LORI SIMON: What are you talking -- what do you mean by that?

MS. ANNE HERRON: APA, AMA.

DR. LORI SIMON: Oh, absolutely.

MS. ANNE HERRON: Like what?

DR. LORI SIMON: To start having more of a relationship with, for example, the American Psychiatric Association. Let them know what you're doing, see what help they can provide. You know, I'm actually involved in the APA with some of the computer technology, and I know that they would -- I'm not going to say no, but I think they would welcome more of a collaborative effort, as well as some of the other mental health professional societies. So I think it's a good idea.

MS. ANNE HERRON: Thank you. Yes?

DR. GAIL W. STUART: So I'm speaking on behalf of the social worker,

counselor, nurse group. And I will summarize our recommendations in three areas. The first one was to expand the view of who are providers, and the recognition being that there will never be enough specialty behavioral health providers. So we have to have a larger workforce. So we thought about, obviously, peers, and there's progress being made on that.

But expanding that to community health workers, who could be prepared to work with our patient population, as well as the 3 million nurses who are not psychiatric nurses, but who are embedded throughout the healthcare system. And what we suggested, that these folks be prepared to better screen, offer brief treatment, and referral. We thought SBIRT was a great model, and the grants that are going out are a great way of doing that.

But we thought maybe you could do something now similar for trauma since you have a program. Suicide prevention, opioid use. So the topics this morning that were the hot topics, if you could roll out a similar because then we'd be preparing the workforce for tomorrow, even if that's not addressing the workforce of today.

And that also would include care coordinators and home support workers. So that's a little bit about how do we not lose people in the system.

The second area that we talked about was increasing the use of technology, and we thought there would be some real opportunities there. We talked a little bit about text messages and how our patients respond, or at least in some of the programs that have used those, that's been very effective.

We mentioned the A-CHESS app, mobile app that customizes treatment. We didn't know if people knew about that. It comes out of the University of Wisconsin. But it's an app related to those folks struggling with substance use, and it really personalizes their text messages, tells in a GPS when they're in the danger zone, et cetera. So we thought technology could help us with some of those interventions.

The suggestion was also made that we package the information and disseminate it to targeted groups, and that gets into the guilds issue. So SAMHSA, you know, we're talking about getting the message out better, and a lot of the professional associations and even social media, such as ResearchGate, if you packaged kind of what SAMHSA is doing, they have member bridge, virtual rolls, and they would be able to actually get it out there to all their members.

So you might be able to query each of those organizations or guilds and ask them how it would be most effective to get SAMHSA's message out there, again through the use of technology and things you already have.

And then we talked -- the third issue was that of scalability or sustainability being the real critical issue, that there's tons of good programs with good outcomes, but

they never catch on. And we thought one easy way to scale things up would be to talk with some of the accreditors and regulators like JCAHO and for outpatient and require that the PHQ be included in all primary care settings.

So we talked about how if you go to the primary care setting, you have to fill out that paperwork that asks if you have diabetes or cancer, et cetera, et cetera. But it doesn't require -- there's no requirement right now that intake include any information related to mental health or substance use. And we thought if you really want to bring about change, you make that a regulation, and everybody falls into line. So we encourage dialogues with those groups for those kinds of activities.

MS. ANNE HERRON: Okay. Very good. Thank you.

DR. DAN LUSTIG: I'm speaking for the psychologist group, and are we addressing Question 1 primarily or all of them?

MS. ANNE HERRON: If you could give us maybe from your perspective what would you say would be the one or two major kind of emphasis. And then we'll have an opportunity to have some -- add some more things in.

DR. DAN LUSTIG: SAMHSA already supports the Minority Fellowship Program, and that's a very small slice of people and of money. But if there could be further relationships with the guilds around increasing the Minority Fellowship Program to promote a diverse workforce because not only is the workforce suffering, but the number of people of color in the workforce is not growing too much. It's growing a little bit, and the demographics of our country are certainly showing that we need to be on top of that with the large number of growth in Asian and Latino populations, too, and we need to meet that need.

The other, building on Gail's, is supporting the para-professional workforce and a peer workforce. Community health workers, promotores. Right now, individual States have State standards to some degree, but maybe SAMHSA could be on the forefront of helping States form some national certification standards, for example, for a para-professional workforce.

I know the National Federation of Families is doing, you know, peer certification for family peers, but maybe we need to think even broader than that and look at the health models that have worked for generations and decades. And the community health worker is a very successful thing not only in health, but also in behavioral health in the growing numbers.

Primary care integration cross training to promote earlier identification of mental health issues with, you know, working with pediatricians in particular, which become the de facto mental health providers because families go to pediatricians with their children. And I'm speaking from the children's perspective that maybe

if we did a lot more with pediatric and mental health cross training, that would be a big help.

Looking at enforcing EPSDT. EPSDT is a requirement and CMS supported, but there is varying degrees of utilization and certainly no enforcement of EPSDT across the country. It has no teeth. If it had teeth, then I think it would do a lot in terms of mental health promotion or early intervention at the primary care level. In particular, starting the first 3 years of life, which is where we need to begin to look, as opposed to much later in that trajectory.

And another related area is schools and making sure that, you know, the Safe Schools/Healthy Students, the Project AWARE, the NITT work, all of that is going in that good direction of looking at universal prevention and health promotion to reduce school violence, et cetera, and that would be something to continue to build on because we need to look at universal prevention interventions because, again, we want to catch it early, as opposed to later in the trajectory.

And then, finally, in the whole area of data, we need to make sure that SAMHSA continues to be on the forefront of the disparities impacts, the statement and strategy work that was initiated in 2013. And SAMHSA leads the way among all HHS agencies in that effort of disaggregating data and requiring DISs, and that's the first time that many communities and States are really looking at their disparities within States. And it's a wonderful thing that you all are doing, and we hope that that, you know, continues to gain momentum and strength across every single grant program within SAMHSA in order to make a dent in disparity reduction.

MS. ANNE HERRON: Very good. Thank you. Yes?

DR. GAIL W. STUART: I didn't know we were doing all the questions.

MS. ANNE HERRON: That's okay. You can go back.

DR. GAIL W. STUART: So let me add we talked a lot about increasing SAMHSA's investment in tribal colleges and the engagement of traditional healers. Specifically, it was suggested that if we could have more studies to show the evidence of indigenous intelligence such that then they could be best practices. So that was an important recommendation.

MS. ANNE HERRON: Okay.

DR. DAN LUSTIG: And I just want to build on that.

MS. ANNE HERRON: Sure.

DR. DAN LUSTIG: Because I forgot that last one. You know, Alaska has led the

way. In the late 1990s, they worked with their State Medicaid agency to fund traditional practices among the Alaska Natives, and it has been quite successful over the years. I don't think other States have done that to that extent or at all. And so, the Alaska model would be a good thing if SAMHSA could work with CMS in helping promote, you know, the reimbursement of traditional practices that are tied to evidence.

And then also practice-based evidence, the community-defined evidence, and the Child, Adolescent, and Family Branch within SAMHSA has led the way in including practice-based evidence and community-defined evidence as acceptable practices as part of their Children's Mental Health Initiative, and that's been a tremendous boost to a lot of effective practices that have worked for generations and decades, especially among indigenous and people of color. And that's one way to address the issues we've been hearing about this morning from our Native brothers.

MS. ANNE HERRON: Okay. Yes?

MR. ADRIAN SPOTTEDHORSECHIEF: Yes, my name is Adrian SpottedHorsechief, and I'm from the Pawnee Nation of Oklahoma and Nebraska.

You know, I was appointed to come up here to sit on this Tribal Technical Advisory Committee, and I've had a lot of things that I wanted to say since this morning, you know, listening to everybody talk. And I think one of the biggest things that I would like to stress is public education and awareness.

You know, we're here to be educated, you know, on SAMHSA's roles and everything like that and how you can better help us and different things. And, but one of the things, too, is that, you know, a lot of people here don't -- they don't understand about Native Americans.

You know, I'll give you a prime example. I went to Chicago to do a cultural presentation and actually had individuals in the audience that thought we were extinct. They actually believed, and this was like 4 years ago, that Native Americans were extinct, no longer living. So amongst us here, you have people that see Natives, hear Natives talk. But once you get out there on the street, you got people that have never seen a Native American in their whole life.

And not only that, you know, what do people perceive of us as Native Americans? You know, everybody thinks of the movies, you know? They see us with war bonnets and feathers. Now my tribe does that, but not other tribes. You know, we have tribal leaders here, you know, that have spoke earlier today -- Mr. Brooks, Mr. Joseph, Mr. Garcia, you know? And we're all different.

And a lot of times, people don't understand that that, you know, we're a nation that has 566 federally recognized tribes. That's recognized. There's other tribes

that their recognition was taken from them. So there needs to be education on that because, like how we're sitting here in this setting here, we're all different. We're all different individuals.

So we all handle things and we all feel things differently, understand things differently, process things differently. So, you know, for what may be Federal standards as far as like how people should be treated to affect certain things might not work for everybody, you know?

And you know, a prime example is if three of us were sitting out here crossing the street, and we see somebody getting mugged. One person might go and help them. One person may just sit back and watch. One person may get on the phone, you know? So everybody has a different feeling or understanding about things.

Same thing with PTSD, you know, people that have been raped, trauma, historical trauma, you know? Everybody handles things differently. So one -- one way is not going to help everybody.

So one of the things that was being talked about earlier about traditional practices, you know, within my tribe, we have ways that can help our people, you know? And, but in society, it's not considered the right way, I guess you could say. But it works for us. And then, so when you have these grants and things that we try to utilize, there are certain things in there that you can't do. So it kind of hinders us in how we do things.

So, you know, with that being said that all these different tribes, they all have different ways. They have different beliefs. They have different languages. They have different cultural backgrounds that people need to be aware of. We're not all the same, you know?

So that needs to be educated to a lot of different people, you know? Because I guarantee you, there's probably some people in here that's probably never seen Native Americans except maybe right here, you know? So even in my State, you know, there's 39 tribes in Oklahoma, but there are still people that don't even understand us.

So I think there really needs to be a stress of public education and awareness, you know, the practice of improvement and all those different things and what they're talking about with traditional methods because not everybody believes in other certain kind of ways of how you deal with things, but they have that connection of who they are and where they come from. And so, when you do those traditional ways, it could help heal them in ways that other things can't.

So I think that's just another thing that needs to be relooked at and relayed to everybody else and every other entity that there is that we have our differences

as well, but, you know, it's beneficial for us.

MS. ANNE HERRON: Okay. Thank you. Yes?

MR. JEROME BIG JOHN: It's pretty good over there, Adrian. Yeah. Okay. I talked a little bit about this yesterday, and I think about this right now. Save a life today. Save a life today.

Let me tell you what I mean by that. I mentioned a little bit yesterday, going to say it again today that this trauma that we're looking at is so overbearing, it's such a big monster, that it's going to take a while to really get to the root of it, figure this thing out, all the causes. And then you got to throw a bunch of money and time in it to figure out how you're going to treat this. And then you need to develop some evidence-based practices that Congress is going to fund.

To do something like this we're talking time and effort. We're talking lives. Save a life today. That's what I talked about a little bit yesterday. I'm going to go back to saying that tribes need to work with SAMHSA to establish these evidence-based practices that Congress will fund.

You know, I know you guys have the stage pretty well set, from what I heard Kana say this morning, and the budget is pretty well set. You know, but maybe next year, let me throw this challenge out there. But let's think about some of these things that are happening up north in northern Wisconsin on my little reservation where people are dying, where they're stealing right today.

Okay, someone's flat screen TV is being stolen out of their home to be converted into money to buy more pills, to buy more -- some of this heroin. We talked about the first heroin death on my little reservation happened 6 months ago. Save a life today.

Let's look at what's going on. I mentioned, I need to mention is again since we have others here today, about this methadone and about this Suboxone and about these Subutex that are being abused on my reservation. We find out -- my council sits there and we find out that we have 40 to 50 people on this free high. Four o'clock in the morning they're on this bus that's paid for -- bus or van that's paid for by Medicare that takes them down an hour away from our reservation every day. They get a 5-, 10-minute session. They take their drink of their methadone, and they're gone out the door.

Private company. It's all about the money. Then I find out later on that same day, there's a second van or bus of people going down to the same clinic. We went down to this clinic, and as I mentioned yesterday, there's a sign above the door that says "Free Tuesdays. Bring a friend." Let us hook them, too, and let us siphon the money out of them or the providers.

Save a life today. These are the things. We got pregnant women back home that are staying pregnant, baby after baby after baby, so they can keep getting these 'scripts of Suboxone and Subutex. They see that it keeps them buzzed up. They see that they can divert this into money.

This is what is happening on my reservation right now as I sit here and speak to you today. I know it's happening because it happened a couple of days ago before I left, and when I go home, it's going to be happening then when I go home.

MS. ANNE HERRON: So it's -- again, it's that community health and our work with communities around just what is acceptable and what the expectations are?

MR. JEROME BIG JOHN: Right. I mean, who would think. They got more methadone grants coming out, and they tell me that there's nothing else right now. That is the best thing we have right now. I hate it. It's killed my people, and it's going to continue to kill them if we don't try and save that life today.

[Speaking Native language.]

MS. ANNE HERRON: Thank you.

Carrying on from that, if I may, I want to also tap into the preventionists because that's kind of what we were talking about around community health and improving. You didn't have an opportunity to mention to us what you thought.

Any preventionists in the room? Go ahead. Thank you, Mary.

[Pause.]

MS. CASSANDRA L. PRICE: I'm pretty loud. If I stand here --

MS. ANNE HERRON: Let's try the mike one more time.

MS. PAMELA S. HYDE: It's not about how loud you are. It's about projecting to the country. So it has to go through the electronic system in order for the people online to hear you.

MS. ANNE HERRON: Thank you.

MS. PAMELA S. HYDE: See if one of the other mikes will work.

[Pause.]

MS. CASSANDRA L. PRICE: Okay. I'm not with the preventionist group. I'm actually with the elected officials, policy leaders, and others. And so, we had a

very passionate discussion. So I'll try to summarize. I'm sure I'll miss a lot of what was said.

But kind of to reiterate, making sure that SAMHSA, that people know what SAMHSA is doing, getting better at telling folks, and learning how to tell a story not just with data, but also the qualitative versions of the story to make sure it's making a human connection. More improved strategic communications focused on more innovative ways of communicating. Like Zoom was the example earlier.

Learning more about the areas and what the grantees are actually using their dollars for. So we talk a lot about what SAMHSA does and being able to brand that, but really understanding from the ground level what's happening at SAMHSA, having that vice versa understanding of the field.

Branding was a big topic in our group about SAMHSA programs. So grants and other things that are funded by SAMHSA that the logo would be sponsored or paid for or funded by SAMHSA, that that really gets branded down to a very local level.

More flexibility of the block grants. So really recognizing kind of the middle, the people who go unserved or early intervention and those type of segments of going from prevention to treatment, that full continuum that sometimes seems to be missing.

And one thing around leveraging. We talked about being able to map or demonstrate how SAMHSA is really -- supports an infrastructure in a State and how that differs in every State. But being able to show that SAMHSA's efforts in funding build on other agencies in the system and how it supports the full continuum of care.

Because sometimes I think everybody is like, well, SAMHSA needs to do this and SAMHSA needs to do that, but in actuality, they're supporting an infrastructure of where things are happening. But it's not really demonstrating how that's blended through a multitude of different agencies and funding so you don't get credit for a lot of things.

So those were some of the ideas that our group had.

MS. ANNE HERRON: Okay. Thank you. Kathy?

MS. KATHY REYNOLDS: Thank you, Anne.

I succumbed to the pressure from my group remaining quiet. The preventionists, we talked about a couple of different things. One Gilberto talked about that we spent a fair amount of time on was our need to make our prevention messages as persuasive as the messages of those who are suggesting the use of

medication. He's nodding. So I think I got that right.

And so, we talked a lot about being able to do that, and then we had an interesting conversation with folks on both sides of the issue of when States have multiple grants from SAMHSA, of having some kind of coordination between and among them. We had someone from CMS who was talking about the number of grants that my State of Michigan has, for example, and how can we coordinate and get synergy and energy going across multiple States?

And some folks were concerned about that as well. So it comes with a double-edged sword, but it seemed to make some sense to us to do that.

And do I have to call on any of my other members or no? Good job? Okay, thanks.

So those were a couple of things that we talked about.

MS. ANNE HERRON: Thank you very much.

You know, many of you talked about a couple of things in common in different ways. One was integration and kind of the integrated team, integrated services. I wonder do you think is, I guess, one of the things that we have heard from providers and from professionals is that one of the big challenges to integrated team is for professionals to know how to work in an integrated team, what that means. How do you work cross the discipline? What are the expectations around scope of practice? Those kinds of things.

From your perspective of your professions and expertise, do you have any recommendations to us around that?

DR. LORI SIMON: You mentioned earlier, you know, the professional organizations, and I think if the -- some of the mental health professional organizations, particularly the APA, would actually go to other professional organizations and -- would go to other professional organizations and also speak at their conferences and sort of have them understand, get to know them better and understand, have more of a meeting of the minds to understand, get them working closer together, that might be one vehicle to do that.

MS. ANNE HERRON: Good, thank you. Yes?

MR. PAUL GIONFRIDDO: There are at least two organizations in the country that I'm aware of, Mental Health Association of Palm Beach County and the REACH Institute in New York City, both of which have trained hundreds of mental health and primary care providers in the basics of integration. And I think SAMHSA could support more trainings like that.

They're already out there and available nationwide, available in person and online in those two instances. At least in the first one in both, and the second one I think at least in person. And I think those are opportunities to help reach out to professionals on both sides because both need help.

And that's sort of the experience, as do people in training at the med schools, the nursing schools, and I think those are the folks that we're going to have the greatest success with in integration. So I'd highly recommend both those programs to SAMHSA.

MS. ANNE HERRON: Thank you.

DR. GAIL W. STUART: Could you please repeat those program?

MS. ANNE HERRON: Sure. Could you repeat the programs?

MR. PAUL GIONFRIDDO: Yes. Mental Health Association of Palm Beach County runs a program called Be Merge. It's available online through the University of South Florida, and the REACH Institute, REACH in New York City also does one. Both have done, as I say, hundreds of people.

MS. ANNE HERRON: Yes? By all means, go ahead. You're on.

MS. SARAH NERAD: Sorry, I was in my new council member schooling. So I was late to report out on behalf of the peers, consumers, folks in recovery group.

I'm Sarah Nerad. I am a person in long-term recovery, which means I haven't used drugs or alcohol since August 16, 2007.

And we had a really awesome discussion amongst -- we were small, but mighty. And I know one of the things that came up as far as bridging the treatment gap was to really utilize peers and folks in recovery, whether that's through recovery community organizations, peer specialists, recovery coaches, to kind of help with some of the intensity of some of the cases, as well as with some of the workforce issues. Utilize peers. It also provides jobs. It does a number of good things.

One thing that came up on every one of our questions that we discussed was about being provided with really awesome case studies, like where is this being done really well? Particularly the one with prevention and treatment working together.

So where are there some examples across, you know, the United States where communities or prevention, intervention, treatment, and recovery folks are all working together really nicely? And there's just this whole system. Everyone is on the same page. We want to know what that looks like and how to do that. So where can we go to learn that? We think that that would help tremendously.

Another thing that was interesting, when we talked about influencing culture, the influence of culture and gender on treatment, and we echoed what was heard earlier about all treatment should be inclusive and with culture and gender. So that should just be a, duh, like no-brainer. But we're not quite there yet. So we need to continue working on that.

But the main thing is that it is reflective of and driven by the people that you serve. So those are some of the main points from the recovery/peers group.

MS. ANNE HERRON: Okay. Thank you.

Does -- would you have from any of the peer/consumer perspective, would you have a comment or reflection for us on the integrated care and kind of how we need to move forward in enhancing and encouraging integrated care, any?

MS. SARAH NERAD: Well, I know in terms of like the peer specialist recovery coaching, like cross training some of them. Because you know there's a lot of co-occurring, and we need to be able to address both.

MS. ANNE HERRON: Mm-hmm, great. Yes?

MS. KATHY REYNOLDS: For the folks that are talking about training for integration, just a plug. If you go to integration.samhsa.gov, and under the "Training" tab, you'll find dozens of training programs on integration that are available online and in person for groups.

MS. ANNE HERRON: Yes, Lacy?

MS. LACY KENDRICK BURK: To respond to your question about being a person who's used an integrative health center for a mental health crisis, it worked really well, and I was able to not have to go to a hospital or inpatient treatment because my primary care physician was able to have a conversation with the mental healthcare professional that was there onsite to answer any questions she didn't know, and they were able to give me the right support, the right connections, connect with the right follow-up.

So the primary care physician followed up with me, as well as the mental healthcare professional, and they were able to converse and really meet my needs so that, you know, the crisis was handled in a way that was really helpful and healing to me. So, so having been through that experience, I can say that it does work, and it worked beautifully. And I only had to go to one place to do it, and I wasn't stressed out trying to make all these extra appointments to try and, you know, deal with a crisis that I was already stressed out about.

So just to say that it works, and it works beautifully when it does. And I mean,

yeah, trainings and all that are great, but talking to more people about how it does work and then training to that end would be great.

MS. ANNE HERRON: Good. Thank you.

Any other comments? Yes?

MR. JOE GARCIA: Joe Garcia from Ohkay Owingeh, New Mexico. I served on the committee of elected officials and policy.

One of the things that has constantly been said here and other places is that need for funding. So I'm not sure how we're going to further address that, but one needs to understand the Federal, the national budgeting process in order to make impact.

So it's a lot of work, and I think we've got a lot of people working on that end of it. But the fact of the matter is that if you look at the past 2 years, it doesn't look very promising and it's not that way for SAMHSA, if you will. And so, if dollar needs are still an issue, we've got to also think about how do we raise more funding?

And I'll give you an example, which might lead to some solutions, is that in New Mexico, we have gaming operations, and we have compacts, agreements, contracts, if you will, between the States and the tribal entities that have the gaming operations. One of the terms in the compact is to provide funding for Gamblers Anonymous. It means that the gambling place or the gaming facility is required to provide funding for those people that may have gambling issues.

And so, in this case, where is the source of addiction problems? Well, we could go to the drug dealers and say, hey, drug dealers, could you fund SAMHSA to provide substance abuse for our people? Well, you know that's not going to work, not realistic.

But the other one that's realistic is to go to the manufacturers, the brewing companies and all of those, and give them a try. I don't know if anyone here has done that. But I'm going to go back to New Mexico and present it to my tribal leaders and say up the road, up in Denver, there's a Coors brewery, and see what they say. But we've got to be a little bit more creative in not going just to the same places for funding, for requested funding.

You know, we've got to be a little bit more creative, innovative in how we approach that. But beyond that, there are numerous other places that we could go for funding just to ask about it and see where it goes. Because the problem is not going to go away unless you get rid of the source.

And just the same about alcohol, it's the source that's causing the problems and

the grief that we are facing in our lives. But we have not gone to battle the alcohol source.

Now I don't know if that's realistic or not because what people are going to argue is, oh, it's we're going to lose a lot of jobs. We're going to have economic development issues, and this and that and the other. But they're all excuses because, eventually, the addictions and all of that unless we're successful in treating it at the maximum level, we're losing lives. Lives are more important than all the money in the world.

And so, that's the change, I think, in our way of thinking, that we have to come to realize, and we've got to do it as a whole society, not just one or two members and a few members. And in this case, you all can't lobby Congress, but the rest of us can. And so, you also got to know your communities where the people in need are, and a lot of the answers are within those communities.

Now here's an advantage that tribes have that may not exist outside the tribal community, and that is that I pretty much know all my members. All of the tribal leaders probably can say that as well, and so they know their community. They know what will work. They even have ways and means by which they can address the issues. But if funding is still a problem, well, you're going to still have some hard terms, hard things you've got to worry about.

But the community is another answer, that the community can provide the answers. And so, if we -- but we seldom turn to the communities. We're more worried about the funded program rather than finding and looking and working with the resources in-house. In-house meaning the community.

And so, those are other things that we've got to look at nationwide. Those are resources that we don't really look upon. We're just looking at the programs themselves and not all of the other connections that we have, which is our souls and our minds and our hearts with our neighbors, our friends, and our relatives.

And so, we've got to kind of put that into our means in terms of finding solution. So I offer that.

DR. LORI ASHCRAFT: While the mike is here, could I just chime in? I want to go back to the idea of peers and integration.

I think aside from addressing the workforce shortage issues, peers could be a wonderful bridge builder between all three elements of substance, mental health, and primary care. And they could do it from a mutual perspective that I think would pull people together in a way that would transcend the barriers that we run up against with professional variances.

So I would really like to see some work done in that area about how peers could

be used in that way. They'd need to be cross trained, but they could go a long ways toward pulling those three elements together for people who use all those services.

Also in primary care, I don't think there's a strong message about recovery. I don't think it's been like you can recover. You can have a full life even though you have heart disease. You can have a full life even though you have diabetes. Like we've done in mental health. I mean, that's been the message.

And if we could convey that message across those sectors, I think that would be a marvelous contribution we could make.

MS. ANNE HERRON: Very good. Thank you. Yes? Phil Donahue is on his way. There we go.

MS. SADE ALI: I'm Sade Ali from CSAT, and I'm a person in long-term recovery, which means that I haven't used a drug since February 14, 1970.

And I wish, like Lacy, that I had the opportunity to go someplace where both my addiction to heroin and cocaine and my PTSD and other severe trauma and historical trauma would be addressed concurrently. I think that SAMHSA has the opportunity to be a leader in saying to providers and showing providers what's in it for me?

Well, you're going to see better outcomes because there aren't going to be serial episodes of disconnected care and what I call appointment fatigue or session fatigue, where people are given an appointment, and maybe they'll get there and maybe they won't because they've already gone to three others this week. And so, I personally -- I've used the SAMHSA Web site on integration many, many times. I'm writing a package on it right now. It lays out steps. It talks about the retention of staff and where to look for people. It talks about supervision, which I haven't heard here yet and how important that is.

It talks about the use of people with lived experience. It lays it out really, really well, and I've used it often. But I think SAMHSA, the opportunity for SAMHSA is to actually show providers, take the fear out of it. Because providers are scared to death. "What's going to happen to my single practice? You're telling me I can't work -- you know, I just can't focus on the alcohol or other drug anymore."

And well you shouldn't. I mean, that's becoming a dinosaur. I've been in the field as long as I've been in recovery, and I've seen some really major shifts. And some things we're going back to, like the use of people with lived experience. When I got into the field, we all had the same degree, and that was from the school of hard knocks. We all had that.

And then, gradually, things changed, and some of us got onboard and went and

got our education, and some of us fell -- some very important voices fell by the wayside. So I think SAMHSA has the opportunity to be a leader in taking the -- demystifying "what's going to happen to me" and the fear that providers have around actually becoming part of a team that's going to promote wellness, not manage disease, but promote wellness.

And I think that's what I'm hearing and that's what I'm seeing on the Web site and that's where the field is going with the ACA and the what's it called -- I'm sorry. I use it all the time, promoting the Leadership 2.0.

MS. ANNE HERRON: The strategic initiatives.

MS. SADE ALI: The Leading Change. Yes, I use it all the time. I quote it all the time. I'm heavily into the workforce development piece.

So I think that SAMHSA can be a leader in kind of taking that fear away from providers so providers don't think "I'm going to be out of business." No, why can't we lead and grow the same way any other branch of health does? I wouldn't want somebody replacing my needs who hadn't had a continuing education course for 35 years.

We're the only field of health that seems to want to stay stuck in what we used to do 40 years ago. It's not going to work. We need to come up. We need to get current, and I think that we're on the right track. And like I said, I wish I had what Lacy had, back 45 years ago, and it wouldn't have taken me as long as it did to feel like I was a whole person.

MS. ANNE HERRON: Thank you. That was an incredibly inspiring end to the session, I think. We're about out of time. Does anybody have any burning issue that you -- Lacy? Josh?

MS. LACY KENDRICK BURK: I did just want to respond really quickly to what they both said about peers and integration, and I was just really, really fortunate because I happened to have one of, I think, the best peers in the field is my husband. So he happened to be there. But had I not had him as my husband and had just a regular peer person, he came in with me. He met with the doctors, with everybody. We all had these conversations together, and this happened to be the same place I go for my health check-ups.

In my intake, they sat down and talked about my wellness goals for an hour and a half and got to know me and all of my issues. And so, everything is all -- I mean, it's literally, my chiropractor and my acupuncturist, they're all in one place. And the structure is very creative how they fund it.

But I just want to say that it does work with peers integrating, as well as substance abuse, as well as mental health, as well as health all in one place, and

people are educated about how to do that. So it really -- it does. It can and it does work.

MS. ANNE HERRON: All right. Thank you very much.

I think the comments around kind of how we need to expand our relationships with professional organizations, to enhance our dissemination and communication around technologies and information and education, and then how we really build on the strengths of communities to support that is incredibly helpful. So thank you all very much.

[Applause.]

MS. ANNE HERRON: I think we're going to take a break. All right. If we could, I can't see that clock because I'm half blind.

MS. PAMELA S. HYDE: It's 10 after, so 20 after?

MS. ANNE HERRON: Twenty after, all right.

MS. PAMELA S. HYDE: Ten-minute break, and then we're going to talk about the science of changing social norms. Get at some of that communication issue you've been talking about. So a 10-minute break.

[Off the record at 2:09 p.m.]

[On the record at 2:22 p.m.]

Agenda Item: Science of Changing Social Norms

MS. PAMELA S. HYDE: Can we get everybody back to their seats? I think you all, obviously, know Kana Enomoto, our Principal Deputy. She's been leading us in doing some great thinking about what we are calling the science of changing social norms, and I think it's going to touch on a lot of the conversation that's come up about communications, about what people hear, about how they think about mental health and substance use.

So I'm going to turn it over to her and let her walk you through this next presentation for a while, while she's getting miked up. And then, obviously, some conversation that she's going to lead you through.

MS. KANA ENOMOTO: Okay. Good afternoon. Can you hear me? No.

MS. PAMELA S. HYDE: Kind of.

MS. KANA ENOMOTO: Kind of. All right. Is that better? It doesn't look any better. Is it going through? Okay. All right. Thank you.

So good afternoon. I am here to talk about one of my favorite topics, which is the science of changing social norms. Some of this work started when we had after Newtown were getting called down to the White House on a fairly frequent basis to talk about what could we do to respond? And how would we address some of the messaging issues?

And as we were talking about some of those things we could do, some of the things we've done in the past, the White House said, well, don't you have any data, like the kind of data that CDC has when they come in to talk about this kind of spokesperson with this message, with a tracheotomy or not a tracheotomy, like that's what's most effective? And I was like, well, we don't have that.

We haven't had 20 years of hundreds of millions of dollars being invested in thinking about public health messaging around behavioral health. And so, we were not able to bring those data, and I think that raised the alarm bells for us that we needed to go talk to CDC and see what they did and talk to others. And from that, science of changing social norms was born.

I also don't have my glasses. So I can't read that far away. So these are things - these are not things that are new to anyone here, but half of all Americans will experience a mental or substance use disorder in their lifetime.

You know, Pam has been pretty vocal about the fact that we don't actually use the term "stigma." We understand that many people do. We get that it's an understandable term. It communicates something very easily and quickly. But we believe that it subtly conveys that having a mental illness or having a substance use disorder actually is a mark of shame, right? Because that's what stigma means. It means mark of shame.

And so, when you talk about the stigma of substance abuse or the stigma of mental illness, you're talking about the mark of shame that that illness conveys. When one out of two Americans is affected by this, you'd have to say the stigma of being a woman or the stigma of being a man. This is half of all of us, and it just doesn't make sense to talk about it in terms of a stigma.

But there are negative attitudes and negative beliefs and discrimination, and we don't doubt that, and so we see that. And there is also sort of an inadequate valuation of these issues and the services and the providers that go along with addressing these issues.

So you see that 40 percent of -- Americans are willing to pay 40 percent less -- this is an analog study. So here are two conditions. They are causing this level of disability. Here are interventions with equal probability of success. How much would you pay for the intervention for the health condition, physical health condition? How much would you pay for the intervention for the mental health

intervention? And people would pay 40 percent less for the mental health intervention than they would for the health intervention.

In a more real-world study they did on patients currently enrolled in a methadone clinic, they said if you were to pay out of pocket yourself for this treatment, how much would you be willing to pay for this lifesaving service that enables you to go to work, stay with your family, stay out of jail, et cetera? And people would be willing to pay about 10 cents to the dollar of the actual cost of the treatment.

So we know that people are not valuing, even people who receive services are not valuing them on par with what they would value for physical health services. And we think, well, how do we -- how do we, as a society understand our things? In some of our conversations, people have told us, well, SAMHSA needs to put out the data on the economic cost, on the health cost, on the co-occurring, you know, the comorbid chronic health conditions cost.

And you know, we actually do do that, and we do it all the time. And yet people still don't want to invest in our issues. And so, we believe there is something more there to it and that we need to look at the underlying values, the social norms around it.

Some of it is people don't think that people suffering from our conditions can recover unless they want to. But they do think that these are really important public health issues. They see mental illness as the second most important public health issue after cancer, and then prescription drug abuse is third.

So if you put those together, we're actually above cancer. So the American public is slowly seeing these things as important issues, but they are not seeing solutions. They don't think we're making progress. They don't think we know what to do.

Pam and I were invited to submit something to Public Health Reports, which is a publication produced by the Office of the Surgeon General, over the winter, and we did an article called "What is Behavioral Health Worth?" And in that article, we sort of outlined sort of the economic costs, the social costs of untreated conditions, undertreated conditions, the failure to invest in prevention and early intervention.

And we came up with sort of a recommendation that we'd need to do six things to improve how Americans value behavioral health. We need to examine the underlying assumptions, beliefs, and values for cultural norms. We need to educate ourselves about how to influence. That's the science of changing the social norms. How do we influence these beliefs and behaviors?

We need to enlist the public in changing these things. We need to employ the best prevention, treatment, and recovery support services. We need to continue

to evaluate the needs of the population and the outcomes of our programs. And then we need to engage individuals, families, schools, businesses, and others to ensure that all Americans receive the support they need to achieve their optimum behavioral health.

So part of underlying these six Es is this effort that we put forward originally in the '14 budget. So how can we raise the profile of behavioral health and make the case the Americans can and should do more to address these important public health issues?

One example that I keep giving is that, you know, I have a nephew. I asked my sister, she was taking her grandson out for a walk, and she says, no, we're not taking him out until he's 6 months old. Then we can put sunscreen on him. I said people are putting sunscreen on their 6 months old, you know? And I slather my daughter like assiduously with SPF-100 before she goes to camp every day.

And you know what? Ten-year-olds, 8-months-olds, they don't have skin cancer. But here we are, as parents, young parents, grandparents, you know, doing everything we can to prevent this particular set of conditions. What are we doing in parallel to prevent substance abuse, to prevent suicide, to prevent mental illness, with our young people?

How are we promoting all their strengths and their resiliency at a really early age? I think people, if they knew how and if they knew what to do and if they knew how important it was, I think they would do it. But we're just not at a place where we can convey that yet.

So the three goals of this initiative are to raise public awareness of the importance of behavioral health. How does it impact your health? How does it impact your education, your social outcomes? Promoting health literacy to reduce the negative perceptions and attitudes about behavioral health issues. And help Americans make behavioral health a priority for public health action.

So this isn't just about eliminating stigma. This isn't just about getting people to treatment. This is about the whole spectrum. How can we, again, get those young parents engaged in promoting their own children's behavioral health? How can we get people to accept people with mental illness and addictions and people who are in recovery in their workplace as part of their families, et cetera, et cetera? How do we get communities to want to pay for these services, to want to pay for recovery, to want to pay for medications, to want to pay for that workforce? And how do we get people to want to be in this field?

So it is a broad charge. I think everyone who is on one of these councils know why now is the time to do this. The moral imperative, the economic imperative, I think there's also it's a moment in time, a tipping point, if you will, where there is

more and more noise about these issues. There's a lot of interest in what's happening around both mental health and substance abuse.

So right now, it's a proposal of \$4 million in '15. There is money in our public awareness and support, as well as our health surveillance lines to do the data piece as well as a messaging piece. And as lead-up to a budget proposal that we hope gets funded is -- I'm sorry, it says FY '15 President's budget, where -- but it's '16 also.

But we've also invested \$1 million in a sort of foundational project with the IOM National Academies of Science, National Research Council. And they have convened a standing committee to give us some -- to do some initial research and to give us some recommendations about how SAMHSA could proceed on this, in this line of action. They've done now two workshops, one of which was yesterday.

One of them was looking at what's been done in public health. How do you do some public health messaging in general? What's some of the basic science that we know about public health messaging? And then some more specific things about what's being done internationally and nationally in behavioral health?

I'm actually going to start to sit down. So in the first one, which I was fortunate enough to attend, we looked at I'm going to give you a couple of examples, including some video examples of successful and interesting campaigns that have been done in other spaces. Here is the Truth campaign, where some people may be aware it's the Truth campaign was funded from tobacco settlement funds and has -- is frequently credited as sort of the gold standard, the Cadillac of public health, social change efforts and is credited with sort of double-digit reductions in underage tobacco use.

Actually, smoking. They are focused on smoking. But they had a lot of money. They had a lot of momentum, and they found that even with that, it is very hard to get to reach your target audience and to get the kind of change that you want to move the needle.

So they said you have to reach your target audience. First, you have to identify a target audience, and you have to identify a message and an action that you want them to take. And you have reach them for about 3 to 6 months just to raise awareness, 6 to 12 months to influence their attitudes, and 12 to 24 months to influence behaviors.

Over the course of the campaign, which I think was 3 years, it was \$320 million. So that seems like a really big number. But when you looked at the reductions in tobacco use or smoking that they achieved, that they credit the campaign with supporting, they're estimating that they saved \$2 billion to \$5 billion in medical cost to society for the number of young people that did not initiate tobacco use

during that time.

So I think the Truth campaign started with a Gen X focus, Gen X target group. So that was -- and that was Truth 1.0. Some people might remember there are some ads with young people doing kind of a commando, getting out of truck with masks on and yelling at the corporate titans who were big tobacco and putting body bags on the street in sort of a Wall Street setting. And so, that was to appeal to an anti-establishment, idealistic generation where smoking at a time, that '80s, '90s was ubiquitous, and TV and movies were the primary ways of engaging with messages.

Now we have millennials, right? So it's just a different -- post millennials, actually. Emphasize social responsibility. They're more cautious. They're not as rebellious in a way. They're more live and let live. Smoking is not as ubiquitous as it was. And there are lots of different ways to share messages and to consume information.

So this is a different -- in Truth 2.0, they did a lot of market research, and this is the way they've approached this community. And I don't have it. Anyone?

So do I need to do --

MALE SPEAKER: Play it from up here.

MS. KANA ENOMOTO: Okay, great. Thank you.

[Video shown.]

MS. KANA ENOMOTO: Thank you.

Okay. So one thing you will notice that they did not do in that ad. Anyone, anyone? Those of you who work with youth, what didn't they say in that ad?

PARTICIPANTS: Don't smoke.

MS. KANA ENOMOTO: Don't smoke. And neither in the first generation, they also didn't tell the young people don't smoke. But they were sort of trying to appeal to this post millennial generation's interest in what they can achieve together, what can they achieve if they pull together with their collective power.

So I thought that was very interesting, and it is early analysis. One of the things that everyone at the IOM, those folks have emphasized is evaluation, evaluation, evaluation, and they are showing good traction and strong social engagement.

But traction is incredibly difficult, as I have learned. And this gets at a little bit more of that. We had a presentation from another person who's done some work

on HIV awareness, and she gave us some information about how do you quantify traction? How do you quantify reaching your target audience?

And it is amazing. This is borrowed from advertisers. This is borrowed from political campaign, you know? This is not sort of our more provincial behavioral health type thinking. This is really like big time.

They're talking about gross rating points. Television is the best way to reach a large number of your target audience. Gross rating points is determined by the percent of your market audience reached by the number of exposures. And when we're talking about a target audience, are we talking about all parents? Parents of 12- to 17-year-olds? All young people? You know, who's our target audience? Whose opinions do we want to change?

And they're saying you need to reach 70 to 80 percent of your audience to be successful. So if you're trying to reach, you know, males between the ages of 35 to 65, that's a big target audience.

That's expensive to reach because 80 percent of your mark, target audience times 15 exposures is 1,200 GRPs per quarter. Times 10 exposures is 800 GRPs. To get the 1,200 GRPs would be about \$7 million a quarter, and from the research that they have, that's about the penetration, that's about the number of exposures you need to get the kind of behavior, the change that you've seen with the Truth campaign or that you're seeing with some of the HIV work that's happened.

So here is -- there is paid advertising is one way to do it. Another way to do it is content integration, and so that's kind of like product placement. But obviously, we don't have a product to place. So we're talking about content integration.

And this example that was given was Grey's Anatomy. Grey's Anatomy was great because it reaches an audience of about 17 million people per week, which includes a significant number of maybe child-bearing, people in their child-bearing years.

And the message they wanted to get across in this one was about negative attitudes or fear about women with children -- women with HIV who wanted to have children and that there was a belief, a strong belief that women with HIV should not have children. So this is I'll show you the ad.

Can I play it? No.

[Video shown.]

MS. KANA ENOMOTO: So in this -- for this effort, they had done pretty significant polling pre and post to this episode. Now how many people

remember? What percent chance do you have of having a baby perfectly healthy if you're an HIV positive mom?

PARTICIPANTS: Ninety-eight.

MS. KANA ENOMOTO: Ninety-eight percent. I think I almost heard everybody say it. Because you weren't at home watching television, getting popcorn, and ironing your napkins or whatever else it is that people do while they're watching TV.

Prior to airing, only 15 percent of those surveyed were aware that the chances of an HIV positive woman having a healthy baby were over 90 percent. After airing, that number got to 60 percent. Prior to airing, 61 percent thought it would be irresponsible for a woman to have a baby with HIV. And afterwards, it dropped to 34 percent.

So you think -- I mean, this is, you know, 45 seconds in a 1-hour show or 45-minute show. That one bit had a profound impact on people and the way they believe, the way they thought about these issues.

However, 6 weeks later, they polled the same people or the same audience, and the numbers started to regress. They went about midway. In 15 weeks, they went midway. In 6 weeks, I'm sorry, midway between what they were immediately post airing and what they were pre airing.

So that's the -- that is the lesson to us about why you need repeated exposures. You can't just do it once. You've got to do it over and over again.

In one of the examples that's a behavioral health example, this is an ad done by Time to Change, which has been very successful in the United Kingdom to promote social inclusion and reduce negative attitudes and discrimination toward people with mental illnesses. And here's -- this is the U.S. version, which was done by Glenn Close's organization.

And there's going to be another one.

[Video shown.]

MS. KANA ENOMOTO: So this is a U.S. version of the ad. In the U.K. version of the ad, it was a little bit different. I think they -- but it is part of an overall campaign that cost \$60 million. So that was \$60 million over 6 or 7 years. Marla was saying it sounds like a lot of money, but when you break it down by the number of people that they reached and the number of people that they can then engage in services and prevent from death and disability, it isn't -- it doesn't -- you can demonstrate a public health benefit.

And I think the -- this is the last example of a social change messaging type effort that's less focused. So that one you could see it's make a pledge to end stigma, go to a Web site, hashtag whatever. And they're showing the social contact between Glenn Close and a person with a mental illness in a very normalized setting, in contrast with the dramatized kind of scariness.

And that shows up -- and evaluation on that shows that after the PSA showed, there was an increase in positive views and a decrease in negative views about schizophrenia. So these things, if we study them, they can make an impact. But we have to keep doing them.

This one is a little bit more vague, I guess, or more diffuse. So I was interested in this one, even though the guy from Ad Council said this goes against all the rules. Like, you know, they tell you to have a call to action. They tell you to have a very specific target audience. This is different from that.

I like that because I think in some ways what we're trying to do is bigger than a specific call to action, go to this Web site or make this particular pledge, because our issues are so broad and deep seated. This is a very interesting Love Has No Labels campaign, which unifies a number of themes.

[Video shown.]

MS. KANA ENOMOTO: I've seen it like 10 times now, and every time, it like brings tears to my eyes. But you can see in this one, it gets that emotional hook. It gets that emotional hook, and it has pieces in it that everyone can relate to. And this is the kind of thing that we're trying to understand how can we bring this to behavioral health? How can we help people see behavioral health in this light?

And any guesses on who was paying for that? I think it was -- was it Coke and Pepsi. Love Has No Labels. But it was an effort of corporate sponsorship -- I'm sorry, corporate responsibility. And they did eventually have an action tag to it, which is #rethinkbias.

And the Ad Council person said, yeah, our clients come to us and say, "We want to make a viral video." And they said, "No, first we have to make a video, and then we'll see if it goes viral." And this one has had, I think, 100 million views now on YouTube. Sorry.

So this is the beginning part of what we're doing around building the evidence base for science of changing social norms. We're looking to get the best that we can, the best science, the best examples that we can from other -- other areas, people who have already done this. And then we're going to infuse this in the campaigns that we already have. We're going to learn from the campaigns we've already done, like What a Difference a Friend Makes and Talk, They Hear You.

And then see what we can build for the future.

And specifically with this, we have some next steps that we're going to do an ongoing program of research in the area of social norms and communications, and then we're going to start to develop and test effective strategies for public engagement. So, with that, I will open it up for any questions.

Victor?

MR. VICTOR JOSEPH: Well, it's really -- want me to speak louder? Okay. So when we're changing public norms or we're trying to using media, I agree with what you're saying here that these media campaigns need to --

MS. PAMELA S. HYDE: Sorry, we're having technology problems today. He went to get the magician. This is working a little bit.

[Pause.]

MR. VICTOR JOSEPH: Thank you. Trying to -- wanting to change social norms, I think there's a couple things that -- thoughts that were just running off of my mind, and I really liked the presentation, and it covered a lot of good areas. I especially liked the last video. Although I didn't get teary-eyed, I had the emotional connection.

But that being said --

MS. KANA ENOMOTO: The tears were on the inside.

MR. VICTOR JOSEPH: The tears were on the inside. Okay, I'll go with that.

But at the same time, you know, those are good things. But when I look at like the tobacco campaign that was really successful in most of America, but not necessarily successful everywhere. Because it didn't reach certain populations because there was no connection.

And that connection is what we're needing to really see in some of our areas. That becomes really important. In rural Alaska, what happens here in D.C. or on the east coast or some big city, it doesn't have the same impact that it would in rural Alaska, different points of view.

And if we're not reaching that population, and I'll just pick on or just talk about Indian Country, you have the high rates of tobacco use, you have the high rates of suicide, you have the high rates of addictions and mental health disorders. And that stigma is going to stay alive.

So having cultural-sensitive type material that's reflective is really important, but

it's also important when we're working with cultures, regardless of what race, that it's reflective of them because it varies so much. If I look at the area that I'm working in and know that I'm working with 42 different tribes, I understand that that culture shifts all throughout, and it's different.

Now I'm not saying that you need to have a campaign for each one of them, but it does tend to say that if it isn't working in some areas, what do we got to do a little bit different? And that's the change that I'm really needing to see is we're looking at.

Also, when we're looking at changing the social norms, you know, an important piece is that education, especially when you're having -- you're looking at maximizing your resources that when we look and start talking about integration into primary care, behavioral health into primary care, is that we have to realize that some of our providers still carry that personal belief about people. And if we're going to be successful in any environment, we have to make sure that we are also making -- we're also educating those people that we think could help us the best, especially if you're going to be putting resources to it.

So I'll just stop there. Thank you.

MS. KANA ENOMOTO: So those are great comments. It's actually interesting you should raise that because at one point in our budget process, it was suggested to us that we do tribal science of changing social norms, and we said, well, that doesn't sound very good. I don't think the tribes are going to respond very well if we say we're going to come change your social norms.

That being said, we agree that there may be different messaging, different delivery platforms for -- for Indian Country. So that, but that's again part of why we need that science. I could guess at what will work better in Indian Country, but I should probably collect some data on it. I should probably engage tribes in telling us what will work better for your youth than what works for mainstream youth? What works better for urban Indians than rural?

And we don't -- without the investment in the sort of data collection infrastructure, we're just guessing, and I think we want to just put a little bit more of a data-driven lens on doing that kind of work.

MR. VICTOR JOSEPH: Okay. And I just wanted to add this as a follow-up. I agree that we need more data. We need more science. But when you're looking at this, it's not always about numbers. It's also about that traditional knowledge that you need to have, as well as the numbers, so that you can have a real successful outcome.

If you don't include that, what we see traditionally in our area are -- over the years is that you don't have a successful outcome because you're not including

that knowledge base that you need to have.

MS. KANA ENOMOTO: I think when we're talking about, in this case, the science of changing social norms, it's a little bit quicker and dirtier than the peer-reviewed journal articles. It's more like the polling kind of work, the coming out and doing the focus groups, the engaging leaders, engaging community members, and doing more research on the front end to say what would work for you rather than us sitting in 810-70 upstairs saying, "Hey, let's do a tribal campaign that does this." "Yeah, that sounds good to me. Does it sound good to you?"

No. I mean, we can't cook it up here. So we do need to go out and ask what are the traditional messages that resonate, right? Because it also could be that I ask a group of tribal leaders what do you think resonates, and then they cook up something. And then I go ask the tribal youth and say, like, "Oh, no, not that."

I mean, I'm sure it doesn't happen for you, but it's been known to happen in some places where, you know, elders and youth are not totally connected. And so, that's the kind of thing that we're trying to do is how can we test it with multiple groups so that we can converge on something that has the best chance of working.

And I think because we've been so underfunded in this area in the past, we tend to kind of it's one and done. You know, we bring a quick group. We get some ideas, and then we start producing it and putting it out there without taking the time to really get information from multiple sources. So absolutely.

And then whether or not the biggest bang for our buck will be to our target audience. Should our target audience be those people who are already working in the behavioral health system? Should our target audience be family members and people in recovery or young people?

I mean, those are all questions to be answered. We don't know yet, and I think that's, you know, where is the best probability for success? Where are the biggest problems? Who is the easiest to reach? You know, should we start with something that's easy, doable, low-hanging fruit? Should we start with the big thing and then work from there?

I mean, that's all sort of TBD, but I think that's the -- that's why -- that's why Pam wanted us to talk to this group about it. You know, if you have advice, that will help us focus.

MS. SARAH NERAD: I know during the Super Bowl, there was at least one like PSA advertisement. I think it was in one -- just in one State that was on opiate overdose prevention, and that was like all that my Facebook newsfeed was about for a week. I was on email chains about that. So, and I don't remember what

State that was in, but that got a lot of traction.

So I don't know if they talked about that at all at this conference you went to, kind of that ad, and I'm not really sure who they are. I was kind of offended by it a little bit, but at least it got the conversation going.

MS. KANA ENOMOTO: I don't know if they talked about it at this particular meeting. I think the meeting was in early March. So probably planning was done for it before the Super Bowl actually aired, and they did -- they had more established things that had quite a bit of metrics already attached to it.

So, for example, the designated driver effort, which, you know, a professor from Harvard had done, or lung cancer, you know, a Deserve to Die campaign that they had done sort of already well-researched campaigns. But that's interesting about that one. We should look into it.

Thank you.

DR. LEIGHTON Y. HUEY: It was implied, but to make it explicit, exposing these kinds of messages to medical schools, professional schools, the people who are part of mainstream healthcare would really be very important and, I think, a wise use of resources.

MR. ANDY JOSEPH JR.: Since I was right next to him, I really liked the videos. And if you -- if you look up a program called We Are Native, they got a Web site. They have YouTube. They have Facebook.

And what it is, is it's a group of young counselor-type people that work for the Northwest Portland Area Indian Health Board. They kind of put together something similar to this that is you can get on Facebook and YouTube, and they'll send messages. And they're really -- some of them are really good messages.

Actually, they give out, you know, prizes to youth that participate. Might be \$75 or something like that, but if a young person needs to talk to a counselor, feels suicidal, they got like they'll act as their auntie or their uncle or something on there so they can interact with these young people.

But it's called We Are Native, and I'd like to see more funding going to this media-type presentations because they are really effective.

MS. KANA ENOMOTO: Thank you. We'll take a look at that.

MR. PAUL GIONFRIDDO: Yeah, I'm Paul Gionfriddo, CMHS. I know we've been forgetting to say our names beforehand.

I was just wondering in looking at these, some of these fit -- because I did public health stuff from my time 15 years ago in that field -- more classically into social marketing-type spots aimed at changing people's attitudes and behavior. Schizo comes to mind that way. Others are more in the media advocacy realm. I think the first one is kind of that rage against the machine, against power and seizing power.

Have you thought much about how you break down the data gathering about the effectiveness of those two tracks and whether or not you're going to need to marry those at some point since people often come out strongly on different sides of which -- which of those should get the greater -- greater amount of attention?

MS. KANA ENOMOTO: I think which approach is a good question or which tact to take is a good question. But that probably comes after we decide what our goals are. And right now, the number of potential goals is so many and is so large. And so, we have to spend some time. You know, is it that we want to raise awareness of young people of one or more issues?

I mean, underage drinking by itself, underage drinking prevention by itself is a campaign. Underage tobacco use is a campaign. Suicide prevention, supporting peers with a mental health problem or a substance use problem. So we haven't decided which, you know, or is it the broad sort of Love Has No Labels, like, you know, your behavioral health is a valuable commodity. We should appreciate it, and we should take care of those people who are affected by illness.

So I think it'll depend what -- you know, if, for example, it becomes underage drinking, that sort of more activist, kind of harness the power of youth to stand up to authority to tackle this problem, that might be the right approach for that topic. But I think we have to kind of match the goal with the approach.

MR. ANDRE JOHNSON: Let the data drive it. What about the data driving, the national household data and --

MS. PAMELA S. HYDE: We need a microphone.

MS. KANA ENOMOTO: I think the question was let the data drive -- the National Survey on Drug Use and Health, have the data drive the topic?

MR. ANDRE JOHNSON: Yeah. Sorry about that. My name is Andre Johnson.

I'm thinking, yeah, let the data drive the priority. So if the data is reflecting that we have a higher number of young people drinking underage, then our messages should be targeting those specific areas. But also really, really being creative in terms of social media in terms of the tweets, the Instagram, the sites that young teenagers are using. Only old folks are using Facebook, like us,

right?

But I think, and even us, you know, Facebook can be a powerful vehicle for adults as well because when I think about prevention, coming from Detroit, an area where we have -- I've seen seniors begin to use drugs. You know, they retire and have a lot of play time on their hands. We have three big casinos in downtown Detroit, and our market, our MGM market has -- is the highest revenue generator in the world, right downtown Detroit.

So we know, because I heard somebody mention gambling earlier, and I'm always fussing with my State about lack of campaign messages targeting gambling because a lot of times in the addiction world, addictions can transfer. So I just think really the numbers should be really guiding a lot of direction as relates to specifics.

Thank you.

MS. KANA ENOMOTO: Thank you.

MS. JEANNETTE PAI-ESPINOSA: This is Jeannette Pai-Espinosa. So you answered one of my questions, which was, you know, where are you in terms of selecting your goals? And you just said, you know, there are a lot of options.

Before I say this, I'll admit to being a former social marketing and public will building consultant. So just a distinction between a focus on changing attitudes and behaviors, and I'm not saying you're doing this, just changing attitudes and behaviors versus connecting your issue with a person's core value. So the reason we all cried, right, is because it's about who we are and how we see ourselves in that.

And the only reason I say that is that as you look at the multitude of audiences that you're going to want to reach, I hope whoever you're working with has you really drill down to the core value level. Because you may find really unlikely matches of audiences that you wouldn't expect if you look at core values that you wouldn't look at if you were looking at messages.

MS. KANA ENOMOTO: Go ahead.

MS. MARLA HENDRIKSSON: It's interesting -- hey, this works. I'm glad you said that because part of the discussion that came up at the workshop was about making sure that whatever we come up with includes just asking the question what matters most?

And sometimes what matters most is different to certain people, but if you can drill down to that core values level, I may not have the same issue that another person has. But if we share the same underlying core value, you would get what

some people would call strange bedfellows, you know? People share the common value, and it's easier for them to then transpose or relate to that, that issue that you're dealing with.

Issue related to that that came up had to do with gay marriage, and the conversation was, well, it's about love, right? So when you bring it down to that level, people could understand that more, and it was effective that way.

DR. KENNETH J. MARTINEZ: Yes. Is it on? Yes. Several years ago, there was a meeting here at SAMHSA, and you were beginning to craft your public messages and the Friends Make a Difference campaign, et cetera, and you had the Ad Council here giving demonstrations of different ways of approaching. And one that stuck in my mind was a Goya product, the Goya company, which caters to Latinos with Latino food.

And they did variations on the same theme of their commercial selling their product. And they had a white version, so to speak, because it was a young, middle class white family in an urban area, and they did their commercial, and that was the setting. To sell to the Latino population, it was an elderly grandmother in a dimly lit kitchen stirring her pot and selling the product.

So it was a very similar commercial in that they were doing -- they were accomplishing the same thing by selling that particular product, but the way they did it was so different, and very strikingly different in terms of just the setting, the dialogue.

And so, just building on Mr. Joseph's comment about tailoring message and medium, for that matter, because we're talking about certain mediums here to use, but there may be other medium to use for different ethnic, racial groups that are more effective than others. And then as well as the actual content and the whole backdrop because that kitchen symbolized values. It wasn't just the kitchen and the grandmother, but it symbolized all that familial, you know, indigenous values about, you know, respect for elders and all of that.

So it just made a tremendous difference, and it was striking how, how much it was.

MR. CHARLES OLSON: I'm Charlie Olson. When I'm thinking about reaching out to people that, you know, you're talking about target audience, and I think of suicide. You know, there is no target audience. You have ages 5 to 105, and every single race, gender, and economic value in between.

But doing something simple, as in maybe every national news channel has, you know, four times a day for a few seconds, they should have a simple page. There is hope. Suicide/depression hotline. Then a phone number.

I mean, that's a very simple. There's no science behind it, and you just get a blanket cover. You know, millions of people would see that, and undoubtedly, there would be people who had never seen it before.

And I just think about -- the other thing I want to say is I'm just really glad that this conversation happened today. I was thinking on the way here, you know, the CDC Web site says that there is 41,000 deaths from suicide a year, and that averages out to 116 a day, and those are just numbers.

But then you think about it. I flew here on a Delta airbus A319, and that seats a capacity of 126 people. And if that airplane went down, there would be investigators there within the hour, and you would have more answers than you could want within a few weeks to a few months.

And if a second airplane of that same model went down the next day, every single plane like that would be grounded, no matter how many millions of dollars it cost, to determine what the problem was. No one would blink an eye. They'd spend that money, and they'd figure out what was going on. And so, what do we have to do to get the public to demand that change?

DR. VIJAY K. GANJU: Hi. Sorry --

MS. KANA ENOMOTO: Well, I think Pam was just noting that we should -- I might mention how much CDC gets to spend on their campaigns relative to what we have for ours. And so, for us, we have done wonderful work with What a Difference a Friend Makes and Talk, They Hear You for maybe \$1 million for a couple of years, if not just a year, and Talk, They Hear You is \$1 million a year.

And CDC, for them, that's nearly a rounding error in what they do. They're spending \$3 million a year on the soft content for social media or Web ad placements. They're spending \$6 million, \$7 million a year on just evaluation. So what they're able to do with purchased media is incredible. And you know, you see Truth campaign at \$100 million a year. CDC is about \$100 million a year for, and that's for tips from former smokers.

So the level of investment that we need is significant. And to the point about suicide prevention and getting the numbers out there, I mean, suicide kills more people than from breast cancer and prostate cancer combined, and yet how many pink ribbons have you seen? They're selling pens with pink ribbons at my Safeway checkout, but what are they doing for suicide prevention?

Now there is also a question. What do pens at the Safeway checkout with pink ribbons on it do for getting women to go get screened or people supporting treatment for breast cancer? So I think there's lots of research that we need to do to understand is showing the phone number really what makes a difference? Because in Scotland, they've achieved multiple years of double-digit reductions

in their suicide rate, and it's not necessarily by publicizing their hotline number. But it is by aggressively screening and treating depression among men in primary care and substance abuse.

So, you know, among other things, following up from people who attempt, and so on and so forth. So there are lots of things that can be done, which aren't necessarily the intuitive things, and I think we need to get data about that.

Vijay?

DR. VIJAY K. GANJU: Well, congratulations again for really focusing in on this whole topic. But one of the things that I'm very excited about is the way you're thinking about this long term because at least when you look at campaigns, whether it's in the U.K. or Scotland, those are 10-, 20-year campaigns. And so, it's sustained over a generation, and so these campaigns which go a year or two just don't have the traction that others do.

But, you know, when one thinks about social -- changing social norms, there are different levels with which people are invested in those, and at least when one's tried to look at the change of norms in other societies around family size, around adoption of, you know -- or just thinking about agricultural kinds of innovations and so on, the sort of use of societal heroes or local peers in terms of not just opinion leaders, but in terms of looking at the impact of adopting the new social norm is huge.

So I'm just encouraging us to look at how one doesn't just think about this as a mass media campaign, but thinks about it in ways that we can infiltrate sort of other areas whether -- I think Leighton was suggesting whether it's audiences in medical schools, how are you going to deal with them because I think that needs to be somehow buttressed by discussions, leadership, payoffs, and incentives for people that essentially do start changing their norms in some way, and some recognition of that.

I think the use of societal heroes. I know in the Scottish campaign, for example, they used rugby players that were sort of like household words in every -- in every sort of -- everybody knew the names of the people who were talking. I think that also makes a huge difference.

Thanks.

MS. KANA ENOMOTO: Yes, I think there's two responses to that. One is New Zealand also used a very famous rugby player to address depression. He was a well-known Maori player, who had struggled with depression and overcome it. But there are also risks to using celebrity spokespeople. Some people would say, well, you know, like on the schizo ad, people say, well, that's so random. Like Glenn Close shows up in your living room? Like that's weird.

That was weirder than having a person with lived experience talking about his experience. And celebrities also can have uncertain futures, right? They're not fixed commodities. They are people with lives that may have ups and downs, and so having a celebrity hero or endorser could have a downside.

Another issue that we know is that social contact is very important. So whether it's local heroes or just local people and people with lived experience and having them as part of the effort to engage them and getting that one-on-one contact and exposure is very good for reducing negative attitudes and discrimination. But whether or not this is an effort to reduce negative attitudes and discrimination, I don't think we've really landed on yet.

DR. LORI SIMON: So I wanted actually to reiterate the absolute importance of the primary care education piece, and we've been talking a lot about integration, but it starts with education. And you had mentioned just, you know, about the Scottish, the Scotland program. And it's extremely important for two reasons because, number one, you know, that's the place that people, more often than not, will go to -- the primary care physician -- if they're not feeling well emotionally.

That's their point of contact. A lot of times that's the person they trust. They've been going to that person for a long time. So that primary care physician needs to be able to feel comfortable talking to that patient, and so now we're dealing on a micro level when a lot of this has been macro. But this is on a micro level, one patient at a time.

The other problem is to get primary care physicians to be able to understand that patients can have physical and emotional problems because sometimes if they hear that they're -- they think they're depressed, the -- a patient is depressed, they're going to ignore any physical symptoms. So they need to be able to distinguish that.

And then they also have to have a network that they can contact of behavioral health providers who they can go to or they can refer a patient to. And so, all of that is critical because that's one of the first lines of attack in reaching a patient.

MR. JEREMIAH D. SIMMONS: Hi, Jeremiah Simmons with CMHS.

Actually, you know, I really do like this work, and I guess I'll kind of give you an example of how this work can actually come out of some of the work that your grantees are doing. You know, when we were doing work with the GLS grant, part of the focus is really trying to change sort of the cultural perspective by doing social norm work within the community, and part of that was trying to have the agencies who provide work with youth kind of agree upon that whole shared responsibility, you know, concept in terms of being able to link together to provide

more integrated services and provide more continuity of care for a lot of young people who are experiencing suicide in the community.

So part of that was, you know, I guess when you're going down the social norming track, you know, there is the injunctive norms versus the, you know, subjective norms or the descriptive norms. And the descriptive norms are kind of more about what's popular versus the injunctive norms, which is more kind of, you know, what is it that exists within your social networks that governs rules -- that kind of governs behavior or what can be approved or disapproved in terms of behaviors.

And I think what you can experience or kind of look for is when they align. Because when we were trying to promote the idea from a popular sense of saying, oh, you know, shared responsibility is how we should be organizing around this issue of suicide prevention, that was in line with the injunctive norms in terms of those are part of our cultural beliefs as well, that we're supposed to be each other's keeper, and that is kind of being reflected in the cultural values. So you can see, you know, where one really helps the other, but also trying to be aware of when the other is counterproductive to the other.

And so, I think that that distinction is really important to try and capture and tease out if possible, especially as you're moving forward with some of the campaigns.

MS. KANA ENOMOTO: Thank you.

DR. ERIC B. BRODERICK: Thank you. Ric Broderick.

Kana and Pam, thank you for doing this. I know you've been thinking about it for a while, and it's extremely important, as you know.

Where I live, people choose not to be treated who need treatment for a lot of reasons, and providers don't do what they should, and so there's lots of work to be done. But the body of knowledge that supports social change is an interesting one for sure, and we've had a number of conversations about it over the course of time.

But I'm not going to tell you how to do it or I don't even know how to do it, but I want to thank you for trying it. And it'll take a long time, it'll cost a lot of money, and it's really complicated, and you know all that. But it's really important to reiterate what the gentleman in front of me said. You'll save lives doing it.

So thanks.

DR. LORI ASHCRAFT: Lori Ashcraft, SAMHSA NAC. You know, I think we're our own worst enemies when it comes to getting a positive message out about ourselves, and I'm thinking in particular about how many people's first contact

with the mental health system is the only contact they ever have because they never go back.

And sometimes, I can't break the stats down on this, but I know it's particularly salient when you look at the number of people brought to a crisis facility. And then how many of them come back, either there or to another service point?

So if we were really welcoming and friendly instead of scary and condescending, which we can sometimes be, I think we could have a much better chance at people returning for services who really need it and also spreading a message to their loved ones and friends about where help could be available.

What if we all had a welcome sign on the door of our facility that said, "Welcome. Thanks for giving us this opportunity." I mean, how many of those do we have out there?

MS. KANA ENOMOTO: We should put one outside of SAMHSA. "Welcome. Thank you for giving us this opportunity."

You know, a lot of very good comments. I think to get back to what I think the two Loris have just said, there are some targeted things that perhaps we could do with our built-in stakeholder audience, the providers, without all of this. Some of this is a little bit probably bigger, more general audience and a little bit outside of the scope of what we normally do. Some of what you're talking about are things that I think are within our current purview.

I mean, we could be doing something to educate primary care providers and create job aids and tools and reference materials for them. We could be -- we have lots of interactions with the provider community of different ilks and with preventionists and treatment providers and recovery support providers that we could be doing some messaging and convening and thinking about how we can best engage and help them put their best foot -- feet forward.

So some of that I think is stuff for immediate use. And then some of this -- the other conversations about how to pick a goal, how to -- and you know, Ric will appreciate this. Sometimes when I think about picking a goal and using the data to drive that, it is sort of a swing a cat opportunity, where, you know, the -- what how do you define the biggest problem in behavioral health?

There is so many different ways to define that. You know, alcohol is by far the most number in terms of people abusing it, and yet prescription drugs is having this increasing number of deaths. Depression affects far more people than schizophrenia, but what is the rates of disability and death from one or the other problem? And suicide, obviously, has many different causes, but one outcome.

So, and that outcome is affecting many people in the community. So it's just --

it's very hard to know, you know, or should we go on our prevention side? There are generations of children being born. There are generations of parents being born. Should we take that opportunity to say, well, we can only do so much on the deep end, but what could we do on the front end?

So saying let the numbers sort of guide this effort, that's a tricky question or it's a tricky proposition because the numbers have different meanings and at different times and different opportunities attached to them. But I think this group, having this group engaged in the conversation is very helpful. I think you're bringing perspectives from the field and from where you -- where you sit every day that we don't have and that give a lens as we're looking at the sciences as we're looking.

As we're talking to the IOM, as we're talking to our Federal partners, you know, you're sort of bringing it home for us and keeping it grounded. So I think we'll continue to bring this back to you and ask for your guidance as we hone in on our next steps.

So thank you.

MS. PAMELA S. HYDE: Thanks, Kana, and thanks to all of you, and I just want to take this opportunity to thank Marla and Pete, who's not here today. But the two of them have been thinking from their respective perspectives and working with Kana on thinking this through. And obviously, our whole executive team have spent time on this issue.

I just also want to take an opportunity to just thank Kana. She and I worked together in lots of different ways, but one of the ways that we worked together is I have some big, lofty idea I have no idea what to do about, and she makes it real. So a couple of years ago, we really started thinking at this big, lofty level of we really need a national dialogue. We really need somebody to think about how to change people's minds about this stuff, and Kana has really taken -- over the last couple of years, really taken a bite at this apple and tried to get at it from a scientific point of view, and everybody is absolutely right. This is the beginning of an effort, not the end of it.

Part of what we've done today -- so thank you, Kana, for the beginning work on this and more to come. Part of what we've tried to do for you today is start with a little-bitty slice of a jillion different things we're doing so you could see how we were doing a whole bunch of stuff in a lot of different areas. And as we've moved through the day, getting your perspective from your affinity groups, which was a really great conversation, and from each of the center and other advisory groups and that perspective, I know I always end up with a whole paper full of notes and ideas about next steps, which kind of drives my head crazy, but in the most positive way possible.

So we will definitely come out of today's conversation with ways to move forward. And we've gone through the day at getting that sort of really lofty or how much we're doing in every different area without going into detail into your ideas, and then back into an area we've just stepped our toes into and have really begun to try to dissect how would we do this better.

And I just keep telling Kana we have to underscore the we've asked for \$4 million to do some of this work, and she gave you some of the numbers that it takes for some of these campaigns. So we are definitely on the beginning end of this.

So if you have other ideas about this, as you go away or as you think about tomorrow or whatever, I really encourage you to shoot an idea to Kana or to me or to Holly, who will bring all of your ideas to us. Or to the person that you work with in your advisory group, if that person you're relating to more, whoever it is. Or Marla. You can send it to whoever. But my sense is that you will be stimulated further by this conversation as you sit on the plane and go home.

So I want to just tell you we have one thing that you are asked to do as an adviser, which is to listen to the public, to the extent that we have a public interested in weighing in. Do you know how many people we've had over the course of the day?

MR. JOSH SHAPIRO: We've had 24 participants and 40 webinar --

MS. PAMELA S. HYDE: Okay. About 60 or so people who have been listening throughout the day or some parts of the day. We have public information out there that we take public input at 3:45 p.m. So that's about 10 minutes from now. So rather than give you a break, if you can just hold it, because we don't usually have tons of input, but we may have a little, and we'd like you to listen as well.

I think I'd like to just take a few minutes to ask if there's any other thing on your mind or any other issue you would like to know about what SAMHSA is doing. Our executive team is still mostly here, or at least there are people representing different parts of the agency still here. So if you have questions about anything you heard earlier this morning that we're working on that you kind of went by and went, "Oh, I'd like to know more about that," if you want to ask questions of each other, whatever it is you want to do, let's spend just about the next 7 minutes or so doing that while we wait for the 3:45 p.m. time period because that's when the public knows we're going to take public input.

And then we will see who wants to provide input. Sometimes it's a person, two, three, but it's not usually too many. But it would be important to hear from them, and we want you to hear from them as well.

Before I ask you if you have a question, remember tomorrow. We're really pushing tomorrow's meeting because we have some really great conversation. It

starts at, Holly, what time?

LCDR HOLLY BERILLA: 11:00 a.m. Oh, the actual? 8:30 a.m.

MS. PAMELA S. HYDE: So the meeting starts at 8:30 a.m. tomorrow. The agenda is -- we're so focused on that 11:00 a.m. time. It's great to have guests. We've had guests at many of our meetings, and tomorrow, the two guests that are coming are very busy people who are really going to be fun to talk to.

Karen DeSalvo is head of the Office of the National Coordinator for Health Information Technology. She's an internist who comes out of New Orleans, as they say. New Orleans. And she's done great work with behavioral health and health in the city and has been here now a year, year and a half.

So she's helping Patrick Conway, who is a pediatrician, actually. But he is now the Deputy in CMS. So he's the Deputy over with Andy Slavitt, who is the new Acting Administrator at CMS.

So they're the ones dealing with Medicaid, Medicare, all those measures, all those innovation dollars, all that stuff. And Patrick has done a lot of work over that time. The two of them are co-leading this issue of delivery of healthcare system or the delivery system reform, they're calling it. And they're both very sensitive to behavioral health issues, and they're driving all the way out to Rockville, which is no small thing, to spend this time with us.

So I hope you get a chance to join. Or if you can't and you have other people in your agencies or otherwise who want to call in, please let them know. If you don't know how to get that call-in number, see Holly. She'll get it for you.

So anybody got any questions or comments before we move to public input?

Cassandra?

MS. CASSANDRA L. PRICE: So your last comment about "when you're on the airplane, it may jog your thinking" jogged my thought right that moment.

MS. PAMELA S. HYDE: That's great.

MS. CASSANDRA L. PRICE: And so, and I'll probably forget to email anyone. So have you guys thought about some corporate sponsorships or partnerships with, let's say, like Delta or Southwest where you could actually put information on a plane? Because I tend to read a lot of things on the plane when I forget my magazine or my book.

So that's just a thought around corporate sponsorship that might not even cost you anything if you can find that kind of -- once you decide what the message is.

MS. PAMELA S. HYDE: It's a good point. I think Government has a tendency not to think about those kind of private sector connections for lots of reasons, but there's no reason not to. We've been approached in the past by NFL, by national baseball -- I was trying to think of the other one. By the national baseball leagues and other sports organizations who are kind of interested in working with us on issues.

We haven't gotten all the way to, you know, football players wearing pink gloves for breast cancer. That would be really cool to have them wearing some color for Mental Health Day or whatever, but it's a good point. We could probably reach out better to business and to corporations and other things.

Yeah, Gilberto?

MR. GILBERTO ROMERO: Gilberto Romero, CMHS Advisory. But Mr. Broderick made a comment, well, I don't know what -- how you go about making these messages, but I know about four elements that have to be in the message.

You know we keep talking about awareness, awareness. Well, why awareness? And the thing -- the four elements that I see that need to be in like a message is awareness, insight, consciousness, and enlightenment. You know, I think that -- and I'll explain that.

You know, making people aware of what the problem is and then giving them some insight about what the problem is. You know, like I'm very well aware of my illness, but I want some insight on how to make it manageable. And when you give me that information, then I can make conscious decisions. "I am not going to do this," or "If I don't do this, then I'll be a happier person."

So I'm making conscious decisions about my lifestyle. And hey, you know what? After I do all that, I feel good. I feel close to the spirit. I feel I'm walking good, you know, walking proud. So, but anyway, those are the four elements -- awareness, insight, consciousness, and enlightenment.

But if you want to be secular, you can substitute empowerment for enlightenment, for those that aren't that spiritual. You know, they can be empowered. Gracias.

MS. PAMELA S. HYDE: Yeah, thank you. Thank you.

All right. Any other comments? We got just a couple more minutes. Any other comments or questions, things it's your opportunity to ask. Anybody at SAMHSA that's still here. There's quite a few of them back there, actually.

[No response.]

MS. PAMELA S. HYDE: We've worn you down, huh? The other thing we tried to do -- believe it or not, the other thing we tried to do today is end a little earlier. So this actually is earlier than we usually keep you. So we'll be through here in a little bit.

But any other comments or questions today? Joe?

MR. JOE GARCIA: Joe Garcia from TTAC. I just wanted to leave you with a little message about there is this doctor who's a surgeon taking care of a lot of patients, and he goes to -- he has a team of other helpers working with him, and they treat the patients the way they treat the patients until -- he never knew how the patients were treated until such time that he himself became a patient because he had cancer.

And so, he was going through the same process of treatment and was going through the same process as his patients were going through. And not until that time did he realize how bad the services were for those patients undergoing treatment.

And so, when we look at the services that are provided for our people in need, we might consider thinking about how are we treating our people? And if we're just following a checklist, many times that happens. And more cases than you would ever know are just following the checklist -- I've done this, I've done this. I've done this -- without the respectfulness. The mutual respect that we should always have has gone by the wayside, and we need to continue to operate in that way because that's who we are.

Too many of the things that we try to do and try to fix and try to change are right here on a paper, on a text, on a computer. It makes more sense, and it is the way we ought to work is face-to-face, mutual respect.

And so, as my brother invited you all to come up to up near the Canadian border, that's where you see what's really happening, and you see it in the street. You see it in the news every day, and yet we have not really stepped up to -- we have maybe to some level, but we're kind of being forced back, to a sense. And that's the part that I think we really, really need to rally around, and that is bringing the awareness.

And I suggested -- in the last session, people are saying, well, who knows about SAMHSA? And so, I suggested that when you get on the airplane or are on your way to the airport and you're sitting at the airport waiting or you're on the plane, ask people. Take your own survey and ask them, by the way, do you know about SAMHSA? Do you know what SAMHSA is?

And I can almost guarantee you that 90 percent of the people will not know. And

come back and report to us on that and report to yourselves and report to your committee members. But I know that for a fact because I've done it at home. I've talked to people about SAMHSA in the community, and they said, "What is that?" And so, I explain, but their reply is, "Oh, gosh, we didn't know that existed."

And finally, the last piece is that the awareness also comes from being involved and because this is such a sensitive area in your own communities people are not willing to even talk about addiction. They're not willing to talk about the issues and the problems that they have. And so, and here we are trying to gather data on what the issues are. So how can a data collector even be close to what the real situation is. It's just going to be a number, just going to be a -- and it's going to also be the data takers are going to look at from their perspective not the realness of the situation.

Because in our cases, the culture, the tradition, the language, unless you're there, unless you've been brought up that way, an outsider can come in and take all kinds of notes and that becomes their perception, their perspective rather than what is real. And so, I think we need to think about how we work and how we do business from those perspectives, if you will.

So thank you for allowing me this few minutes.

MS. PAMELA S. HYDE: Yeah, good point, Joe. I think we have a challenge now. When you're on the plane before they make you turn off your device, you bring up SAMHSA's Web site and you say, "Hey, look at this cool Web site. Do you know about this group?"

You can be our emissaries, but your points are well taken, Joe. Thank you.

Agenda Item: Public Comment

MS. PAMELA S. HYDE: So let's see if we've got anybody on the phone, or have we got somebody signed up for public input?

Operator, if you are still with us and haven't fallen asleep with us yet, is there anyone who's indicated they want to be making a comment for public comment?

OPERATOR: I can open all lines for you.

MS. PAMELA S. HYDE: Okay, let me say as you do that, Operator, we're going to take -- if you get people's hands, we're going to ask them to keep their comments to about 1 or 2 minutes. So no more than 2 minutes in case there are others. We can always come back a second time if we need to, but let's see who's available for a couple minutes.

OPERATOR: All right. All lines are currently open. And if anybody would like to make a public comment?

[No response.]

MS. PAMELA S. HYDE: Nobody raising their virtual hand?

OPERATOR: Not at this time.

Agenda Item: Closing Remarks and Adjournment

MS. PAMELA S. HYDE: All right. Well, I appreciate it a ton. Thank you, Operator, and thanks to everybody in the room for your time and for hanging in there with us.

You know, we don't actually usually pass out, although maybe we should, Holly, sort of a formal survey or a formal "how did you like the day," an evaluation for the day. Maybe we'll send one out to you and have you give us some feedback.

We spend quite a bit of time planning these meetings, and I know they get long. And some parts of them you may see as useful and other parts not. We actually try to do them in some combination of ways that we think are going to be helpful to you, but that we think we're going to get something back from you as well.

And let me just continue to tell you we get so much back from you and just so much good information, good ideas, good thoughts. Makes our head spin a little bit, but it is exactly what we need from you. So thanks for doing that. And hopefully, you've gotten a little information that will stimulate your thinking as well.

And then, once again, join us tomorrow if you can, by phone, by whatever. 8:30 a.m. it starts. And if you're going back this evening or tomorrow, please have safe travels, and we will be in touch very quickly.

Thanks. Thanks, Holly, for getting us through this.

LCDR HOLLY BERILLA: Thank you. Thanks, everyone.

[Whereupon, at 3:50 p.m., the meeting was adjourned.]