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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Table of Contents

Committee Members Present

Pamela S. Hyde, SAMHSA Administrator
Geretta Wood, DFO
Mitra Ahadpour
Omisade Ali
Lori Ashcraft
Matthew Aumen
Johanna Bergan
Yolanda B. Briscoe
Eric B. Broderick
Jean Campbell
Victor A. Capoccia
Christopher Carroll
Henry Chung
John Clapp
H. Westley Clark
Sheila Cooper
Allen S. Daniels
Peter J. Delany
Deborah DeMasse-Snell
Paolo del Vecchio
Kana Enomoto
Michael E. Etzinger
Suzanne Fields
Mary Fleming
Nevine Gahed
Theresa Galvan
Joseph A. Garcia
Nathan Garcia
Vijay Ganju
Paul Gionfriddo
Junius J. Gonzales
Steven A. Green
Frances M. Harding
Dianne Harnad
Gale Held
Anne Herron
Larke Huang
Leighton Y. Huey
Andre Johnson
Cecelia Johnson
Daryl Kade
Stefano "Steve" Keel
Lacy Kendrick Burk
Jeremy Lazarus

Committee Members Present (Continued)

Elizabeth Lopez
Loretta Lewis
Keith Massaway
Elinore McCance-Katz
Jeanne Miranda
Michael Montgomery
Charles Olson
Indira Paharia
Jeannette Pai-Espinosa
Elizabeth A. Pattullo
Cassandra Price
Juanita Price
Terrance A. Range
Kathleen Reynolds
Patrick A. Risser
Gilberto Romero
Dee Davis Roth
Wes Sails
Ruth Satterfield
Josh Shapiro
Jeremiah D. Simmons
Lori Simon
Brenda V. Smith
Alberta Unok
Carole Warshaw
Christine Wendel
Christopher R. Wilkins
Marleen Wong

PROCEEDINGS

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

MS. PAMELA S. HYDE: Hello, everyone. Good morning. You found us. You found the place.

We're going to get started here. Do we have a person on the phone or an operator? Emily? Hello, Emily on the phone? Operator?

OPERATOR: Yes, you are now connected.

MS. PAMELA S. HYDE: Hi. Can you get us started on the call?

RECORDING: You are now rejoining the main conference.

OPERATOR: Yes, you've been connected.

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

So welcome, everybody, to the -- to a sister agency. We're glad to have you here and glad you found us, and we're glad we found us and all that. So if we can get everybody sort of sit down, we'll get started here this morning.

So I understand our building is back in shape. So we will -- for the national council, we will be there tomorrow as originally planned. So for those of you who are on that council, we'll see you there.

So let's start by doing a very quick -- well, I'm going to turn it to Geretta first, let her get us formally started.

MS. GERETTA WOOD: I just want to remind you guys to silence your electronic devices and please speak into the microphone when you speak and also identify yourselves for the purpose of the transcription.

And also if there's anyone on the teleconference, if you mute your computer speakers, it will eliminate feedback when you speak over the phone. If you have any technical difficulties, please contact Josh Shapiro over here. His email address is jshapiro@capconcorp.com.

And I unfortunately am not very familiar with the building, but I believe there are restrooms just across from us, and I'm not sure if there's a snack bar. Do you

know? Anyone know?

MALE SPEAKER: There is a room with vending machines in the parallel hallway to this one. If you go out towards the elevators, make a right, make right, about half way down the hall. Also your visitor badge will get you in and out of the building without going through all of that stuff again, and there's a very nice café in the middle building of our cluster.

MS. GERETTA WOOD: Thank you. Thank you very much.

And please note the emergency exits. That's something that I failed to point out before, but we should all take note of that.

And thank you again for your patience with the changes that we made, and I'll now turn the meeting over to Pam Hyde, Administrator.

MS. PAMELA S. HYDE: Terrific. Do we need to do the minutes first?

MS. GERETTA WOOD: Yes.

MS. PAMELA S. HYDE: Okay. So you should have in your packet -- not for here, tomorrow. Sorry. I'm a little distracted. You're going to have to forgive me today. This has been a wild week, and I will say some about all of that, including forgiving me for not silencing my own device because I have to be listening for something here this morning.

So what I'm going to do is spend just a few minutes telling you a little bit about what's on our plates here at SAMHSA, and some of it is we have sort of a microcosm of that this week between having you all in, which is, frankly, one of my favorite times of the year. It's a little intense for all of us, but having you all here is very rewarding for us.

It's a time for us to step back and think about what we're doing. It's a time for us to interact with some really smart people who have experiences out there to share with us. And it's an opportunity for us to get some advice from you.

So I'd like to do a really quick round of introductions, and that means people can just say who they are and what council they're with, or we won't have time to get through all this. But at least so you all will know who each other is and in the room.

So let's start way over here with Michael and we'll -- just a quick introductions.

MR. MICHAEL MONTGOMERY: I'm Michael Montgomery. I'm with the CSAP group.

MR. KEITH MASSAWAY: Keith Massaway, with TTAC.

MS. PAMELA S. HYDE: I'm sorry. You will have to use the microphones because if there are people on the phone, they will not be able to hear you without that.

MR. KEITH MASSAWAY: I am Keith Massaway, with TTAC.

MR. STEVEN A. GREEN: Steven Green, with CSAP.

MS. PAMELA S. HYDE: Lori?

DR. LORI ASHCRAFT: Lori Ashcraft, CMHS.

MR. JOSEPH A. GARCIA: Joe Garcia from Ohkay Owingeh, New Mexico. I'm with TTAC.

DR. YOLANDA B. BRISCOE: Yolanda Briscoe. I'm with the ACWS from Santa Fe, New Mexico.

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

DR. JOHN CLAPP: John Clapp, CSAP.

MR. JEREMIAH D. SIMMONS: Jeremiah Simmons, CMHS, from New Mexico.

MS. CECELIA JOHNSON: Good morning. I'm Cecelia Johnson. I'm from Ketchikan, Alaska, representing Alaska Native Health Board.

DR. JUNIUS J. GONZALES: I'm Junius Gonzales on the SAMHSA council.

DR. CAROLE WARSHAW: Carole Warshaw, ACWS.

MS. DEE DAVIS ROTH: I'm Dee Roth, with the National Advisory Committee.

DR. LORI SIMON: Hi, I'm Lori Simon, with CSAT.

MR. CHARLES OLSON: Hi, I'm Charles Olson, with the National Advisory Council.

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

MS. DIANNE HARNAD: Dianne Harnad, CSAP.

MS. RUTH SATTERFIELD: Ruth Satterfield, CSAP.

MS. CASSANDRA PRICE: Good job, Kana. So much easier. Cassandra Price, Georgia, with the National Advisory Council.

DR. ALLEN S. DANIELS: Allen Daniels, CMHS.

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

DR. JEAN CAMPBELL: Jean Campbell, the Advisory Council for Women's Services.

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

DR. JEANNE MIRANDA: Jeanne Miranda, CSAT.

MR. PAUL GIONFRIDDO: Paul Gionfriddo, CMHS.

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

MR. STEVE KEEL: Steve Keel, CSAP.

DR. HENRY CHUNG: Henry Chung, National Advisory Council.

MR. ANDRE JOHNSON: Good morning. Andre Johnson, CSAT.

DR. JEREMY LAZARUS: Jerry Lazarus, CMHS.

MR. GILBERTO ROMERO: Gilberto Romero, CMHS.

MS. JOHANNA BERGAN: Johanna Bergan, Advisory Council for Women's Services.

MS. CHRISTINE WENDEL: Good morning. Chris Wendel, CSAT.

MS. KATHLEEN REYNOLDS: Kathy Reynolds, CSAP.

MR. WES SAILS: Wes Sails, TTAC.

MS. OMISADE ALI: Sade Ali, CSAT.

MS. LORETTA LEWIS: Loretta Lewis, TTAC.

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

MS. PAMELA S. HYDE: Is that it? Did anyone come in while we were doing that

that didn't get a chance to introduce themselves?

MS. THERESA GALVAN: Good morning. Theresa Galvan, TTAC.

MS. PAMELA S. HYDE: Okay. And can you give that mike to the folks around the edge of the room so our staff can say a quick hello?

DR. ELINORE MCCANCE-KATZ: Good morning. I'm Ellie McCance-Katz. I'm the chief medical officer for SAMHSA.

MR. NATHAN GARCIA. Nathan Garcia. I'm just a guest.

MS. ALBERTA UNOK: Alberta Unok, Alaska Native Health Board.

MR. CHRISTOPHER CARROLL: Chris Carroll, SAMHSA.

MS. SUZANNE FIELDS: Suzanne Fields, senior adviser for healthcare financing.

MS. MARY FLEMING: Good morning. Mary Fleming, Director of the Office of Policy, Planning, and Innovation at SAMHSA.

MS. GALE HELD: Hi. I'm Gale Held, used to be at CSAP, currently a consultant.

MS. NEVINE GAHED: Good morning. Nevine Gahed, SAMHSA.

MR. MATTHEW AUMEN: Matthew Aumen, Center for Substance Abuse Prevention.

MS. DEBORAH DEMASSE-SNELL: Deborah DeMasse-Snell, CMHS NAC DFO.

MS. SHEILA COOPER: Greetings. Sheila Cooper, SAMHSA OPI.

MS. PAMELA S. HYDE: Sometimes our staff aren't quite how to introduce themselves. They wear so many different hats.

[Laughter.]

MS. SHEILA COOPER: It's been a week. It's been a week.

MS. PAMELA S. HYDE: Okay. And we have great contractors here around the room, too. Well, Mitra is way over here. Mitra, maybe you can come up to the -- yeah.

MS. MITRA AHADPOUR: Good morning. Mitra Ahadpour, Office of Communications at SAMHSA.

MS. PAMELA S. HYDE: Fantastic. Up here.

MS. FRANCES M. HARDING: Fran Harding, Director for the Center of Substance Abuse Prevention.

DR. PETER J. DELANY: Pete Delany, Director for Center for Behavioral Health Statistics and Quality.

MS. GERETTA WOOD: Geretta Wood, committee management officer.

MS. PAMELA S. HYDE: And I'm Pam Hyde, Administrator here at SAMHSA.

MS. KANA ENOMOTO: Kana Enomoto, Principal Deputy.

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

Agenda Item: Update on SAMHSA's Priorities

MS. PAMELA S. HYDE: Okay. So whoever's got the other mike, we could use it back up here. Yes, thanks.

A couple of -- I just want to take an opportunity because I think all of you by now know that we had sort of a wild week, and we're still in the middle of this wild week. But having to vacate our building for a couple of days, there were some people who just did a fantastic job in doing a lot of things, including Anne Herron and all the DFOs who are working with all the advisory councils and getting us five new places to have meetings yesterday. I want to thank them.

Phillip Ames is running around out there, doing things like bringing me coffee and driving me around to hotels and at the same time doing substantive work in between all of that. Selby, who was here earlier, working with the AHRQ folks, getting the stuff set up.

And then, we have some just amazing exec officers and facility people that I just want to call out. Mike Etzinger, who's our executive officer, and then Ralph, Jeff, Charles, who else? Corey. There's just a whole bunch of folks who have been over at the building, making sure it's safe and ready for the staff, who are actually back there today.

We decided to stay here since we had already made the adjustment to get here,

so -- but there are staff back in the building today. So thanks to everybody who did all that great work to get that done.

It makes you know in times like this what a kind of team you have. And in fact, interestingly enough, this week, we were supposed to do something they call "eagle horizon," which is supposed to be a test of our ability to move to other buildings in an emergency.

[Laughter.]

MS. PAMELA S. HYDE: And they called off that test for reasons having nothing to do with anything other than scheduling stuff. And instead, we had a real one. So, you know, these tests are a good thing.

So the other thing I wanted to say about this week is I think most of you know that we've also had some challenges this week. Wall Street Journal articles sort of I started to use the word "lying." I guess I will. Lying, inaccuracies about SAMHSA and about our mission and our direction and what we do. New York Times articles about a hearing that's going on as we speak this morning on a bill that is a challenge for all of us, the what we sometimes refer to as the "Murphy bill" because it was introduced initially by Congressman Murphy.

Those issues have raised all kinds of interesting issues for us and pressures and needs to respond and to deal with lots of things. And at the same time, I'm sure all of you, if you watched the news this morning, woke up to the situation that occurred yesterday, one more situation in our country of a shooting on Fort Hood yesterday -- another one there -- by a person who was, in fact, in the process of being assessed for PTSD, in addition to other things.

So these continue to be huge challenges for us. And so, you may hear a little bit later, if you didn't already hear in the process of working on communications issues in your meetings, to the extent that you did that, why we see in some of the work that a lot of the public right at the moment is equating mental health or discussing mental health in the context of gun violence.

At the same time, it wasn't too long ago when actor Hoffman died by an opioid overdose, and so the amount of conversation that's going on around heroin and other things has actually opened opportunities. It's always horrible when things like mass shootings or death of someone raises opportunities, but sometimes it does.

And this has raised an opportunity for some public discussion about the need for treatment for heroin and other opioid addiction and medication-assisted treatment and some other things that we've been really trying to work on, so in ways that is both challenging and also offers opportunities.

The other thing I just wanted to tell you about that's on our plate is the passage, I think some of you heard about it yesterday, the passage of what we affectionately call the "doc fix" bill, or the SGR bill, or the Medicare fix bill, depending on what you want to call it here in D.C. It was actually a bill to deal with a Medicare payment issue, but there were two mental health amendments on it, one of which was something called the Excellence in Mental Health Act pilots.

This is something that some constituents have been working on for a very long time and some stakeholder groups, and we certainly have been interested in seeing whether or not these pilots about quality and cost could be useful. So the pilots got passed. As with most laws when they happen in the way this one did, the language is confusing as heck, and we are now left to try to sort out what some of that means. So we're struggling with that.

So the good news is we got this new thing to do. The bad news is now what the heck does it mean? The other amendment that was on that bill was an assisted outpatient treatment program. So the bill authorized an assisted outpatient treatment grant program. It did not, however, appropriate any money for that.

So that also is not unlike something that was appropriated. We had a depression -- a Centers of Excellence for Depression authorization that never got appropriation either. So sometimes this happens. Congress authorizes a program and then never gives any money to implement it. We'll see whether or not Congress does, in fact. There is obviously a whole lot of discussion about assisted outpatient treatment, and so that's something we're watching closely as well.

The other thing that we're watching all in the same sort of issue of very public attention to things is the IMD demo. Now if you have no idea what I just said, that's okay. Lots of people don't. I'm not sure I do exactly. But there is something called the IMD exclusion, or the institutions for mental disease exclusion, in Medicaid that prohibits Medicaid from paying for inpatient care in certain types of inpatient and residential facilities for psychiatric care.

There was a demo, demonstration, that was put into the Affordable Care Act, and that demo has been going. The report on that demonstration is in the process of being finished and sent to Congress. They really haven't got any findings yet because it's too soon in the process.

But nevertheless, that's something else we're watching very closely because this is something that's in the Murphy bill and lots of discussion about it. And there are huge pros and cons and challenges about that. So something else that's on our plate.

The other thing that we're sort of looking at or watching is the ACA itself. If you

did not watch all the amazing stuff about that that we watch here in D.C., we were literally getting email updates about three times a day on what the latest was. At last count, there were over 7.5 or 7.1 million individuals who had signed up for insurance through that process, and that didn't count a lot of the other things that hadn't come in yet.

So I think the goal that people hoped to hit in terms of enrolling people was exceeded, and those who like the Affordable Care Act are extremely excited about that. Those who don't like the Affordable Care Act are saying that the numbers are cooked. You know, what can I say? This is D.C. and politics.

So, at any rate, we're very excited about that because we know that a vast number of people in those, who are signing up for coverage will, for the first time, not only have coverage, but have coverage that has behavioral health benefits in it. So we're really excited about what the implications of that are, and it, once again, creates a new opportunity.

You're going to hear from young people a little bit later today. One of the things that I've been saying in some of the speeches that I've been doing recently is that we are going to have a generation of young people -- so Lacy and others, you're probably beyond that. You're now old. But we're talking about the 9-year-olds and the 10-year-olds who are actually going to grow up in a world where coverage is expected, and behavioral health benefits as a part of that coverage is expected, and where discussion about these issues is much more regular. I started to say "normal." That's probably not the right word, but regular.

And I think that will have a profound impact. Oh, they will also be growing up in an era that if they do have behavioral health issues, they will not get kicked off of their coverage because of it. They won't have lifetime limits because of it. They won't have yearly limits because of it. So there's just some amazing difference about that.

I said to somebody, I've said it several times, it reminds me of the commercial about the kid, the kids they show on a bus who say these children have never seen albums. Well, now we have children, hopefully, who will be growing up never seeing a situation in which they don't have coverage of some sort. So this is like way cool, and it creates, again, both amazing opportunities and equally amazing challenges for us in terms of helping people understand what that means and how to use those benefits and what the limitations are. And each State is different and a bunch of other stuff.

The other thing that's going on for us and will be coming out very soon, we're very close to releasing a set of media guidelines on how to talk about mental health and substance abuse issues or substance use issues for the press and the media. So watch for that. We've been working very hard to try to think about how to help the media frame this. And given all the attention to mental health

and substance abuse issues right now, that's really important, and we're pleased that that's about to come.

We also have been working with the Veterans Administration. The Department of Health and Human Services is represented in a three-way interagency task force. I actually get the opportunity and the privilege of representing the Secretary on that three department task force. It's ourselves, VA -- HHS, VA, and Department of Defense. And in addition to that task force that's doing some work around an executive order specifically around service members, veterans, and their families and their mental health, there's also some substance abuse efforts in that and, in fact, increasingly the research efforts that are going on are looking at substance abuse issues, in addition to the mental health issues.

There is now something called a CAP project, which is an OMB-led project for an interagency work to implement some efforts around mental health and substance abuse among military populations and veterans populations. So we're in that game because from our perspective, and all of us in the room for obvious reasons, but for the reason of being that a number of people who come out of the military and certainly a lot of people's military families' members don't have coverage through TRICARE or through VA. And so, they get their coverage through community-based health systems or through private insurance.

So the Affordable Care Act is important about that. The SAMHSA programs are important about that, et cetera. So we've done a lot of work in that area, and it continues to give us opportunities.

As you can see, as I reel these off -- I'm going to reel off a few others. But as you can see, some days we step back and say, you know, if things don't get better, I'm going to have to ask you to stop helping me because we have so much help at the moment and so much interest at the moment that sometimes the SAMHSA staff and leadership are a little overwhelmed with all that's going on.

The other thing we've been doing about this is we've been calling together groups of stakeholders. So we had a great stakeholder meeting in December and another one in February, and we've got some others planned. And what we are trying to do with these small groups of stakeholders, pulling in the CEOs of some major national organizations, is to try to have a conversation about what is common among us that we really could work on together.

And actually, I will call out Ric Broderick here, who we are just pleased as punch to have back. He was our Acting Administrator and our Deputy Administrator for a long time. And stakeholders give Ric a lot of credit while the ACA was going through -- I mean while the Parity Act was going through at bringing stakeholders together and actually being able to get -- help get people on the same page about that, and it was how important that was.

So we're trying to sort of re-create that and figure out what the issues are today that everybody can kind of agree on and work on together. And right at the moment, the three issues that are emerging -- this could change. But the three issues that are emerging are integration. So good timing because we're having that conversation here today. And also the other thing that is emerging is messaging. So how we talk about mental health and substance abuse in the press and media and otherwise, and also more work on parity. Not just the parity Reagan law, but actually the concept of parity or the concept of equality of benefits. And that has implications for the parity discussion as well.

So I think I could go on probably a long time. I mentioned the medication-assisted treatment work we're doing. There's also a significant amount of electronic health record work that we're doing. Wes Clark leads that for us. He's not here yet? He will be here probably later.

We've been doing a lot of work in this area, and I think a lot of you who live in the world of substance abuse and addiction treatment know that there are special laws about privacy and consent for substance abuse treatment records. We have been struggling with the way those laws, written back in the 1970s and the regs in the 1980s before anybody really thought about use of electronic health records, they are written in such a way that they are really problematic for the use of electronic health records.

So we've been having lots of discussions with lawyers and other colleagues and folks about what could we -- vendors, stakeholders -- what could we do about that while still protecting the privacy interests of that law or the reason that law and reg was put together in the first place? So just know that we're doing those conversations and that we expect to be having some public meetings about it and other things. So you can watch for that as well.

Okay. I suspect there are many, many other things we could say, and we probably will as the day goes on. But I want to stop here and see if there are questions and see if there are anything that folks here up at the table think that are big highlights of stuff that's going on.

If you haven't seen it, as I look down the table, other things come to mind. If you haven't seen the underage drinking campaign that's been going, Fran's shop and CSAP and the Office of Communications have just done a terrific job of getting to parents about talking to their kids earlier about underage drinking.

Do you want to say more about that, Fran, or anything else? Let's just do a really quick anything you want to add about what's on our plates, big stuff we're working on.

MS. FRANCES M. HARDING: We're on the second video. The first video is a

father-son conversation. Second video is a mother-daughter conversation. The soon-to-be third video is targeting the tribal community, and where we go from there, our NAC yesterday gave us a lot of advice. So we're getting multiple hits.

Our print material that goes along with the video is in many airports, large airports across the country. Walmart has over 500 of their supercenters that are carrying it, and it's just taking on really well.

MS. PAMELA S. HYDE: Great. Thanks.

And next to Fran, Pete's Center for Behavioral Health Statistics and Quality. This was something that 4 years ago, 4 1/2 years ago was a small office, and it has really grown into being, I think, an adolescent center, and we'll eventually have it grown up, Pete, right?

So this is a fourth center we've been growing, and Pete has been doing a great job at that, including bringing in other kinds of data. So other than our own surveillance data and starting to utilize other kinds of data. You may want to talk a little bit about the barometers and also maybe what's coming up in the work you're doing?

DR. PETER J. DELANY: Sure. I think the barometers, which are -- you can get online are essentially data we've drawn primarily from the data that we collect, but also from CMS and CDC, and we're slowly moving other types of data in. And essentially, it's a snapshot of the Nation and a snapshot of each State. We're working on a snapshot of the region, but it takes a little longer to figure out how to crunch those numbers.

But those are out on the line now. We're busy working to bring the common data platform online, working now to get common workflows, common measures, and a few other things that happen to -- and I can't explain, but we have some people that are really good at that geeky stuff that I'm not good at.

We have a fully staffed economics team now with -- well, not -- we still have one person outstanding. So they're doing an awful lot of work in terms of analyzing multiple kinds of data to try to determine some of the key ACA questions, including how many people we think might actually show up in treatment programs if they all take insurance.

So that's been kind of exciting, and then Pam asked me more questions. So then we have more stuff to do. So --

MS. PAMELA S. HYDE: Thanks, Pete.

So we're really trying to make SAMHSA the place to go for information about behavioral health issues and not just our own data, but our ability to look at a

variety of datasets and sources and create a picture or paint a picture or answer a question about behavioral health. So we're working really hard on that.

Paolo has been -- you've probably gotten the most help in the last year. And I say that euphemistically. Paolo has done a great job at leading our efforts around the national dialogue on mental health and reacting to all of the work that the White House and the President kicked off last year.

Do you want to say a word or two, Paolo, either about that or whatever else you want to highlight from your center?

MR. PAOLO DEL VECCHIO: I guess, Pam, what I'd like to highlight, first of all, is our work in terms of helping to prevent suicide and the National Strategy of Suicide Prevention and all the work that we do there. This past year, our Lifeline Network received a million, over a million callers for the first time ever.

And testimonials that we received there about how literally saving people's lives. And so, I think that's really important work that we're doing, but where else to start? There's so much.

But outreach and engagement efforts, our Children's Mental Health Awareness Day on May the 8th. I hope I have the right date there. Work that our council discussed yesterday regarding serious mental illness and definition of such. Looking at issues of putting forward a new 5 percent set-aside in our block grant regarding early treatment approaches for early serious mental illness, major work going on there.

Looking at, as Pam mentioned, the work on the national dialogues, our centralized Federal Web site, mentalhealth.gov. We've produced materials for faith communities recently. I'd like to highlight that. And really, the staff leadership that we have within the agency in terms of efforts such as Now is the Time that Kana can talk much more about here in a moment, but really amazing staff efforts on a daily basis.

MS. PAMELA S. HYDE: Okay, great. Thanks.

So I'm sure you know that every one of these people could talk with you all day about all the great things that they're doing. So it's really terrific. There are other terrific staff, too, that we don't have time to go through everything.

But there's a lot of work going on interagency with -- around workforce issues. Anne Herron is taking on a new leadership role in that area, and we'll talk more about that later, and that has emerged over the last 2 or 3 years in part from some of the conversations here.

And we have -- obviously are continuing work on healthcare finance that

Suzanne leads, and a lot of work on regulatory review. I was telling somebody yesterday -- it's really sometimes when this happens, it still amazes me. I, from time to time, get a phone call from the head of Medicare, who says I really want to understand what you guys think about this reg before we put it out.

Or I get a call from the head of CDC, who says I really want you to know that we're doing X, Y, and Z about suicide, and we want to make sure we're collaborating with you. And Mary Wakefield and I talk almost every week.

So I tell you that to say the amount of -- I could go on about that, but the amount of interagency collaboration that's going on is really phenomenal, and it really underscores, I think, what SAMHSA's growing role is. I think people are getting that behavioral health is critical to health. It's critical to healthcare costs. It's critical to our Nation's health and prevention and wellness as well as treatment and, frankly, recovery, for that matter.

We have lots of interactions that we're doing around things like the innovation projects for readmissions to hospitals because people now have figured out that readmissions to emergency rooms in hospitals, about 20 percent of them, are behavioral health related. So I think we're getting behavioral health on the map in both good ways and bad ways, and in ways, again, that offer us both challenges and opportunities.

I'll let Wes say a word when he gets here about some of the work that CSAT is doing. Or if he's not going to get here, if somebody is here representing him, we can get them up? Okay, great. He's coming a little bit later.

So I think I'll stop here. Again, there's a lot more we could say. Actually, I want to do -- I want to say one more thing. Part of what's going on in this process for us in this just amazingly rich and intense time of change in our Nation's health delivery system and health coverage and health discussions is sort of a rethinking for us about what SAMHSA's role is.

Because we're also in this huge time of budget constraints, and that will feed into what you're going to hear about next. We have a better budget this year than we did in the last couple of years. But nevertheless, that said, we're still in a time when we're not looking at budgets growing a lot. We do well if we just stay flat. And so, the issue is how, within all that, do things stay fresh and do things stay focused on new initiatives?

So you will frequently see, and you'll hear about that in a little bit from Kana and Daryl, about things we've had to sort of give up and not do as much of in order to do some new things. But it's also let us realize that we have resources other than money. One of the biggest resources we have is our people, our talent, and we've thought a whole lot more about how we use our folks and how we use -- how we make our presence known.

So we're doing a lot more thinking about our role in public messaging, a lot more about our role in product development or practice improvement, a lot more about our role in collaborating and in trying to influence policy, and a lot more in our role about how we use our grants in ways that are actually moving the Nation's behavioral health system, not just doing a particular grant in a particular community.

So we think about that a whole lot more and talk about that a whole lot more, and you're going to hear about that throughout the day. There are some themes about that that will keep coming up as we go through the various topics throughout the day.

The other area, frankly, that we do not a lot of, but where we do, it has profound impacts, and that's our regulatory role. So one of the things that I personally have been working on with Fran's folks the last year is the workplace drug testing program and some guidelines that are coming out to update that program.

This program affects like 75 million people in the country because either we directly set the guidelines for how that workplace drug testing happens for the Federal Government, or in some cases, the private sector uses our guidelines as a guide themselves. So it has profound reach, and it's a major prevention effort, as well as an engagement into treatment effort in some cases.

And as I said earlier, our 42 CFR Part 2 regulatory process is something we're just starting to look at. It's another major impact on the country's health delivery system, not just on substance abuse, but on vendors doing healthcare electronic records. So we have pretty profound impacts, even though the number of regs we do is fairly small.

So there's a lot on SAMHSA's plate. So that is my point in the last 30 minutes to tell you that, give you a little flavor of some of the things we're working on. I chose particularly not to highlight a lot of the grant programs because you will hear some about that in budget discussions and other things as we go through the day.

The final thing I want to say is just about the agenda. You're going to hear little budget updates this morning, and then we're going to hear from you about the feedback from your integration discussions. I got to be in several of them, but not all of them and not all of all of them. We're also going to hear from the young people on our councils who've been talking about their role and recommendations they have for us.

We will also spend some time this afternoon on our strategic initiatives because we're ending our 4-year process. We're in the last half now of the fourth year of a 4-year strategic plan and about to kick off another 4-year process. And we're

going to get some real good work out of you this afternoon in helping us think about those strategic initiatives.

And then I think that's the last thing. Oh, and then before we're done, we're going to come back to Kana again to talk a little bit about how we're thinking about retooling SAMHSA as an organization because, if nothing else that you heard in the last 30 minutes, it should be that there's a lot of change going on, and SAMHSA has got to change with it. So we're doing some work there as well.

So that's what the day is going to look like. I hope you're ready to rock and roll. You've got your coffee and sugar, which we're not able to provide to you anymore. We're not allowed to buy coffee or sugar. So I hope you have some way to get that. And I know a little bit later we'll tell people where and how lunch is available, et cetera.

So, with that, I want to see if there's any quick questions, and then we'll get on to the budget conversation. Any questions at this point?

Yes, Lori?

DR. LORI SIMON: Pam, I was wondering if you could take maybe 2 minutes to highlight what was in that Wall Street Journal article. The reason why is because we're going to be doing the breakout sessions, and I think it would be good for us, because I haven't read it, to understand so that we can respond to that through the -- you know, when we're talking about recommendations.

MS. PAMELA S. HYDE: Okay. Paolo, why don't I let you do that? Just highlight a little bit. And frankly, if you don't have copies of it and would like to see it, I mean, we don't want the whole conversation today to be about that, but I get the point. It might be helpful as a background for you to be aware of it.

So, Paolo?

MR. PAOLO DEL VECCHIO: Again, I can share the text, but specifically, it was highly critical of the agency, specifically for the work on, as they claim here, undermining treatment for severe mental disorders. It further talks about that critical of our work, particularly in the area of recovery and as well feels that more effort should be done in the areas of assisted outpatient treatment, critical of our work in terms of peer-based efforts and particularly around the alternatives conference as one item.

I think you get a sense for the flavor of the editorial from what I just said.

DR. LORI SIMON: Okay.

MS. PAMELA S. HYDE: So are there people who haven't seen that and would like to? Okay. So we'll get a few copies, if we can get -- we'll figure out somebody to get some copies, Geretta. Paolo has a copy if you need to get it.

Okay. Great. Other questions?

[No response.]

MS. PAMELA S. HYDE: You can see, I think, from what Paolo said that the analogy I used, which I used in a couple of the meetings I was with you yesterday, is would be a little bit like saying to CDC you should only be dealing with people with heart disease who have -- who are at the point where they need a transplant and can't get a heart. That's the only people you should be dealing with.

Shouldn't be dealing with prevention. Shouldn't be dealing with ways that people can change their lifestyles to help their heart, et cetera. So that's kind of the analogy I think of this is a group of people who are feeling pretty focused on adults with serious mental illness who refuse treatment and who have to be mandated into treatment in order to get that care. That's the -- that's sort of their focus a little bit.

So part of it is our need to be clearer about what we do, as I think we've also learned. And actually, Ellie has been really great about this is we've learned that we don't talk enough about our treatment efforts and the things that we do in this area, and we talk more about some of the things they don't like, which is the peer work, the recovery work, and things like that.

And people don't get what we mean by recovery. And so, Ellie has been really great about helping us to try to rethink that and reframe it as well. We continue that effort.

Okay. Other questions? Yeah, Jean?

DR. JEAN CAMPBELL: I just wanted to continue the analogy and say it also suggests that it's only people at the end stage of cardiac disease that they have a heart attack.

MS. PAMELA S. HYDE: Yes, yes. Well, yes. We could have actually fun with the analogies, I guess, in a way.

All right. Any other questions?

Okay. I'm going to -- oh, I'm sorry. Yes, Lori?

DR. LORI SIMON: Peter, just a question for you. Are you getting involved in

some of the meaningful use quality initiatives, you know, particularly for behavioral health?

DR. PETER J. DELANY: Yes.

MS. PAMELA S. HYDE: There's lots more he could tell you about that. Maybe at a break, you could get some more. And Wes, too. He's doing a lot of work on it through the electronic health records.

All right. I'm going to turn this over to Kana and Daryl to talk about budget.

Agenda Item: Budget Update

MS. DARYL KADE: Okay. Good morning. I'm Daryl Kade. I'm the Director of the Office of Financial Resources, and I report directly to Kana, who leads and directs me very well.

And I'd like to go over some of the budget highlights and in particular some of the critical numbers with regard to our budget. On the first slide, we talk about how our budget is supporting the President's commitment to and investment in the Nation's health through key behavioral health priorities. Critical to that is that the funding for the block grants have remained level and also that the block grants are not subject to the PHS evaluation tap. That is a critical component. It means that with the amount of funding, we have more going out to the States.

The critical funding ratio between substance abuse and mental health is sustained at 68 percent relative to 32 percent. So our budget remains in balance. A couple of years ago, we switched from a single appropriation to four appropriations. When we look at all four appropriations, including what we call health surveillance and program support, we have maintained the relative balance of support for substance abuse and mental health throughout all four.

The next slide, and I'm going to check with my other handout, shows you the progression of our overall budget increases. And when you look at the last three bars, or the bars to the right, as you go from 2013 actual to 2014 enacted to 2015 President's budget, you can see that our total goes up and then goes a little down. But you can see that the components also are shifting.

We have three components to that budget -- prevention funds, PHS evaluation funds, and budget authority. We like budget authority very much, but the other two sources are also very viable. But they do have some challenges associated with them, as we are finding out every day now. And in particular, to the extent that we are funded with prevention funds, and you can see that that's the red amount, and that's actually -- excuse me, that is the green amount. And that is a

substantial amount at this point. In 2015, it's about $58 million.

Unlike budget authority, because these are prevention funds, there are special requirements for them not only in terms of reporting, but actual clearances. It does require a huge amount of work across the agency and with the department and OMB and, quite frankly, DPC as well, to actually clear grants and actually post them. So even though the money is good, the money is also challenging.

PHS evaluation funds also a good source of funding, but it's not a direct budget authority. So what that means is that the department has the authority to tap, to tap funds across HHS for PHS evaluation activities. It's a very broad term, and it has been broadened in the 2015 budget to include services. So when you look at our PHS evaluation components, not only evaluation but also services, and I'll clarify that as we go more into the slides.

The next slide actually talks about the components of our budget in terms of the funding source, and I would point out in terms of the PHS evaluation funds, in 2014 it used to be just evaluation. In fact, it was Pete's budget, quite frankly.

However, as we approach the 2015 budget, and there is a -- the department tries to balance and move -- cover, I should say, the expenses of those operating divisions that are not covered by the PHS Act with BA. So they try to look for alternative sources of funding for us.

So, for 2015, for PHS evaluation funds, we're actually covering the tribal behavioral health grants in CMHS. We're covering the SPF prescription drug abuse, Rx -- that's right -- and SBIRT in CSAT. So this is sort of a new thing for us. I don't think it requires additional clearances, which is very good. So it's better than prevention funds, but it is -- it does require, and if you happen to look at our appropriation, it does require some special language to allow this to happen.

With regard to prevention funds, in 2014 these funds were used for ATR and for suicide prevention-related activities, actually about three grant announcements that are going through the special clearance process. As we move to 2015, the funds will be used for PBHCI, health surveillance, and additional suicide prevention activities. So, again, this is a good source of funds, but it does have its challenges.

Does anyone have any questions on this yet?

MR. JOSEPH A. GARCIA: Question.

MS. DARYL KADE: Yes?

MR. JOSEPH A. GARCIA: Yeah, Joe Garcia from TTAC.

A question about the correlation between the funding and what the data shows about in terms of the suicide, that the funding follows the suicide rates, and does the data show that there are certain regions that have that higher rate of suicide? And would the funding follow where those regions are?

MS. PAMELA S. HYDE: Mary, do you want to take a crack at this one? Where are you? I saw you. She stepped out.

Yes. The data does show that there are higher rates in some places than others, and so what we've done or what we're trying to do in that RFA is do what Congress asked us to do, which is to target those areas, those tribes that have the highest rates.

So there's some math in how to calculate that, and we give the tribes some flexibility about how to do that. But we can talk to you a little bit more about that offline as well.

MR. JOSEPH A. GARCIA: Thank you.

MS. PAMELA S. HYDE: Yes?

DR. VIJAY GANJU: Hi. I'm Vijay Ganju from Texas, on the CMHS National Advisory Council.

I just wanted more of a clarification of these PHS evaluation funds. Now I understand that there's going to be this increase, and at least what I understood was you were going to allocate those to SBIRT and a couple of other things. I wasn't very clear how some of those funds were going to go to mental health.

So if you could talk about how that -- if there are any funds that are going to go to mental health or not?

MS. DARYL KADE: Yes, the -- in 2015, the tribal behavioral health grant, which is funded within the mental health appropriation in the President's budget request, would be funded from these PHS evaluation funds, with special authority written within the bill language allowing that to happen.

MS. PAMELA S. HYDE: Are you asking about the tribal grants, per se, Vijay?

DR. VIJAY GANJU: No, I was not. I was just -- you know, it sounded like sort of the previous budget, most of the allocation was going for evaluation to Pete. Now it seems like there are additional dollars and now there's more leeway and there is programmatic. And it seems to be going programmatically to SBIRT, prevention program.

And here it seems to be going -- on the mental health side, it seems like it is -- and I don't argue with the emphasis on going to the tribal programs, but it doesn't seem like it's the additional funds are going to support mental health prevention activities or whatever. I don't know.

MS. DARYL KADE: So the PHS evaluation funds are not exclusive to prevention. So that's different from the prevention fund, okay? So the prevention fund has a very, very broad definition of prevention, but PHS evaluation funds and this more expanded authority is not specific to treatment or prevention, mental health, or substance abuse, and our special language will allow it to be used in this case within CMHS for the tribal behavioral health grant.

MS. KANA ENOMOTO: And Vijay, I would add that PHS evaluation funds, which go to CBHSQ, will continue to have a broad role in supporting data and evaluation activities across SAMHSA. So it's not that we are no longer doing data and evaluation on the mental health side, but don't let the name fool you. PHS evaluation is no longer limited to evaluation, and this year we're doing --

MS. DARYL KADE: PHS evaluation plus, right?

MS. KANA ENOMOTO: Right. Right. And it would be the same with prevention fund. That's also now prevention fund plus because we're funding the ATR grants out of the prevention fund, which is interesting that prevention, they're taking that primary, secondary, tertiary view of prevention, which includes treatment and recovery support.

So we -- so I'm going to talk a little bit more in depth about some of the programming and the policy priorities that we're really pleased to see represented in the FY '15 budget.

When Daryl mentioned that we're supporting the President's investment in our Nation's behavioral health, some of the key activities, in addition to the block grants, are the Now is the Time initiative, which is actually growing in '15. We received tremendous support from the administration and from Congress in FY '14, and we're pleased to see that support growing from the administration and, we hope, also from Congress.

We're also focusing on prescription drug abuse prevention and expanding our activities in integrating behavioral health and healthcare. We -- again, we have traditionally had about a 70/30 proportion between mental health and substance abuse. So substance abuse is 68 percent now of our budget, and mental health is 32 percent, as compared similarly to our ratio in 2014.

The block grants, Daryl mentioned that they are level. We received increases in '14. So we maintained. Congress appropriated additional funds beyond what we requested in '14, and the FY '15 request maintains those increases. So that's

very important.

We also are continuing a set-aside for evidence-based programs that address the needs of individuals with serious mental illness, including psychotic disorders. So 5 percent, new 5 percent set-aside, which is being implemented in FY '14. We are continuing that into FY '15. There are no other new set-asides for either block grant. And as Daryl mentioned, the elimination of the PHS evaluation tap on the block grants is important.

And the FY '15 budget overall reflects a commitment to the health of American citizens and our population through increased funding on a focus of the intersection of behavioral health and health, including not only primary care and behavioral health integration, but following up on a pilot that we're doing this year, really bringing those HIV services into the primary care setting so that people with mental illnesses and addictions can address their HIV health needs better, we hope, and more completely.

Now is the Time has been a very -- it had a very unfortunate origin, but it has created a very positive opportunity for SAMHSA and for the Nation. In FY '15, we're requesting $130 million for the Now is the Time initiative. This is an increase of $14.7 million over the FY '14 request. We have three new activities.

One of them the science of changing social norms. When we first started doing our Now is the Time activity or responding to Newtown, we were asked often what data we have in terms of messaging, what changes people's minds? How can we get people to think and act about mental health issues differently, substance abuse issues differently? And they asked us about, well, do you have anything like CDC's tips from former smokers?

Well, that's over -- it's a $100 million-plus initiative with extensive data collection, social marketing, as well as media purchasing. And we realized that in mental health and substance abuse, we really don't have that. We cannot put that fine a point on what people think about this term or that term or how they are responding to particular issues in the news, et cetera.

And so, we've requested $2 million in our HSPS budget to collect data and expand the science piece of people's views, attitudes, behaviors toward mental health, mental illness, substance abuse, and the prevention of substance abuse, as well as $2 million for media activity, social media activities in this area.

We have one of the requests that came, that was in the original Now is the Time request but wasn't funded, we are resubmitting to -- in the President's budget, which is $10 million for a peer professionals program. So in the -- and I can talk a little bit more about it, but in the current behavioral health workforce activities funded by Now is the Time, it includes professionals and paraprofessionals, but which will include peer professionals. But we believe that peer professionals are

a particular group which would benefit from additional focused funding.

And also workforce data. We've been partnering with HRSA for some time. We believe that we need a steady and consistent way of monitoring the behavioral health workforce from a data perspective, and so we would partner with them in that with $1 million in 2015.

What we are continuing is $55 million for Project AWARE. This is to improve mental health awareness and increase referrals to behavioral health services and supports. That's $40 million for Project AWARE State grants. This builds off of our Safe Schools/Healthy Students model. And $15 million for mental health first aid.

In 2014, that's $10 million, which is braided with our State grants for Project AWARE, and $5 million, which will be going to local education agencies. In 2015, we anticipate expanding eligibility for the local grants to community-based organizations and others like law enforcement and veterans service organizations.

In 2014, we also received $20 million for Healthy Transitions, which is a very exciting program to support youth ages 16 to 25 with mental health and/or substance abuse problems and their families. That would be young people that are already in child-serving behavioral health system, as well as young people whose mental health needs are emerging in that really critical time period.

And we have, as I mentioned, $40 million for behavioral health workforce activities. Thirty-five of that is jointly administered with HRSA to expand the behavioral health workforce education and training grant program, or it's actually to develop it in 2014, and we would be continuing it in 2015. That is a program dedicated to training master's level professionals with the addition of psychology -- doctoral level psychology interns, as well as paraprofessionals, which, again, includes peers, but also community health workers, curanderos, and others.

In SAMHSA, we have $5 million for the expansion of the Minority Fellowship Program, which is focused on youth, again 16 to 25, that is developing master's level professionals, building off of the infrastructure of our existing Minority Fellowship Program, as well as adding $2 million for addiction counselors, master's level addiction counselors, which is a program that's funded in CSAT. So those will all be continuing into 2015.

As I mentioned, the level of funding for the block grant has stayed stable with 2014. That's $1.8 billion for the substance abuse prevention and treatment block grant. That's $110 million over 2013, and $484 million for the mental health block grant, which is $47 million over 2013.

So, as I mentioned, there is a new 5 percent set-aside that got introduced in

2014, and that essentially is a fully funded new set-aside that came with new money. And we're currently working with the National Institute of Mental Health on developing guidance for States on how to implement the new set-aside.

Building the workforce. So, in addition, we have $51 million in Now is the Time. That's plus $11 million. So that's the peer workforce and the data piece that are new. In addition, overall, we're requesting $56 million for the behavioral health workforce activities when you include our Minority Fellowship Program base program, the one that has been ongoing for many years.

Because of this, this ties into the conversation about our strategic initiatives because we hadn't had a workforce SI in the last round. But given this increased investment in workforce, we felt like it was -- it made more sense to have a structured activity and policy priority here.

MALE SPEAKER: Is there someone assigned to lead that?

MS. KANA ENOMOTO: Anne Herron. Anne Herron is assigned to lead the workforce SI. So you'll get to talk with her more later today.

Strengthening and integrating care. We have a couple of very, I think, exciting initiatives here, which so far that I can tell have received pretty uniform support from stakeholders that have responded.

The first one is primary care and addiction services integration. So building off of our very popular and successful Primary and Behavioral Healthcare Integration Program, which has been funded out of the mental health appropriation, we are dipping our toe into the substance abuse side, recognizing that people with addictions obviously also have significant physical healthcare needs, primary care needs, et cetera, and that addiction treatment providers need a similar support to partner with their local community health centers to provide a continuum of care for their clients in the sort of a one-stop type of way.

So this is $20 million to support the new PCASI program. It will be funding for addiction treatment providers to partner with local community health centers and provide a full array of physical health and substance abuse services to clients.

In 2014, we are doing a pilot HIV/AIDS continuum of care, where we're braiding funding across mental health, substance abuse, and prevention in our Minority AIDS Initiative lines, and we are bringing HIV services into the treatment settings, as well as partnering with community preventionists to prevent substance abuse and HIV transmission. And so, we will be continuing that partnership into 2015, linking our Minority AIDS Initiative, our PBHCI funding, and the PCASI lines.

Again, I think this is very in line, and we're thankful to Ellie for bringing this -- Dr. McCance-Katz for bringing this perspective to SAMHSA. It's very aligned with

the continuum of care efforts going on overall with the White House HIV/AIDS initiative.

Reaching Americans in common healthcare settings, the GATSBI program has been a piece of our trauma and justice strategic initiative for a number of years. We proposed it, I think, in '13 and '14. It hasn't been funded yet, but it's a $2.9 million research demonstration program, which would advance the knowledge base to address trauma for women in primary care, OB/GYN, and emergency departments.

And this originates, this is focused on women. It stems from an IOM recommendation, which has been adopted by the department that screening women for interpersonal violence, women and adolescent girls, should be a standard of care that is covered as a preventive service and was supported by the U.S. PSTF.

In the IOM recommendation, they also note that women should be screened for histories of abuse and trauma. So in addition to the current IPV, that we should be screening for histories of trauma and abuse because we recognize the relationship of those issues with later health outcomes, and we continue to feel at SAMHSA that we need to develop the science in this area.

We've started some work. We had a very exciting meeting of experts just recently, and we're building our foundation so that when and if we get appropriated funds to do a research demonstration, we're poised and ready to go.

State grants within the Strategic Prevention Framework, again funded out of prevention funds. No, did you say PHS eval? That is the SPF Rx, which will be done in a coordinated way with CDC, who is also addressing other public health aspects of prescription drug abuse and prescription drug overdose. It is eval.

And that will be funded out of PHS evaluation funds, and we're going to have more of a focus on the prevention of prescription drug abuse and misuse, as well as looking at how to -- the intersection of PDNPs and public health and behavioral health authorities and the pharmaceutical and medical communities.

Preventing suicide. In 2014, we received $2 million to begin the implementation for the National Strategy for Suicide Prevention. That will be coming out as State grants for States to look at what they can do to implement the recommendations of the NSSP. In 2015, we are requesting an additional $2 million for that implementation.

The goals are to assist States in establishing and expanding evidence-based suicide prevention efforts; address the middle-aged population, which is not covered in our current Garrett Lee Smith portfolio, suicide prevention portfolio; to

improve follow-up after suicide attempts with the goal of reducing the number of deaths by suicide, as well as reducing the number of suicide attempts.

We also, as mentioned before, are expanding the tribal behavioral health grant. So we have $5 million in 2014. We'd like to see that number go to $10 million in 2015. But overall, we are seeing a $10 million reduction in our suicide prevention portfolio. But again, some of that is offset -- in our suicide prevention grants, $10 million below 2014. That will not affect any existing grants. It will mean fewer new grants.

Building behavioral health coalitions. This a new activity, but within existing funds and existing budget lines where we will be braiding a small amount of money from the mental health appropriation, small amount of money from the SPF appropriation to provide supplementary grants to existing coalitions to address shared risk and protective factors across mental health and substance abuse. We'll be again paying a lot of attention to make sure that the braided funding is used for the purpose for which it is appropriated.

And we have a few other increases from the 2014 budget. We'll see $2 million more in the substance abuse target capacity expansion line that is to create a Behavioral Health Privacy Center of Excellence. As Pam mentioned, the CFR, the Part 2 work is burgeoning. And then about $1 million over 2014 for our disaster response activities.

Some notable reductions from 2014, $24 million reduction in our PBHCI line, partly because we saw an increase in PBHCI in 2014. SBIRT also goes down by $17 million, total at $30 million. And ATR is eliminated. So that's reduced -- we have $50 million in 2014. That will go down to zero.

But with respect to ATR, we are looking at the expansion of the funding of recovery support services in the block grant, as well as having more conversations and technical assistance to States about the ability to offer clients choice and through the use of vouchers and through substance abuse block grant funding.

In criminal justice, we have a reduction of $10 million, which is returning to the $64 million, still slightly more than we had in 2013. And as I mentioned, $10 million lower in GLS, but we also have the $10 million in tribal behavioral health grants.

[Pause.]

MS. PAMELA S. HYDE: We're looking at time here. So I just want to underscore something here. What Daryl told you is what we're in right now, and it's the money we have in our hot little hands and we're using and we're doing. All the stuff that Kana was talking about is in the President's proposed budget.

So Congress hasn't done those new things yet.

So just to make that distinction. And believe it or not, we are already starting to develop our 2016 budget proposal. So it takes about 9 months to do that. So we're in the process of doing that.

So, Kana, I don't know if there may be a few questions and other things you want to say, and then we probably need to get on to the integration discussion.

MS. KANA ENOMOTO: Yep, yep. This slide just shows where the prevention funds are going, but I think Daryl also talked to that already.

So are there any questions about the budget? Charlie, then Ric.

MR. CHARLES OLSON: Charlie Olson here.

On the last slide, if I could have a spell-out of a few of those acronyms? And then I would also like to ask specifically about the GLS suicide prevention.

MS. KANA ENOMOTO: This slide?

MR. CHARLES OLSON: Yeah.

MS. KANA ENOMOTO: Okay. So Primary Behavioral Healthcare Integration; Screening, Brief Intervention, and Referral to Treatment; and Access to Recovery. Substance abuse block grant. And Garrett Lee Smith. Does that make sense? Okay. Ric?

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

Kana, you talked about some of the funds that are going toward integration of primary care and behavioral healthcare. They're not a lot of money. Are you seeing any concomitant resource requests from sister agencies who do primary care to support the concept? Is HRSA, for instance, requesting integration funds? Are any of the other public health service agencies doing that to form the collaborative or the partnership, so to speak, from both sides of the fence?

MS. KANA ENOMOTO: You know, I don't know about their 2015 request, but I do know that in 2014, HRSA had considerable funding from their BPHC funds going to community health centers. So they did a mental health expansion out of the CHCs this year.

And I don't know if -- Suzanne looks like she has a comment. So --

MS. SUZANNE FIELDS: I was just going to offer that --

MS. PAMELA S. HYDE: You're going to have to get a mike.

MS. SUZANNE FIELDS: There is a range of --

MS. PAMELA S. HYDE: Try the other one.

MS. SUZANNE FIELDS: There are a range of integrative-like proposals across a variety of the Federal agencies that may be of interest. We do have that information. Obviously, we work closely with our partners from the Administration of Children and Families, CMS, ASPE. We're happy to share that information and provide that as a follow-up.

There are many things that are clearly in that lane of integration in a more formal way, and then there are many things that somehow that are connected to integration in that broader public health sense that we're going to be talking about with you next.

MS. KANA ENOMOTO: Yes?

DR. LORI ASHCRAFT: Lori Ashcraft.

If the $10 million for peer support is approved, do you have plans for how you'll be using that money?

MS. KANA ENOMOTO: Sure. I'll let Paolo --

MR. PAOLO DEL VECCHIO: Ten million pure workforce initiative is proposed to be State awards to entities within States like community colleges is one possibility to help provide training for peer specialists, recovery coaches, parent support providers, and the like.

DR. LORI ASHCRAFT: Okay. Thanks.

DR. LORI SIMON: Lori Simon, CSAT.

I was wondering if you knew what the rationale was for eliminating the funding for the ATR program? Was it because they wanted the States to pick up some of that? We saw a presentation yesterday in our meeting, and it seemed like a great program.

MS. KANA ENOMOTO: It is a great program, and we are the ones proposing -- the President's budget is the one that's proposing to eliminate it. So, unfortunately, we can't ascribe it to a "they." It is an "us." And I think that we are -- we are they. You know, it is consistent with SAMHSA's theory of change that things sort of evolve, and they move toward wide-scale adoption.

And if you look at Access to Recovery, it has been very successful, and people have sort of adopted or recognized the value of recovery support services, as well as the role of nontraditional providers. And so, we are looking at what we've done with the block grant application over the past couple of iterations in terms of the expansion and the clarification of the role of recovery support services, as well as what we're going to do forthcoming around increasing the use of vouchers and choice.

MR. JOSEPH A. GARCIA: Question.

MS. KANA ENOMOTO: Sorry, and I forgot to mention in addition to the increased availability of clinical services to people based on insurance.

Sade first. And then here, and then there.

MS. OMISADE ALI: Thank you for your comments about trauma, Kana. And I was wondering when we discuss trauma, are we talking about trauma in broad ranges? Are we talking about intergenerational and historical trauma and loss as well?

MS. KANA ENOMOTO: When we talk about trauma, and we do have a trauma concept paper, which we can share. It still is not -- it's in draft form, but we can, I think, get you a copy of that where we do address how we are conceptualizing trauma, which does include the broad range of activities.

But how we do a screening, how we develop our screening or our identification, you know, we really want that to be a research demonstration where people kind of sort out what are the ways of doing this effectively, safely, in a supportive way in a healthcare setting. So this is for more routine types of identification of issues rather than an in-depth trauma screening in a behavioral health setting.

I think we actually do a pretty good job of assessing trauma, well, I mean, to greater or lesser extents, but I think certainly we have the technology to assess trauma in a broad way in a specialty service setting. But it's what are the one or two or three or nine questions that you ask in a general healthcare setting of all people that you're seeing come through so that you can then do a more in-depth assessment.

MS. OMISADE ALI: So it's very much driven by the provider and the community being served?

MS. KANA ENOMOTO: Again, this is proposed as a research demonstration. So, Carole, did you want to make a comment based on -- Carole is on our Advisory Committee for Women's Services, and we had an extensive conversation about this yesterday.

DR. CAROLE WARSHAW: I think it's trying to figure out what kind of screening is appropriate to do in primary care settings and what you can do safely and how you could do it in a way that feels safe. So there's a lot of thinking through what that even means and how to do it well and to try to pilot that and figure out what makes sense in those settings. So --

MS. KANA ENOMOTO: Right. So we're not charging into implementation and giving money to start screening. We're giving -- we're proposing to give academic institutions and community settings partners -- money to partner and test out different ways of doing it.

DR. CAROLE WARSHAW: And it's partly based on the new recommendations with the ACA as part of women's preventive health benefits package to do routine screening for intimate partner violence and then other kinds of violence. So the work on intimate partner violence has been developed over the last 20 years, and adding in other kinds of trauma is newer, and trying to think about how to do that safely and what you have in place if somebody does talk about it. So there's a lot of things to think through and pilot.

MS. KANA ENOMOTO: Joe, did you have one?

MR. JOSEPH A. GARCIA: Yeah, just a question on the ATR. If you're proposing to allow the State to take over the programs, I don't know if you gave any thought about there may be good and bad relationship between States and tribes. In many cases, there is no relationship between tribes and the State. In some cases, they're good. But if there is a discrepancy in terms of how they function, then that will hurt the tribes if it's fully given to the State and not elsewhere.

DR. H. WESTLEY CLARK: With the winding down of the program, the objective is to facilitate the jurisdictions in adopting some of the precepts of the program. So we will still be promoting recovery constructs, the involvement of alternative -- of supportive systems in order to facilitate recovery, and I think that can occur both at the State and tribal level.

So there won't be any additional funding for this initiative. So this will be a policy press on our part, encouraging jurisdictions to look at the benefits of ATR and recognizing that they can adopt and adopt some of those benefits at their own level.

MS. KANA ENOMOTO: Last question? Yours is the last question.

MS. JUANITA PRICE: Oh, yes. Juanita Price.

This is on ATR as well. I'm in D.C., and we have a pretty robust ATR program. The worry is I hear how you say it's going to be molded into -- moved into other

categories. But I'm wondering how to be able to track it. Because with ATR, it's not a lot of money. In fact, we can spend maybe less than $600 per client.

But the good thing about ATR is it really opens up access, and it's like a threshold for people to get in and the eligibility is very easy to be eligible for ATR, Access to Recovery service. So I'm wondering now, how would those of us in the community, community-based organizations track that ATR money to see where? Because in the block grant, it's just more complicated to get to than how ATR is currently set up.

MS. KANA ENOMOTO: So I should probably be clearer. The money is going away. So there's not going to be money to track elsewhere. It is that the principles that have been promulgated in ATR will be promoted in other places. Does that make sense?

MS. JUANITA PRICE: It makes sense, but it doesn't make sense.

MS. KANA ENOMOTO: Right. Right, I can accept that you don't agree with it, but that's -- but it is that the money is going to zero. So it's not like you're going to find that $100 million going in other places other than to the coffers of the Treasury.

Okay. That would wrap us up, and I think we have a presentation by Suzanne, who is going to look at the impact of behavioral health and healthcare integration on SAMHSA. So --

Agenda Item: Impact of Behavioral Health and Healthcare Integration on SAMHSA

MS. SUZANNE FIELDS: Good morning. We are going to shift gears a bit, and this morning has been a lot of information coming at all of you. There's been a lot of details that we wanted to share with you as our kind of joint advisory committees coming together.

But in the next hour or so that we have in the agenda, we actually want to dedicate this time to a discussion with you, and this is our opportunity to dialogue with you and hear smart thoughts and your recommendations related to a specific topic that I think all of us around the room will recognize is a pivotal issue for mental health and substance use, and I'll use behavioral health interchangeably with that, for mental health and substance use in the next 3, 5, even 10 years out.

And so, we wanted to collectively use this time to be thinking about this concept of integration with health and what that means for us in our field, what that

means for the broader healthcare environment, and then specifically your recommendations, your smart thoughts about what SAMHSA could do, things, priorities, action steps that we can begin to take action on now, as well as think about in the coming years. So, again, this is meant to be a dialogue. So we are switching this up a bit in terms of wanting to hear from each of you.

As part of the committees that met yesterday, each of you were asked to spend a little bit of time in your agendas thinking about some questions we had posed to you about health integration. So one of the pieces that we want to do with our hour is actually have a report back. We want to hear from each of those groups about the specific themes, recommendations, ideas, even questions that came out of your specific advisory committee discussion. And then we will turn that to a broad discussion here in the room and then move us forward to action steps.

Before we start hearing from each of the committees in terms of a report-out, I did want to provide some frame to what we mean by health integration. So, today, in terms of health integration, certainly we all recognize the practice issues around health integration.

Somebody going to, say, a primary care location and how behavioral health is incorporated to maybe that well child visit, to a primary care visit, to some type of medical condition screening. But for our discussion today, we also need to be keeping in mind two other concepts that aren't necessarily just about the practice.

The ACA is bringing forward tremendous change in how healthcare is going to be delivered in the next 3, 5, 10 years. That means the delivery mechanisms that are going to be used are shifting, such as an increased use of, say, the current coverage in managed care around 83, 85 percent in the country. On the Medicaid side, we're going to see that dramatically increase upwards into the 90s is my projection. So I'm happy to come back to you in a few years and see if that's correct in terms of my thoughts about that.

So we're going to see delivery platforms change. How healthcare is financed is changing. We're seeing a kind of paying for performance instead of fee-for-service payments. We're seeing accountable care organizations in terms of the Medicare demonstration and other States' initiatives to think about entities and organizations being responsible for a whole person.

So that's the second piece we need to keep in mind. So the first is the clinical practice issues. The second is how delivery is going to change, how the financing is going to change. And then the third piece I would ask that we all keep in mind is this concept about equality between behavioral health in terms of how we think about healthcare.

When people think about healthcare outside of our field, a lay person, they don't

necessarily think about mental health or substance use. They don't think about behavioral health. We have conversations about eating right, exercise, taking care of ourselves in terms of preventive measures. But those are not often inclusive in terms of the general population of mental health or substance use.

So that third concept of how we think about integration from that public health, that whole population perspective is kind of the third leg of the stool we would like you to keep in mind for today.

Any questions before we begin in terms of what we're setting out to do with the hour or so we have?

[No response.]

MS. SUZANNE FIELDS: Okay. Very good. Thank you.

So, with that, I would like to have each of the committees do a very brief report-out. If I could ask that people limit their comments to the most salient remarks from your committee, and perhaps let's look at approximately 3 minutes or so in terms of report back. Because again, the intent is for a group dialogue. So there will be plenty of opportunity for us to hear from everybody today.

I'm not quite certain who was volunteered or volunteered themselves to do the report-outs. So what I would like to do, given I was able to sit briefly with the Tribal Technical Assistance Council, and I know that Joe kindly agreed to do that, if I could turn to you first, please, with a report-out from the health integration discussion from our tribal council that occurred yesterday?

And if you could highlight for this large group the most salient feedback from that very in-depth discussion?

MR. JOSEPH A. GARCIA: Thank you. I'll give it a shot here, and you said 3 minutes. Time starts now?

MS. SUZANNE FIELDS: Time starts now.

MR. JOSEPH A. GARCIA: Well, first, we thank -- our committee thanks you for the opportunity to provide a little bit of input on the tribal side, and there are -- there is like a two-page report, but I'll try to highlight the most important ones.

First is that there needs to be guidance for the people who are administering the programs at all levels for the tribal way of life, and that's in school settings. That's in community life. That's in workforce, and all of that. And many times, that's kind of left out and forgotten about. And so, we want to be sure that at all levels of SAMHSA, including the committee work and including the staff and the workforce at the work level in the regions and in the home communities be

appraised of what those issues could be and what fixes there might could be.

We also suggested that SAMHSA also take advantage of national conferences that are occurring and include the youth. We suggested that through the National Congress of American Indians, there is a youth group that is the counterpart of the National Congress, which is the Youth Congress. They meet three times a year, and if we could use that kind of an environment and use the resources that we have, which are the youth, and help them or allow them to help us to get the message about the needs in behavioral health through and through. And if we get them started in the early age, so much the better.

People are the community connections, and many of the things that we've talked about you can read about them, you can write about them, and people will talk about them. But you don't really know the community way until you've come out to visit a tribe, a tribal setting, and that's where it's really at in order to get a little bit more feel for what it's really like, what is it that we're talking about. So that's an important thing.

And we termed that "cultural sensitivity education," and so I think that needs to occur at all levels within the not only SAMHSA, but with HHS and other Federal entities, that too many times that never happens. And so, if people are working on tribal issues, at some point in time, maybe they need to take a cultural sensitivity training. I'll call it Tribal Cultural 101 or something like that. And we'd be willing to talk a little bit more about what that really means.

Allow flexibility within the grant funding to reflect tribal way of life, and I think that you all are working on some of that, but we reflected a little bit on the data collection piece versus what a grant application would look like, and it turns out that it was not very clear as to the authors of the grant application don't really get together to talk to each other about commonalities in terms of what should go in a grant application. And so, if you've got four different grants happening, you've got four different authors, and they're not connected in that way. But you want to connect them when it comes to the grant has already been issued, then the data collection comes into play.

And the two kind of go hand-in-hand. You'll never get the grant if you can't -- if you can't meet the terms of what the grant is covering. And so, it's important for there to be continuity, if you will, and the integration at that level before the grants go out.

And one more here. The Internet connectivity. Yeah, I can get online. If I go home, I can get online. But there are a lot of tribes who don't have that luxury, if you will, and so we got to understand that we cannot just communicate always with online services, if you will. And the Web site is great if you have access to it, but there are many tribal remote locations that don't have that.

And so, imagine trying to fill out an application online and your screen takes 40 seconds to come to resolution enough to be even able to read it, and there are places that don't even have that kind of access. And it's hard to -- I think the assumptions at this level here are made that everyone has access, and that's the furthest thing from the truth.

But that's a different issue we're working on trying to correct, but that's the highlights of some of the issues we've brought up.

MS. SUZANNE FIELDS: Well, thank you, both for the salient summary. I was actually part of that discussion, and it was a very rich discussion. And I think the points you brought forward today will be most helpful.

And also thank you for helping us stay on time in terms of our group discussion.

Next I'd like to turn to the Advisory Council for Women's Services. I'm not quite sure who the spokesperson may be from that discussion. If I could ask you to identify yourself, a volunteer?

MR. JOSEPH A. GARCIA: I can go again if you let me.

[Laughter.]

MS. SUZANNE FIELDS: You're going to do it again, Joe?

[Pause.]

MS. KANA ENOMOTO: I'll do it. Excuse my absence. We had a different barn burning down. So we're trying to deal with that.

We were actually very fortunate to have Dr. McCance-Katz join us for a conversation about integration and especially briefing the committee about what's being done around our pilots in 2014 with HIV and AIDS, and the conversation about what are the particular needs of women and how our population may fare differently maybe in different settings. Obviously, OB/GYN, pediatrics, they come into play.

And then also the role of trauma and the trauma screening, we had an extensive exploration of the recent -- there was a NIDA and ACF co-convened meeting around the IPV, and then our GATSBI meeting. And where we started going to was how to not only it's obviously a thorny issue of how to identify individuals' experiences of trauma in primary care setting, but that doesn't mean that you couldn't take a universal precautions approach.

And then what is the -- what would then be the change of primary care practice to accommodate the high prevalence of what we know trauma to be in not just

the behavioral health population, but in all populations? And so, what are ways that providers -- docs, nurses -- could behave differently with the anticipation that many people are affected by trauma? So what questions could they be asking? What policies could they have in place? What practices could they have in place to accommodate our issues?

And I think that's where we spent a lot of very good discussion time. I don't know if any of the committee members can help me with specific responses about the HIV programming, other than I think the strong need to look at the role of risky alcohol use and the high-risk behaviors that put women at greater risk for HIV infection and the strong need for the community prevention piece of that in what we're doing. And the interrelationship of the prevention and the services work around primary care and healthcare.

MS. SUZANNE FIELDS: Carole?

DR. CAROLE WARSHAW: I think around -- the conversation around HIV/AIDS is the integration of attention to HIV/AIDS in behavioral health settings, which is different than incorporating behavioral health approaches into HIV more medical settings. And both are really important wherever somebody comes in to think about it in both ways because the role of mental health, trauma, and substance abuse as risk factors and in terms of disease burden, medication adherence and viral load and immunological responses, all of those are really critically integrated. I think we're thinking about those together.

MS. KANA ENOMOTO: And I think another thing that was pointed out was the increase, the even greater disparity for women -- or for African-American women being at much higher risk for new HIV infections, even relative to the overall population, as well as even to men.

DR. CAROLE WARSHAW: I don't know if you want to include the PPW discussion, Kana? Because that's also an integrated approach, somewhat. About the Pregnant and Parenting Women Program that is also -- it actually is a kind of integrated program, and so there was a lot of -- there was some -- Dr. Clark presented some of the data on that, which was very compelling and worth thinking about not only for that particular population, but also as a model. So --

MS. SUZANNE FIELDS: Did the women's group have a particular priority for SAMHSA that you articulated or based on your reflection that you could articulate now?

DR. YOLANDA B. BRISCOE: We had several priorities, but we also brought up the notion of let's keep in mind the aging population and women aging and opioid and prescription drug increase among older women.

DR. JEAN CAMPBELL: In addition to discussing the bidirectional approaches to

treatment of illness and prevention that have been mentioned, we also had an outstanding presentation by Wilma Townsend on the focus on wellness and promoting emotional health and physical health, which is, I think, an important addition to this discussion, that we agreed that women intuitively understand, but we really need to be more definitive in our articulation of that, the intersection of wellness and recovery.

And I was thinking that based on our discussion, I would actually call this session the future of behavioral health recovery through health integration, to bring in the concepts of emotional health and physical health.

MS. SUZANNE FIELDS: Thank you. Brenda?

MS. BRENDA V. SMITH: And I guess one of the reflections that I had just in terms of the conversation about integration, and I think that it also relates to privacy, is to make sure that in those conversations about integration that we make sure that we're not doing harm to vulnerable populations. Because one of things that often happens is certainly we've seen this for pregnant women who have substance abuse issues, that they also become enmeshed in other systems that are punitive.

And so, when we're thinking about integration, it's very important to make sure that we also evaluate the risks because there are also risks to people who are vulnerable.

MS. SUZANNE FIELDS: Are there other hands? Kana, anything you'd want to say to summarize those additional points based on your meeting yesterday? Okay. Very good.

Thank you all for that.

Next, if we could turn to the Center for Substance Abuse Prevention. Fran, I'm not quite sure who may be designated from that yesterday?

MS. KATHLEEN REYNOLDS: Yes, this is Kathy Reynolds. I believe I was volun-told on behalf of the --

MS. SUZANNE FIELDS: Volun-told?

MS. KATHLEEN REYNOLDS: -- CSAP National Advisory Council to report out for us.

[Laughter.]

MS. SUZANNE FIELDS: Well, then let's make it more uncomfortable for you and ask you to stand, you know? And I'm just teasing. You don't have to, but

that's fine. Whatever you like.

MS. KATHLEEN REYNOLDS: When I'm volun-told, I do what I'm told. So, no, really, pleased to have this opportunity to speak with you about our conversation about integration, and we talked a lot about the efforts to date have been talking about really the whole health and the individual person's integration and integration in the clinical settings. What we wanted to bring to the conversation is the real need for integration at the community level and with the community coalitions and with the prevention work that is already going ahead.

And we actually talked about, I thought, a very fascinating concept of sort of the community health home or the community neighborhood that would complement the patient-centered medical home or the behavioral health home, but would engage our communities in this integration discussion in a broader way.

To that end, we actually had a recommendation on something we're thinking about, which it would be a SAMHSA demonstration project that could actually look at broadening this beyond the individual and clinic settings to the community setting for integration and how we might be able to bring the work we've done. We thought that the Strategic Prevention Framework might be a useful tool to use in terms of moving forward on that.

A second strong conversation that we had throughout our time together was the workforce issue as it relates to this, and we actually offer our preventionists that are out in the field to the workforce. We think they're ready and available to move out on this integration. We're not done talking about it, but we don't need to be convinced anymore. We're ready to do that, and we're ready to move into the physical health settings and to help folks move this forward with our 30 years of solid science that we have.

What we think the workforce may need is some cross-training, but not just didactic training, but the actual opportunity to experience each other. We talked about walking in each other's shoes. So that a preventionist can get into the primary care setting and that we might be able to get primary care out to some of our coalitions and our behavioral health homes and places to work.

We love the health focus and becoming part of healthcare and thinking about that. That would reduce stigma. And bringing our work in risk and protective factors to the project.

At the policy level, we're concerned that we still have a health system where the incentive is to provide treatment for sick people and that that's how folks make money. So from the policy perspective, we think we need to shift that and hope SAMHSA can help us shift that to incentivizing prevention and incentivizing people keeping themselves well rather than going into the healthcare system, but to be at a policy level focusing on prevention.

And then we also identified a challenge. Some of us who are out on the ground talked about just the infrastructure cost and challenge of doing integration from an infrastructure perspective and needing some support and conversation around that.

And then I don't know if anyone else -- I was told that my committee had my back here. So, committee, anyone else have something they want to add from our discussion that I've missed in terms of a key point? But I think those three points -- the inclusion of the community, the workforce, and then the incentive for doing preventive health works rather than just paying when we get sick.

MS. SUZANNE FIELDS: Did you all in that discussion about both the neighborhood kind of coalitions or neighborhood health homes concept as well as with the use of preventionists as workforce and then the third, you know, the shift to incentivizing prevention, where did that go in terms of some additional specificity on those three that you could summarize for the group?

MS. KATHLEEN REYNOLDS: I think the one was the demonstration project where we could look at this community involvement in a different way than maybe that we did talk about the great success of the PBHCI program, and we loved the expansion of that to addiction in 2014. So I think the demonstration project.

The challenge with the workforce, what we talked about is our preventionists may not have the same types of credentials that the traditional folks that are working in integration have. So they may have lived experience. They may have a lot of training, but not maybe the formal credentials. So how are we going to embed them in the system as we move forward with the process?

And then I would look to my committee members to offer additional thoughts on that. But those were some of the things. I think the training opportunities of getting our prevention staff into the primary care setting and helping those doors get opened to the work that we're doing would be another key element.

MS. SUZANNE FIELDS: Any additional comments on that?

[No response.]

MS. SUZANNE FIELDS: Okay. Very good. Thank you very much.

The Center for Substance Abuse Treatment, CSAT. Wes, who was volun-told?

DR. INDIRA PAHARIA: Okay. So we had a very lively -- oh, thank you so much. Yeah, we had a very lively discussion.

While we all really recognized the importance of integration and the value of it, we went a little bit off script and talked a bit about the potential concerns and barriers and sort of cautionary tales that we have experienced from our own experiences in behavioral health, one of which was behavioral health getting lost in integration, sort of becoming diffused, a decrease in funding, or sort of becoming dominated by a biomedical model.

Another was the concern that financial incentives are still misaligned and that, you know, we have a lot of great opportunity out there, but we don't yet have the infrastructure to actually take advantage of integration.

Training was a very big topic, especially with providers, and the importance of timing of training. For example, when is the best time to train medical residents in behavioral health? Because they typically are overwhelmed during their training, and it's not until later in practice that they may value the need to understand that. And also training for behavioral health providers.

Then we did discuss how there are reimbursement inequities among behavioral health providers and medical providers, and that there needs to be maybe more equality and value placed on behavioral health. And that still today we have very different clinical and service models among all of the different provider types.

So the other focus we had was SAMHSA's role and how you all could help break down those barriers, and one of them was to help us create some standards and maybe those standards would be, you know, a guidance for accreditation, maybe with NCQA type of work. Bringing in community organizations so that integration is not just a clinical focus, but that it includes large community agencies.

We thought that SAMHSA could provide a lot of leadership and knowledge with technical assistance as organizations try to integrate more. We felt that SAMHSA would have a major role in guiding IT integration, especially how we were talking about 42 CFR Part 2 and the barriers with that. And then, finally, managed care standards for integration, how important -- managed care, because we're seeing more folks, especially with the Medicaid expansion, moving into managed care, and giving them some standards and guidance on what that should look like.

And I apologize having my back to everybody, but this cord does not allow me to turn. And if anybody on my committee has anything they want to add that I may have missed, please do.

DR. LORI SIMON: Yeah, this is Lori Simon, CSAT.

As a direct provider of behavioral healthcare, one of the things I think it's very important to recognize is that I do not get paid for any integration work I do. And certainly, there is no time within the time I spend with a patient, let alone

afterwards. And I do it because I think it's the right thing to do, but there's no incentive. There's only so many hours in the day.

So it's extremely important that funding changes and payment changes directly to providers so that they -- that their work is valued, that integration work is valued. And the other side of that is on a regulatory basis, I mean, I cannot tell you how many times I have had people who are hospitalized, and I and my colleagues, we all hear that we do not get called.

You would think that we are the people who are dealing with our patients on a week-to-week basis. We understand them. We do not get called. And it's even worse when I work with the homeless because it's much harder to track where they are.

And so, and the only time I will get a call is because I think in New York State, it's regulated that they have to provide, just the hospitals have to provide discharge summaries.

MS. SUZANNE FIELDS: Excuse me. So then you're starting to frame how there needs to be communication and responsibility and accountability in both directions in terms of --

DR. LORI SIMON: Yes. And so, the only time I will get a call is literally I still remember for one of my homeless patients, oh, the patient has been here for 10 days, and they're being discharged, and so I need to contact you. But you know?

So, so there has got to be -- and recently, I've had a patient in New Jersey where I actually have filed complaints with the New Jersey Board of Health because of ramifications of that. So the point is both in incentivizing and also a regulatory basis.

MS. SUZANNE FIELDS: Thank you. Victor?

That's not the microphone I tried to use earlier, is it?

DR. VICTOR A. CAPOCCIA: No, this one worked. Yeah, it still works.

Indira did a great job, I think, summarizing our discussion. The one other point that we did also talk about is that if we look at the environment out there now and the drivers that are shaping that environment of how healthcare is currently being organized, we see some very, very clear directions. You can give those examples, and we talked about the Partners HealthCare System, for example, that bought the Neighborhood Health Plan, bought an insurance company, has various behavioral health components within their system. The Lahey Health System has that embedded in their health system currently.

We have examples of the CMS demonstrations in Vermont, the way in which Oregon has organized their care, which has been not only integrative, but included behavioral health that they are, in effect, building or have as part of the system. So what's the implication of that for the community-based provider that remains outside? And the point is ultimately that we have a system designed at this point in time, by and large, that encourages fragmentation and silos.

And if, in fact, we want integration, then it requires the redesign. The implications for community-based programs is that they have to find the way, both mental health and the addiction community based programs, to connect with these systems that are becoming organized.

MS. SUZANNE FIELDS: So, Victor, if you were to take that conversation, and I open that up to your colleagues from that committee, having that -- discussing that theme, what do you see as SAMHSA's actionable steps related to that larger design issue?

DR. VICTOR A. CAPOCCIA: Indira referenced -- I mean one that she referenced and can expand on it a little bit is that the standards involved in purchasing contracts can create the incentives. They can create the environment or the incentives to integrate or not.

Those standards are all over the place at this point in time. I mean, each State does that on their own. Each State Medicaid program develops their own. So if there were pulled together, you know, some smart managed care people, some smart Medicaid people, and you begin to develop through a consensus process a set of -- you don't want them into regulations. They're not mandated. But what you want is some reference points that make sense that will drive the redesign that promotes an environment for integration.

MS. SUZANNE FIELDS: Great. Thank you.

DR. VICTOR A. CAPOCCIA: At this point, we have an environment that promotes silos.

MS. SUZANNE FIELDS: Leighton?

DR. LEIGHTON Y. HUEY: Even though behavioral health has a little bit of a leg up in terms of working as interdisciplinary teams, historically there's still a lot to be desired in terms of that integration. It seems to me from a specific proposal that if SAMHSA were to work with its partners on the use of simulation as a way to train people in how to integrate behavioral health with physical healthcare, that could be quite valuable and powerful to the field, okay, on both sides, behavioral health and physical healthcare.

The other comment is that, you know, if you look at some of the innovation from CMS on bundled payment care initiatives where, yes, they're talking about physical healthcare, but they're talking about big-ticket items that are very costly in physical healthcare. Their mantra is "everything a patient needs and nothing more" that drives that concept.

And if that is the concept, as we get into different payment structures where there's going to be bundled payment, your time for integration work is going to have to be part of what you're going to be doing, and it's not going to be fee-for-service that's going to drive what it is that a person does in terms of work on integration.

It seems to me that those are the concepts that are going to be the ones that are going to be operational, as we proceed down this road. But I think the simulation issue, which is used extensively in training in medical schools and residencies and after graduation, would be a model for showing people how to do it.

MS. SUZANNE FIELDS: Great. Thank you.

Was there anyone else from the CSAT discussion that wanted to offer up a comment?

DR. LORI SIMON: I just wanted to add on to Leighton about the simulation because, you know, you have integration and then, okay, what do you do with it? And there is still stigma out there amongst primary care providers and in ERs.

And so, that's another piece of it that needs to get better because -- because you can provide the information to these providers, but then what do they do with it and how do they interpret it? And so, that's still a problem that needs to be addressed. So I think the simulation would be a great way to do that.

MS. SUZANNE FIELDS: Next then I'd like to turn to the Center for Mental Health Services discussion yesterday. Paolo, who was volun-told? You were?

MR. PAOLO DEL VECCHIO: I was. I try avoid any coercion.

[Laughter.]

DR. VIJAY GANJU: So you got coerced.

MR. PAOLO DEL VECCHIO: Right. Exactly. So what I'll do is I'll kind of -- I did a little quick summary here of our discussion, and then ask our council members. We had a wonderful discussion on this, in fact, to such a degree that the council really wanted to take a deep dive into the issues looking at integration, health financing, and health reform and really offer some more in-depth analysis.

But some of the -- and similar to some of the earlier reports out, the council saw both promise and peril as we move towards integration. Certainly the promise of holistic approaches and meeting the individualized needs, person-centered approaches, as one potential there.

We also saw the importance of issues of -- look at integration and financing issues of disparities, as well as looking at issues of medical necessity and how the need for important recovery supports and address some of the social determinants of health and behavioral health as well. Certainly touched on workforce issues and the need for both training and looking at team-based approaches. Issues here are looking some of the burdens that primary care providers face.

And again, as we've discussed, there are very busy time periods in order to interact with individuals, how to address these issues. How do we make integration easy and financially stable were key factors that were identified in terms of helping to promote the adoption of integrated care approaches.

There was also discussion about how do we ensure checkups for behavioral health within primary care settings? Some of this is also a messaging issue. How do we communicate that it's okay to talk about behavioral health issues more?

We also looked at issue, the importance of cultural practices being part of integrated care approaches, costs, the drivers of cost, importance of outcomes, and as well the role of peers and peer supports within integrated care settings and developing specific things, for instance, suggestions around basic information for consumers and families on what health insurance is itself at that basic level. And other things that we can do to promote wellness, such as training peers to help monitor and address metabolic syndrome issues, to help avert early mortality and promote positive behavioral and health overall.

So I want to, at this time, invite my council members to add to this. Vijay, you're right in front of me. Would you care to start? I'll volunteer you here.

DR. VIJAY GANJU: Sure.

MS. SUZANNE FIELDS: Could you use the mike, please? Thank you.

DR. VIJAY GANJU: Well, I thought you sort of covered a lot of the major points. I think, just to elaborate, I think there was this whole issue of like the divide of language and culture and some of the priorities people have had. And I think one of the big issues that we discussed about this integration is that in some ways, as we talk about whole health, and on the mental health side, we've been talking almost about whole life. And so, as we look at different areas of home, health, community, and so on, that spectrum of sort of emphasis is very different

from what people do on the physical health side.

So there is this whole issue of how do you sort of deal with that concept of integration when you look at concepts of recovery that are very broad with things that are narrower in terms of just health, on the physical health side? And so, there was this whole issue of how do you essentially deal with sort of essentially trying to fit our language, which is sometimes a parochial sort of language that other people don't understand, into that broader health world?

And there were lots of ideas that came. I think Allen was talking about how you could sort of take concepts of recovery and move it into the health world. We talked a lot about models, and I think there were some good examples of models in terms of what had happened in Minnesota, in some other places like that.

The basic concept was that, you know, if we're really going to move this forward and try to attack this issue of language and culture, that we actually had to keep on sort of making a case for integration in terms of payoffs and sort of some of the sort of financial sort of payoffs in terms of how the cost of physical healthcare might essentially diminish if proper and adequate behavioral healthcare was provided.

And I'm just trying to remember. I thought I might have some notes. Just let me see if I've left anything else out that I can think of.

MS. SUZANNE FIELDS: It sounds like that particular theme you're raising is both about the investment and what physical health, the medical side and the behavioral health side, may reap in terms of health outcomes, which is where Paolo started, and then you're raising kind of the cost implication pieces as well?

DR. VIJAY GANJU: Yeah. I think the idea was that we actually -- you know, while I think it's a good concept and we want it, we still have to develop sort of the platform for it, and I think we talked a lot about how to essentially for integration to stick, we did have to attack like the infrastructural issues in terms of funding, the information technology, some of the other things that people have talked about and the training in the workforce and how we might even need to be looking at new models of sort of responsibility in terms of sort of care of people with mental illness.

MS. SUZANNE FIELDS: Thank you, Vijay.

Paolo, any other comments from your members? I'd like to turn --

MR. PAOLO DEL VECCHIO: Dr. Lazarus perhaps? It would be great to have his perspective.

DR. JEREMY LAZARUS: Yeah, thank you.

A couple of things come to mind that haven't been discussed. One is that we actually had a very broad discussion with different definitions about what integration really meant to those of us on the council. We talked about how some systems, like you had mentioned Lahey and partners, Southcentral Foundation up in Anchorage, and others have already developed these organically.

But these tend to be large organizations that have been in this long before we talked about integration, saw that this would be something that would be helpful. So we've got decades of separation of physical and mental and behavioral health with different value systems and different funding mechanisms that have not come together that need to come together in a better way.

We've got the new and emerging forms of healthcare delivery, as you mentioned, like the ACOs and bundled payments and other things that are, I think, for many physicians still experimental. We don't know how they're going to work. We don't know if they're going to work out. We don't know if they're going to survive.

Then you've got probably 40 to 50 percent of medical practices that are actually small medical practices that don't have the funding or capability of integrating in the way that a Lahey and partners are able to do it and are probably not going to want to move towards connecting with those organizations. And also they're in rural areas, where they don't have the capacity.

So a couple of suggestions in terms of what SAMHSA might do. It would be to recognize that integration is on a continuum from those that are sort of true believers in doing it already and doing it in an effective way and finding ways of both improving the behavioral health and physical health of the patients that they take care of, all the way to those who have not even stepped into the pond. And to recognize that you might be able to present models along that continuum about what might work.

So, for example, at the first stage, you might have to at least get people together to have a shared value system and have a shared financing system that would work. And that might need to be funded in a particular way.

So I gave, for example, the situation in Colorado where there are pilots in both the urban areas and the rural areas to try to provide stable funding so that the behavioral health and primary care can come together. I won't go into detail about the challenges, but I can tell you that they are substantial. They are substantial.

So, at the front end, how do you get people together in terms of value systems and funding?. And then, at the far end, I'm not sure what you could provide to

the Laheys and the partners that would be helpful to them. Maybe more financial incentives or pay-for-performance or quality incentives. And then all those in the middle that are believers that this would work but don't have the wherewithal to actually put it together, and what kind of models can you place in front of them that would help them to work better?

Again, I think the funding mechanisms are one of the key issues. Pam, I mentioned this to you yesterday. I mean, we had this doc fix, but it didn't allow actually a change in how we pay for Medicare, another 13-month delay. So I think we have to recognize that it's going to be in fits and starts. There are going to be challenges. We don't know exactly where it's going to go.

But I think if you could present on that continuum what might work best, what models work, what you have to have in place to make it work, and what funding mechanisms would make it work, I think could be helpful.

MS. SUZANNE FIELDS: Thank you.

I'd like to turn now, we have about 15 or so minutes, and I want to open it up to the -- all of us here in the room. We've had an opportunity to hear from our colleagues from varying perspectives and varying discussions, and we can see that there is a lot of similarity and some differences in the thoughts, the recommendations, and in the discussions.

As you all think about SAMHSA, and to go back to Pam's words earlier, we're a smaller agency within the Federal Government. We have limited dollars. They're often earmarked for particular things, in terms of our very broad mission with our limited financial resources and certainly our limited staff in terms of our size as a Federal agency.

So, as you think about the levers at SAMHSA's disposal, which is not only our own grant making, our block grant dollars, but certainly our capacity to influence discussions within Federal Government, partner with our sister agencies to influence their levers at their disposal, and as we think about the three legs of the stool, the practice elements, and I mean community practice as well, from that prevention perspective, as we think about the practice elements, the financing and delivery changes, but that broader public health goal that we've articulated, what does the larger group see as specific recommendations around those three kind of legs of the stool with the levers at our disposal? Our ability to influence, our ability to use our limited resources in certain ways. Please.

DR. LORI ASHCRAFT: Lori Ashcraft.

I think this might fall into the area of influence, but on the ground, what happens is regardless of whether you're a doctor or a nurse or a peer, is you have to keep thinking about is what I'm doing billable? And too bad that we have to do that,

but that's what the reality of how services get delivered.

So perhaps you could start thinking of what -- what does integration look like, and can it be defined as a billable service? So people do it not just because it's the right thing to do, but because they need to do it.

MS. SUZANNE FIELDS: Thank you.

DR. MARLEEN WONG: Well, this is a -- Marleen Wong from University of Southern California.

This is a complex, you know, problem for sure. But one of the things that I see is that there has to be -- if we're going to practice together, there has to be training together, and that certainly is not happening. So you can have collocation at a center, but that doesn't mean the people know how to work together.

And I think we have to back up a little bit into the graduate programs and how we're going to train together. I'm involved in one of the SBIRT grants, and even the training in that is along discipline lines. It doesn't bring the groups together, whether it's social work and medicine and psychology. They're just still in the silos. So that's just one aspect of it. I admire whatever you can do with this whole thing. It's just -- it's just a very, you know, with a lot of pieces to get.

MS. SUZANNE FIELDS: I'd say whatever we can do, but yes, thank you.

Please.

MR. GILBERTO ROMERO: Gilberto Romero.

And I would just like to -- you know, you talked about a three-legged stool, and Mr. Lazarus talked about a value system, and I think my comments are relative to that. And I see a perceived weakness. You know, you talk about holistic approach, and at one time, we were using language by bio/psycho/social. In my simple way of putting that, it's body, mind, and spirit.

One of the values of the consumer movement or a way is attain, maintain, and sustain. My perceived weakness is on the social or spiritual side. I don't know how you approach this in a secular world. I mean, we call it social, and I think that part of people's way out is shedding that untouchable syndrome, and that's the social aspect of getting better and sustaining that.

But in thinking about integration, I think about -- without dating myself or whatever, I've seen some other types of integration, and the problems have been biases and prejudice and attitudes, and no matter how good or how much money you attach to that, if people have bad attitudes, it ain't going to work.

Thank you.

MS. SUZANNE FIELDS: Thank you. Victor? Victor?

DR. VICTOR A. CAPOCCIA: Yes, okay. I was just trying to get a mike.

Thank you, Gilberto. That was bringing integration to a higher level and I think important.

I think about two functions that SAMHSA identified that you all talked about today that you can follow up on. One is communication. So here's the thought about communication. As I'm listening to each of the perspectives, one of the things that we haven't totally captured is what is the client/patient experience in going through these systems? What's the client experience in walking through and into the addiction treatment organization, the mental health organization, the community health center with multiple needs?

All right. So, so what if we did kind of the walk-through, start with the patient experience and map that, and began to tell the story of the patient with multiple health-related needs and what it is like to experience care in this setting, that setting, that setting, or didn't get to the third setting or fourth setting or lab or what have you. And I mean, I think it would be a powerful communication tool for you to begin to use to understand what the redesign is.

So that's the one function, the communication function, but really start with the patient kind of experience and walk through.

The second is your convening function. I mean, it doesn't cost you huge money. It's powerful.

MS. SUZANNE FIELDS: I'm going to laugh at that a little bit.

DR. VICTOR A. CAPOCCIA: Well, I know. You've got the -- et cetera. But relative to a grant program, it doesn't cost you big money. And you think about -- anyway, I won't --

MS. SUZANNE FIELDS: Convening dialogues?

DR. VICTOR A. CAPOCCIA: Convening relative to the discussion that we had toward the end here. If, in fact, the drivers through health reform are to create bundled or episode-based payments, then the questions about -- the questions about "how do I bill for it" become subquestions. They become less because it's going to be in a bundled experience. And so, then it's a question of how do you allocate a bundled payment?

But the point is those are the drivers, and be they rural or not, we are going to

have -- these drivers are forming more organized systems of care. And so, the question then for convening people are what are the different kinds of experiences that you can map and then have as reference points or standards for types of payment, for purchasing, for how you organize patient handoffs and flows between systems, and within systems.

And so, it's a convening function that I think you can do.

MS. SUZANNE FIELDS: Thank you, Victor.

Allen and then I know Joe also.

DR. ALLEN S. DANIELS: Allen Daniels from CMHS Advisory Council.

So I think we're on the precipice of a new age of healthcare in terms of coverage, payment, and the way delivery systems are reformed. And I think that we have a specific challenge to figure out how we bridge that integration gap.

We were talking yesterday. We have terms like SMI and SED. Healthcare just has things like cancer and diabetes. We talk about recovery. They talk about illness self-management. We actually probably have a fair amount to contribute in the notion of illness self-management by the principles we've developed around recovery because that's what helps people actually get better.

And similarly, we have peer support services. They have community health workers. And so, again, I think language is going to be a key, and you guys -- you, as SAMHSA, have an opportunity to model new ways of approaching language. And if we can't break down the language barriers, we're never going to break down the integration barriers.

MS. SUZANNE FIELDS: Right. Thank you.

Joe, did you have a comment?

MR. JOSEPH A. GARCIA: Yeah, thank you. Joe Garcia from the TTAC.

I just want to build a little bit more on what my brother from Santa Fe said, Gilberto. And it's about the holistic purview of the human being, that if I have a mental illness and I have a physical illness, I'm still the one person. And sometimes we've forgotten about that, and I think that our entire system of healthcare has been built and built without that understanding of the holistic purview of our way of life and who we are.

And unless we go back and relearn some of the teachings that we've been taught about what a system looks like, it is that broken-down system that separates. It's a segregation, if you will, and we continue to do that. And unless

we begin to converge with a systematic and systemic way of approaching that, that includes relearning a lot of stuff that we've learned. That includes a bunch of people in this room.

And the people that are outside of here, the ones that are the real service providers back home, the people on the floor, they provide the services, but their teachings have also been somewhat segregated in what they've learned, and it happens in school. And so, I think that that's why we mentioned that. We didn't dwell on it, but the education process of this country and the technical services that is provided to the individuals in need needs to also be reflected.

And I think unless you address that piece of it, then we'll segregate, then we'll integrate, then the teaching will continue to segregate. And so, it's going to be a ping-pong approach, you know? Let's do it. Let's not do it. Let's do it. Let's not do it.

And so, all of the other things that are pieces to that is the funding cycles, the grant language, all of that information is in that mode, and I think we've all got to work at it together, and so we'll do what we can to make it work. And I think the fact that everybody is here today is a good indicator for one small group to have major impact on the bigger.

So think of it as a holistic approach. Thank you.

MS. SUZANNE FIELDS: Great. Thank you, Joe.

I'd like to do a check-in. There are about a dozen hands up yet in the room, and this discussion is to end at around -- we were thinking around 11:00 a.m. to give you about a 15-minute break before the next session. So we want to turn to you in terms of how you want to best use this time. This wasn't intended to be the only conversation with you about this. We don't have to cram it all into today.

But would you all like to continue to wrap up in another 5 minutes and just take one or two more comments, or would you all like to forego a break? So those who want to forego a break, raise your hand.

[No response.]

MS. SUZANNE FIELDS: Okay. So we've got clarity.

[Laughter.]

MS. SUZANNE FIELDS: What I will say, I'd like to take just one more comment, and then spend the time talking about next steps because we only have time for one more comment. I know Henry has had his hand up for quite some time.

DR. HENRY CHUNG: Hi. Henry Chung from New York.

I have several thoughts, and I think this has been just tremendously enriching. I'd like to focus in on a couple of areas.

In the public health space, I think that SAMHSA has a powerful role in terms of allying yourselves with the other agencies that develop the public health national messages. We get a lot of messages about the benefits of exercise, for example, for cardiovascular disease and hypertension. My experience in the community has led me to believe that we need to anchor these behavioral health messages together with the whole health message, that that's really what's more powerful in terms of lowering stigma for a lot of our populations in the community.

So you can have your separate messages about the importance of emotional well-being, but you also need to integrate that in terms of the benefits so that exercise is not just simply seen as a benefit for physical illnesses and physical health, but also for the mental health side. So I think SAMHSA has a key role there.

On the issue of electronic medical records, this is a critical, critical issue because it goes into two aspects that I think that will drive the future integration. One is the notion that our measures in standard EMRs do not capture the greatest risk factors for behavioral health. So issues about homelessness and social support, these are not data elements that are gathered in electronic medical records. But you need to gather them in order to adjust for quality and to look at quality measurement.

And quality measurement is going to have a big impact in terms of risk adjustment for cost and payment. So in the era of bundled payments, which are not going to go away, they are not going to fail. In the era of ACOs, these accountable mechanisms are not going to fail. The issue around risk adjustment is totally key. So I would say that a big focus on SAMHSA on electronic medical records and these data elements is totally important.

And third is I think you need to think about disruptive technologies. We've been talking about integration in a very I would say people-intensive way. That is not the future of integration because of the challenges of what we see in the rural communities and also the challenges of what we see even in urban communities like Bronx, New York. You do need to think about what those disruptive technologies are and find ways of scaling those technologies as quickly as possible.

Those are some of my comments. Thank you.

MS. SUZANNE FIELDS: For those in the room, folks in the room may not know

what is meant by "disruptive technologies." Would you like to just offer a --

DR. HENRY CHUNG: I think disruptive is just a word for saying that these approaches perhaps get us outside of our normal way of thinking about disciplined training and the way we bill for services and, I think, puts it back in the hands of consumers where they can decide what level of integration they want.

I would just add one more thing. I just had a whole free-flowing thing. In terms of the consumer experience, another powerful thing that you should consider is working with the folks who developed the consumer assessment health surveys. If you really want to attack this, those questions are completely devoid of behavioral health experience, and yet they are so core to the performance of primary care physicians and systems right now.

So if you could include one or two test questions, which I know the CAP's folks are always interested in, and say here is an example of what we want to include. Has the primary care provider asked about your emotional needs in the past year? Or something like that. And you develop something that could be very powerful in changing the landscape of how systems think about the consumer experience in this way.

MS. SUZANNE FIELDS: I do want to turn now to -- thank you very much for those details.

I want to thank all of you for the richness of the discussion and just the tremendous smart thoughts that came from today, and we're sorry that we couldn't get to everybody. I know that there's many more comments, and I would encourage you to feel free to be in touch with me, with one of the center directors, Kana, and, of course, Pam about any additional thoughts you have.

So thank you all for that.

In terms of next steps, we are going to have some summary of this at the meeting tomorrow, and then we will be taking back this discussion as a leadership team to be thinking through the opportunities that your thinking provides us. So we very much thank you for the discussion.

Pam, anything else you'd like to add?

MS. PAMELA S. HYDE: Only also to add my thanks, and I could tell that the people who had their hands up, you're just now getting your brain going on this. So please take up Suzanne, and giving her a call, sending her an email, or your center director that you work with on the center advisory committee/council.

And if anybody is willing and interested in sitting in tomorrow, the NAC always does a debrief. The national council that meets tomorrow morning always does

a debrief of these big conversations. So if you're around and would like to come and listen to that, please do. It will be back over at the other building.

So, great. We're going to give you guys a break, but we really want to hold it to 10 minutes because the youth have been doing all kinds of work about telling us about youth involvement, and we'd like to make sure we get started right at 11:15 a.m. by that clock over there.

Three clocks are at three different times. So we're going by that clock on the far right.

[Break.]

MS. PAMELA S. HYDE: So can I get the panel up here? Matt?

So let's all get our seats so we can participate and listen to this next panel, and we're going to be led here or the staff person who's going to help get this started is Matthew Aumen. He works with the CSAP Advisory Council and has been working with these young people to prepare this presentation and discussion today.

So, Matt, come on over here.

[Pause.]

Agenda Item: Report Out – SAMHSA Youth and Young Adult National Advisory Councils/Committees

MR. MATTHEW AUMEN: All right, folks. You have to give me a second to collect myself and my bearings.

MS. PAMELA S. HYDE: A little louder, Matthew, I think.

MR. MATTHEW AUMEN: Gotcha. Is this on?

Okay. So for this session, we have about 45 minutes. We have six young adult members of our various national advisory councils here. We have two who were not able to be here today. I think Megan will be here later, and then Khiree Smith is also not here today.

But I can go through their Cliff's Notes version of their bios real quick and then go from there. Actually, I'll wait a second on that. But with the young adult members, what we really wanted to do is address issues that are important to them and germane to them with the council. What the members had decided on

for this session is to discuss the Leading Change 2.0 document, the new SAMHSA strategic initiatives, leading forward. And they will give or they will go through and answer some questions on their perspectives of what SAMHSA can do with its strategic initiatives.

So really the purpose of the session is really to begin a conversation with the youth/young adults on issues as they relate to the work of SAMHSA. One of the desired outcomes for today is, you know, after today's discussion really keep that momentum going of engaging our young adults and youth. There is a possibility to explore opportunities that really continue to engage our young adult members of the various councils.

So SAMHSA currently is engaged in a number of youth initiatives and topic areas. Some of the members, through some pre-meeting discussions, identified some areas that are of high interest to them. Some of those include youth peer support, bullying and suicide awareness, addressing the relevance of adult-focused programming on the youth audience, youth mental health first aid, as well as a whole health perspective on wellness.

The format for today, again, we have four of our young adult members present. I'll have three questions that I want to ask the council members to respond to about the Leading Change 2.0 that members, they will react to based on their perspectives. I want to do about 10 minutes per question, you know, 2 to 3 responses, really depending on the time available, and we'll try to leave about 10 minutes or so for questions and to talk about next steps.

So I'll real quick go through the bios, and then we'll get started with the questions. That way, you have an idea of who the folks are here on the panel. I'll again go through the Cliff's Notes version. You should have the bios in the available materials.

So we have Terrance -- well, I'll go through each one from the end. So, Johanna, national board member of the Youth MOVE from Decorah, Iowa, and she's on the ACWS council. Ms. Bergan is a youth advocate and a voice for young people involved in various systems with special focus on mental health system. Consumer experience as a young adult and young mother allowed her to see the need for positive change, and through her work as a board and past chair of Youth MOVE -- which is motivating others through voices of experience -- National Incorporated, Ms. Bergan has found that the most effective change stems from conversation and dialogue with individuals with lived experience.

We have Terrance, now second, Oakland, California, University of California-Berkeley. As a conduct specialist in the Office of Student Conduct, Mr. Range communicates, enforces, and interprets the university's conduct policies for the academic and nonacademic departments. He assists the University Health Services Center in triaging student mental health concerns and developing

institutional policies that minimize behavioral health risks among undergraduate and graduate students.

Charles Olson from Parkers Prairie, Minnesota. Mr. Olson has been a mental health advocate since his youth. He struggled with mental health challenges beginning in elementary school, and at age 16, Mr. Olson was the youngest person to be appointed to the Children's Subcommittee of the Minnesota Mental Health State Advisory Council. As part of his duty as a Children's Subcommittee member, he helped create and advertise a statewide communication tool for local advisory councils, assisted LACs with implementing best practices, and attended conferences, workgroups and other committees to assist in action planning.

And finally, we have Lacy Kendrick Burk from Hattiesburg, Mississippi, and Ms. Burk has worked with youth and adults around issues concerning youth engagement and served as the lead for the National Youth in Transition Database, a project with the Administration in Families Children's Bureau. She has served on several boards addressing adoption and foster care issues, including the Missouri State Youth Advisory Board, the ABA Bar Empowerment Project National Advisory Board, and the Multicultural Advisory Committee for the National Child Welfare Resource Center for Adoption.

And so, that was my way of trying to, as quickly as possible, give you a little bit of background of the folks we have on the panel, and now we'll get started with the questions we have.

So for the panel members, from the perspective of the young adult voice and the interests, I do want to ask what you think has been done well in the proposed Leading Change document?

So, Lacy, I'm going to point to you and ask you if you have -- if you'd like to lead off with a response?

MS. LACY KENDRICK BURK: Sure. Thank you. I might have to actually -- I'm going to have to do this. People say they can't hear me well.

Well, thank you for the introductions, and first of all, I get to talk about what you guys have done well as far as SAMHSA goes. Really excited about that. There are so many things. So I'm not going to mention everything, obviously. But you know, one of the first things I want to point out is that you have a youth panel here at your National Advisory Joint Council meeting. I think that's huge.

And from what I understand, this is one of the first times that youth have been engaged at this level at this stage of development for your strategic initiatives. So I say, first, huge, huge, huge step, and I'm really appreciative to be here and represent that voice.

I think the second thing I do want to kind of mention in light of recent criticism and really fun stuff that you guys get to respond to from the Wall Street Journal is that, you know, your document is called Leading Change, and as part of leadership, you know, part of leadership is engaging criticism and is really pushing the status quo and pushing us beyond where we are.

And so, I think that if you didn't have criticisms and you didn't have critics out there, I think that you wouldn't be doing your job regarding innovation and moving things forward. So I just want to say that I think that that's indicative that you truly are leading change and look forward to supporting the response to that article.

And so, then really specifically with the strategic initiatives, some of the things that I wanted to touch on that I think are really exactly where they need to be, one, overall the different categories that you have as far as the strategic initiatives, I think that they are right on point as far as what young people are needing now to be able to support our development of our wellness and our behavioral health needs. And especially specific to recovery, integration and workforce development are the three things that I have noticed.

I went through the whole document, and recovery, really everything in there, you know, it's just been going really well, and I'm really looking forward to seeing that continue. Youth have been engaged in that process fairly well, and so I actually didn't have a lot of recommendations on how to further engage youth because I think that just continuing your practice that you've been doing is really helpful. Really looking forward to how that plays out, too, in the next 4 or 5 years.

Integration is another piece. I think that the conversation is awesome. I've shared a little bit about that I'm actually involved with an integrative healthcare center, and I think that that direction is a huge step in the right direction. We, as young people, often have barriers in access to services, and I think an integrative approach would be helpful to some of those barriers, really specifically logistics and getting to appointments and finding doctors' appointments and navigating the healthcare system and navigating insurance.

And a lot of that stress is alleviated or reduced by having one place to go that can talk to you about your whole person and your whole health. And then really talking about with workforce development, including whole health peer support, you know, in that conversation, and bringing integrative health and peer support together I think is going to be really huge and really helpful to young people. I know myself included.

So, overall, those are some of the really positive things that I've seen. And then really specifically, they may or may not be explicitly in this document, but I do know that SAMHSA is supporting the development of a youth-guided guidelines,

if you will, on how to engage young people and the way that SAMHSA engages young people. And I think that supporting that conversation, supporting the development of those guidelines and really working to be a leader on practicing those guidelines and setting that example I think is a huge step, and it is definitely showing leadership in the way that we want to engage young people across the country in the work that we all do.

And obviously, the HTI initiative, having that open and being supportive of that. If you haven't heard much about that, there's a lot of stuff coming out now with issue papers and different lessons learned from this. And there has been some amazing work in States, especially with regard to the transition from child-serving systems to adult mental health systems, and some of the policy changes that have occurred and practices that have changed because of this initiative. And so, the fact that we are expanding that is really great.

And then I think that is all. I think I'm going to pass now to Terrance or to the second question.

MR. MATTHEW AUMEN: Sure. Terrance, if I can repeat the question for you, if you wouldn't mind chiming in here? So what do you think has been done well in the proposed Leading Change document?

MR. TERRANCE A. RANGE: Thank you.

Good morning, everyone. Good morning. My body is running off, what is it, 8:00 a.m. back in California. So I'm feeling it right now, but I'll be good.

You know, I read the document in depth, and I conducted a thorough read. And in my day-to-day work, as Matthew mentioned, I'm a conduct specialist. And so, for many folks in brief and very simply, that means that I work with the police and the chancellor, okay?

So when students enter into my office and in my space, we have accountability conversations at the intersection of oftentimes substance abuse. And I think the important point about the document when I read it was that you all highlighted very quickly and very immediately the prevention around substance abuse and alcohol use among young adults and youth.

There was an article in The Atlantic in the recent issue where they talked about fraternities on college campuses, and for many of you in academia who are affiliated with fraternities and sororities, that's probably been in the past several months one of my biggest thorns in my side, specifically as it relates to the office, for two important reasons. One, and we all see this in the President's message around Title IX legislation and sexual assault and rape, but the second in terms of alcohol consumption among undergraduate students, particularly freshmen on large 4-year public and private campuses.

When a fraternity is called into my office, we typically have a very candid conversation about what has occurred. And every conversation and dialogue, they always talk about serving alcohol. And what I'm finding from preliminary anecdotal kind of feel in terms of our campus is that fraternity men, at large, are serving alcohol at the fraternity house as a way to engage in conversation and have dialogue with folks that are attending.

Obviously, for me, as I wear my risk management hat, that's problematic, okay? And so, being here and actually reading the document and seeing that SAMHSA and the specific committee that I serve on, CSAT, and many of you all in the room have made a specific commitment to prevent alcohol use and abuse among youth and young adults makes me feel very comfortable. And I'm excited to see that change, and I'm hoping that we can do more in terms of policy and practice as pushing that message forward and making it relevant for students and undergraduate students particularly.

And the last piece that I'll mention here is that before I worked in conduct, I worked in orientation and admissions, and so I would always recruit. And so, part of my job was going on the road and convincing people in Palo Alto and in Boston why they shouldn't go to Stanford and Harvard and, in fact, come to Berkeley, okay? And I think my yield numbers are pretty good. But anyway.

[Laughter.]

MR. TERRANCE A. RANGE: Part of my job and role within that scope was engaging young people. What I found was that in order to engage youth and young people specifically as we communicate, it's important that you offer a carrot. What's the value, okay, to augment their college experience? But historically, we know that the sociology around going to college, you kind of assimilate it with drinking culture.

And so, for us, I think we have to be very innovative and in many ways controversial in how we press the issue and articulate the benefits of college separate from alcohol consumption. And the last, I promise, the last piece that I offer for students that are in my office is that my role isn't to necessarily discourage you from consuming alcohol. I'm just asking you to be a responsible consumer if you're of age.

MR. MATTHEW AUMEN: All right. Excellent comments. Does anyone else want to chime in on this one? We have a few minutes.

[No response.]

MR. MATTHEW AUMEN: Okay. Hearing no response, we will go to number two. And what opportunities would you identify to strengthen the Leading

Change from the youth or young adult perspective?

Now, Charlie, would you want to start off with that one?

MR. CHARLES OLSON: Yes, I can. So I'm just going to start by saying these two got the lucky job of saying what you guys are good at, and I do want to be strength-based and --

[Laughter.]

MR. CHARLES OLSON: I do want to be strength-based and say that I am really -- since I've been on this council, I've been really excited to see how many -- how many youth-involved things that there are. I had no idea that there was this many nationwide, and certainly in the State, in Minnesota, there is not very many. So I was very excited to see how much youth are involved.

I guess I want to start kind of with an overall -- an overall tip and a reminder was that in this document and through every stage of developing an idea or developing a project, there is questions all the way through. And you have to ask yourself, you know, how can we tweak or how can we modify every part of it so that it can serve youth better, and how can youth be more involved?

And you know, you find a lot of programs that serve youth, but there is a growing number, but not a lot right now that actively engage youth and get them involved. And I think it's the same question that you have to ask regarding minorities. How can we create a program that better serves minorities, and how can we create that better involves minorities? And so, it's the same question. You just have to keep that in mind through every single part of it.

As far as I don't know if you wanted me to point out certain parts of the document? The one concern that I had was in -- does everyone have this document, do you know?

MR. MATTHEW AUMEN: The members do, and we can talk about it broadly.

MR. CHARLES OLSON: Okay. I guess that's what I would start with is just making sure that there is wherever youth are, you know, in the schools, in the community, make sure that they're being engaged. And I did notice a few particular goals that could be tweaked or modified to better include them.

MR. MATTHEW AUMEN: Okay. And Pam, do you have a comment on specifically referencing specific goals in the document?

MS. PAMELA S. HYDE: At some point, we would like that, but you need -- just use your time the best you want, and Charlie, clearly, we'd like to hear those specifics at the right time. So, yeah.

MR. CHARLES OLSON: And being that the other person that was supposed to help with my question isn't here, I think that Johanna and I did talk about kind of sharing this question. So if it's all right, I'll pass that on to her now.

MR. MATTHEW AUMEN: Okay. Great. And our follow-up question, I think, will perhaps address some of what you're talking about with perhaps examples of modifying some of the SIs. So it should be interesting for the next question. But, Johanna?

MS. JOHANNA BERGAN: Sure. Again, thank you for this opportunity.

One slight update to my bio, which I keep forgetting to submit, I now serve as the Director of Member Services for our chapter network with Youth MOVE National. So I work with 70 youth organizations across the country, all of which focus on infusing youth voice into creating positive change within our social systems.

I feel kind of like Charlie. It looked good when Matthew said, oh, you can take question two. But then I color coded my document, and purple was positive, and there was a whole lot of purple.

So while I'm not going to share that with you today, the overarching feeling of Leading Change 2.0 was -- felt really good compared to past conversations that really I understood and had a lot of buy-in with where the strategic direction is going.

I have two sort of overarching themes where I see opportunity to infuse both youth voice, as Charlie is saying, and also a concrete focus, and maybe that involves adding the specific language of youth and young adults throughout the document. And one of them Administrator Hyde was kind enough to explain on our briefing call that the data and the communication work of SAMHSA, while not highlighted as a strategic initiative, is now infused throughout the organization's work.

So I wanted to take just a moment to acknowledge that and emphasize that the importance of our community conversation about how young people are perceived when they experience a substance abuse disorder or a mental health challenge is very important. How do we create a national community that we can talk about it and feel safe about talking about it, we can feel safe accessing services and accepting services when they are offered?

There is -- I'm hearing as language in the science of changing social norms. That was exciting. I've heard lots of work about the community conversations directed by President Obama, and that is all exciting.

Not a good or a bad vote for this, there are a couple of interesting conversations

bubbling in the social media network. One is Ban Bossy, which is supported by the Girl Scout Initiative, to help young girls access their leadership skills without being labeled bossy. There are some positives and, you know, two sides of that argument is that's a good initiative, and then there's an initiative to help fathers stop saying "be a man" to our young boys.

And I think that these are two interesting conversations that are happening, and my question is, is where is the behavioral health impact of these conversations? And can we be a part of these conversations that are talking about addressing our society's traditional norms from a behavioral health lens?

The second overarching theme that I wanted to address is that of recovery, and I was all purple in the strategic initiative of recovery. And so, it is supportive. What I want to say is that youth and young adults are infinitely hopeful, and as you continue to provide services, create policies for us, keep in mind that we are whole beings and we, in our day-to-day life, have to address our mental health challenges.

We have to take care of our physical health, our spiritual health, and our social life. And if you can always hold us as whole beings, the recovery conversation is much easier, and we'll move forward in a positive light.

And I am a part of the ACWS. We had an excellent conversation about wellness yesterday, and just to reiterate, a thankful message to SAMHSA, your ability to stand out and to identify wellness, and I'm particularly fond of the Wellness Wheel. Just by being the communication leader that you are, you make it easier on the groundwork, on the ground level to share the conversation of whole wellness, and that is very important to the young adults that I work with.

Super quickly, three sort of specific opportunities that I see the document could be addressed. I echo everything Terrance said. My personal story doesn't need to be shared, but if we could talk about binge drinking on college campuses and high school, particularly of young women and why we end up pregnant and alone, that is vital.

Second, if I can find my notes, the section on trauma is important. My question and thought to you is do young adults know what trauma is? And most of us do not. So if you help us understand what trauma is, then we can identify that we have been traumatized, and then you can help us find out how that's affecting the rest of our lives. Does that make sense? Language matters.

And third, finally, as we talk about integrated health homes, yes, I want one. I want one for my kids. What do they look like for youth? And what do they look like from the youth perspective? And I would imagine that that answer might be a little different if you ask a practitioner versus you ask a young adult, and maybe specifically pulling out some specific populations. What do health homes look

like for our LGBT community? What do health homes look like for those of us who are trauma survivors?

They are different, and it's not one answer fits all. So three specifics, and I'll get into more in question three.

Thank you.

MR. CHARLES OLSON: I would like to quickly add onto that. Whether or not we're brought into the conversation, I mean, even though youth are not actively involved to the degree that they should be yet, I guarantee you that we are having the discussions on our own.

I can see in social media. I mean, we're talking about world issues. We're talking about depression. We're talking about suicide. We're talking about, you know, the rape culture. All these hot topics right now. Whether or you ask us our opinion, we're having that conversation amongst ourselves.

And I lost my best friend to suicide 4 1/2 years ago, and the biggest mistake I made was not seeking therapy, not seeking support. And it's very easy when a person is traumatized to think sideways, and I remember -- I remember the point where I thought it was okay to commit suicide. I was surprised that more people didn't do it.

And so, I mean, we're having that conversation. We are dealing with those things, and I'd really encourage you guys to seek the youth out and actively engage them.

MR. MATTHEW AUMEN: Great comments from folks, and if we have time at the end, I'd certainly like to go back to some of these thoughts and get the councils or the -- or particular SAMHSA staff opinion on these. But we'll right now to go question number three, which is if you have an example of something, you know, whether it be one of the goals or objectives in the Leading Change document that could be better reflective of the youth or the young adult voice, what would that be?

And I'll open it up to Lacy to start, if you'd like to?

MS. LACY KENDRICK BURK: Sure. So we do talk about, you know, some themes and some less specific items in the strategic initiatives. Something really specific that is an amazing example of SAMHSA engaging young people and promoting youth voice especially within the national dialogue that we've been involved with are some of the major initiatives and campaigns that SAMHSA has embarked on, especially around Children's Mental Health Awareness Day and Recovery Month and all of the events and press briefings and sort of things that go along with those.

I know that they're not again explicitly listed here, but there's a lot that SAMHSA does that, you know, if they listed every item that they did in this strategic initiative document, it would be very, very, very long, and we would run out of purple marker to be using on it.

So, so really specifically, you know, engaging young people appropriately and through their partners and through vanguard and then through fellow peers who have experience in sharing their story in a public setting to help change the way that people think about young adults with mental health challenges and behavioral health challenges. And so, that's very specific things that they have been doing and that I imagine that they would continue to do because they have just gone so well, and they are doing that again this year.

And so, and really engaging young people in the development of these conversations. I know the texts talk at initiative and creating community solutions, and those are very specific examples of how young people have been engaged and have been engaged well. And that youth culture has been infused through those campaigns in using media that's familiar with youth and offering sort of an anonymous opportunity to share our voice, if we so want it.

So those are really specific things that have gone well, and I just really quickly want to touch on a couple of really specific things that I think that we could really do a lot more work in for the next few years. I know the Now is the Time initiative has allotted, what is it, $15 million for mental health first aid across the country. While I think that's great, and I think it gets to some end that we want it to, I think that there are some things that need to be really looked at closely and identified.

You know, there is some evidence base around mental health first aid, and primarily studies done in Australia have shown what it does and what it doesn't do. But I think that we need to look really closely at it. And one thing that I know that it does not do is, you know, we talk about youth mental health first aid, and I think that the message needs to be really clear that that is for adults. It's a training for adults to support young people in identifying and recognizing symptoms of behavioral health and then referring them to resources.

There is no training that's mental health first aid that is developed by youth, and there is none that is for youth to be trained. And so, I think that's a huge, huge opportunity for like Charles said, we are talking about it. We are posting about it on Facebook when we are having suicidal thoughts, and people see that, and they are not responding to it. Or they're saying "keep your stuff off of Facebook" or "this isn't appropriate."

Youth are the first people to see these signs. They're the first people to see these symptoms. They're the first people to have conversations with youth in schools and in communities around what's happening, and what does that

conversation look like? It depends. Sometimes it's bullying. A lot of times it's bullying, and it doesn't help the situation. It makes it worse, and the youth ends up attempting or completing suicide.

And so, that is a huge, huge opportunity for SAMHSA to take initiative to help young people develop a training and a way to have those conversations with other young people in a way that is supportive, is identifying those accurately, and is referring them to the appropriate resources.

I also want to say, you know, evidence-based practice around youth peer support is a huge thing, huge opportunity that we can take, you know, especially with the peer support movement now, and really specifically, there are some unique needs and things that youth have around peer support. And so, just keeping that in mind that it's not -- you know, we can include it in the larger sense of peer support with consumers and family and all that, but that youth do have some unique needs and supports needed around that area.

So just to keep that in mind as we move forward.

MR. MATTHEW AUMEN: Great. Excellent comments.

Johanna, would you mind sharing with us?

MS. JOHANNA BERGAN: Okay. Promise we did not plan this. It just happened when we saw each other's notes.

So two examples that I have from the strategic initiative about how we can better engage young people and serve young people. The first is in regards to suicide prevention. How do we train young people to support their peers when they're showing signs of an attempted suicide?

I've taken the mental health first aid training for those of us that support young people. It's okay. I didn't turn around and invite my 16-year-old neighbor to take it the next day because I didn't think she was going to receive it in the way that I was ready to receive it. I'm a QPR-certified trainer, which is emotional CPR.

When I provide that to a group of young adults who are 22, it is a very different training than when I offer it to a group of adults. And I feel like I've been lucky to have a couple of good trainings. They worked out really well, but that's because I was pretty close in age to those that I was teaching, not because the content had been developed specifically for young adults to receive and hear.

And so, if we can build our natural support systems, which is our peers in school, in the community, and help them identify when their peers are at risk, I just -- I can't encourage that to happen more. And I'm not sure if SAMHSA does that through a grant program or through talking about it or, you know? But there is

some potential.

And then the second is that I loved that I saw workforce development not only in the section workforce development, but also in the recovery support section. And I did a lot of arrow drawing, connecting the potential of or the need for employment or a vocational purpose, be that volunteer or what not, in our journey to recovery. And I am not alone in saying that my ability to turn around and help other young people is vital to my day-to-day maintenance of recovery.

If I'm not helping my peers and helping the people that are younger than me, I am not helping myself. And so, could we connect and combine this synergy of needing to provide vocations for those of us with lived experience in recovery and connect that with the need to increase our behavioral health workplace? And I just see a lot of hope for an integrated healthcare system where we get treated by people who have lived experience and understand us in a way that others cannot.

So thank you, Lacy, for letting me copycat you, but we had identified very similar examples.

MR. MATTHEW AUMEN: Great. Thank you for your comments.

And we do have about 7 or 8 minutes left. So what I'd like to do real quickly is go back to a few of the comments that the panelists made and get some response from the council members and key SAMHSA staff who may be here who may want to address a few of these. Again, very quickly and then talk about possible next steps for the -- for the councils.

So one comment that came to mind, I believe it was Johanna talking about with question number two and opportunities to strengthen the Leading Change from the youth or young adult perspective using social media. Is that -- is there any council members who would like to respond to that? Or if, Johanna, you want to give a little bit background for the other folks in the room to respond to?

Johanna, do you want to start real quick, and then I'll --

MS. JOHANNA BERGAN: Sure. So the opportunity to engage young adults via social media?

MR. MATTHEW AUMEN: Right.

MS. JOHANNA BERGAN: Sure. Well, that's where we are everyday. We wake up in the morning. We check our phones. I didn't realize I did that until I led a panel of young adults, and we were talking about how social media could help us. And they're like, well, I don't know, it's the first thing I do in the day. It'd be great if there was like something happy to check instead of last night's berating

bad pictures of Instagram, whatever we were doing.

And so, so just the idea to understand that young people wake up. They look at their phone. It's their first social interaction. We're accessing our resources on mobile devices and tablets. So it needs to be short and simple.

We don't like to log into things. Apps are the way to go because they have push notifications because we'd never remember to log into anything. And -- and we like to be part of the conversation, right? So, Lacy and Charles, I think you both mentioned that.

Social media gives us a really great way to tap into a conversation. All we have to do is search the hashtag, and there we are and there we meet people. And all of a sudden, you're in a conversation about how to prevent or how to help media understand how to respond after a young person commits suicide. And you're like, wow, it's Tuesday morning. I am feeling sort of productive.

That is it's so organic and natural to us, and so just think about it as a really big potential.

MR. MATTHEW AUMEN: Do any of the council members here see an opportunity to engage with SAMHSA on using social media? I can't see names. So --

DR. LORI SIMON: Lori, yeah. I was just wondering, and it may already exist, whether there could be some kind of an app or some entity on Facebook that if somebody -- if you're on Facebook and you see a friend or somebody who's talking about suicidality, that you could very easily, you know, engage either something on Facebook or an app.

Now the app would have to have people behind it. It would be a first, you know, an easy way to enter into that where somebody who, a person or people are looking at that can then start engaging and -- you know, and either help you or help the person who you're concerned about.

MS. JOHANNA BERGAN: Really briefly, Facebook and Google both have -- monitor all of their sites and have policies in place about how to react when a post is tagged potentially suicidal. So it's really easy for any user to report on Facebook a post like that, and there is a policy behind that.

And similar with Google searches. So if you search things that are tagged or flagged as potentially suicidal, Google first offers you the Lifeline prevention number to get help. So those are things -- those are almost more impactful than kind of what we do peer-to-peer wise.

But I manage the social media for Youth MOVE, and we've had some

conversations about so when are the most suicides attempted? So those are the days that we post our resources. When do young people feel the most depressed? Sunday night when the week starts over. So that's when we post our resources.

Thinking really strategically about how to have those resources all over Facebook and Twitter so they're in everyone's news feed, and they're easy to share. You can't share those messages enough.

DR. LORI ASHCRAFT: Right.

MR. MATTHEW AUMEN: Next?

MS. PAMELA S. HYDE: Matthew, do you know the names well enough to call people?

MR. MATTHEW AUMEN: I don't. I don't.

MS. PAMELA S. HYDE: I saw Henry's hand up here, but he is declining. Pat? And then over here.

MR. PATRICK A. RISSER: Okay. My wife used to have a sewing program that she ran out of our house, and I learned that few years ago, as she was helping teach kids that she told me, "Don't ever be alone with these youngsters." And I said, "Why not?" I mean, I didn't know any better because I'm not a dirty old man. My head doesn't even think like that.

But when you're talking about interacting in the social media, now I've been trained that my head automatically goes to how do I not get labeled a stalker, a pedophile, a dirty old man, whatever. I would really appreciate hearing from our young folks.

You say you want us to engage with you, involve you in the discussions, communicate, and I'm wanting to know how do I do that without somehow, you know, getting the prejudice of discrimination coming my direction?

MR. TERRANCE A. RANGE: Yeah, I can answer that. I got the answer. Young people don't respond to "Don't do this." Do not do that. You're going to lose people. You're going to lose them. They want more affirmative things and suggestions, quite frankly.

And so, I think, as we think about social media, we also have to understand and remember that people are creating alternate identities online. And so, the young person you might interact with in the clinic, on campus, in the street, in the neighborhood, in the home next door may be a very different individual online, as evidenced by their profile picture and friends that they may have or associate

with.

And so, you know, if think about Twitter, I think it's, what, 140 characters? That's kind of all you got. And so, as you're sifting through the news feed and the Twitter feeds, I think becoming familiar with the language. I think Johanna said it perfectly. Keep the message simple, succinct, and relevant.

And if you really want to get a sense of relevancy, I'd just encourage you to log onto Twitter right now. In fact, my Twitter feed is going off of my iPad, and so I'm monitoring kind of the activity in space and what's going on in social media among young people. And even for me as an administrator, I'm somewhat removed from the undergraduate experience, yet I find a way to connect with students because I make it relevant.

And so, I have to kind of, you know, go into a space of popular cultures where we're talking about Beyonce, Jay-Z. You know, we're talking about drinking culture within popular music. I have to kind of be up to speed on what's going on in the fraternity houses. I kind of have to be out in the mix, you know, in the community, on the plaza handing out flyers and materials getting us into what's going on.

In fact, some days I dress up in a hoodie and jeans just to blend in, you know, so that I can get a sense of the community because you don't want to be so estranged or so disconnected that you lose the students. And they pick up on that very quickly because youth and young adults are very intelligent. And I think if you don't catch or grasp their attention in the first 5 to 10 seconds, it will be very hard to get it back.

And so, as you begin to familiarize yourself with the Twittersphere and things that are going on social media, I encourage you just to log on to a news feed. If you have younger relatives that you're affiliated with, just ask them to log on for you and just look at their news feed, look at their language, look at what folks are checking their status update about.

In fact, you know, there's recent data out of the University of Arizona that suggests about 40 to 45 percent of young people actually use social media for all their news. They're not watching CNN. They're not watching Fox. They're actually logging on Facebook and finding out what's going on today, and they're hearing about the earthquake or protest or riots or, you know, things that are happening outside of our country using social media.

So it's a very powerful platform, and I encourage everyone to use it.

MS. PAMELA S. HYDE: Let's take one more question, if that's okay, Matthew, and then because we're --

MR. MATTHEW AUMEN: I certainly want to be respectful of everyone's time. I want to talk about next steps.

MS. PAMELA S. HYDE: Oh, okay. All right.

MR. MATTHEW AUMEN: So do you want to do that question?

MS. PAMELA S. HYDE: Yeah, let's do this because I saw your hand up. Let's do this question, and then you go to next steps.

MR. JEREMIAH D. SIMMONS: This is a great conversation. I used to manage a GLS grant. It was a tribal grant, and it was housed within a K through 12 complex on a tribal reservation. And you know, I think inadvertently because we were so isolated and some of the housing communities are kind of geographically separated from each other and lack of access to transportation, you know, it made it difficult to go and try and visit or see one another.

So they ended up using Facebook a lot, and actually MySpace. They used MySpace a lot, which most people don't even talk about now anymore. Yeah. But anyway, but now they end up using Facebook a lot.

And so, I remember when I was working at the schools and we were working with this grant, you know? The school policy said that any school officials couldn't get on the Facebook. They couldn't check it because we were also still wondering, well, you know, how are we going to be able to check in on young people to see what their thoughts are, to see how they're talking and communicating about issues of depression, suicide, bullying?

So it took some effort because we were a BIE school, Bureau of Indian Education school. So we had to call, get special permissions to allow us to gain access to Facebook sites. And so, basically, what I'm trying to say is that if you can kind of work with some of the -- work with the administrators in schools that create the policies that make it okay to have access to Facebook and who can be designated to check it, I think that's really great.

But the initial approach always seems punitive, especially if adults are viewing the pages of young people, you know? They can't believe what they're doing, what they're writing, how they're expressing themselves. And you know, I mean, if you're going to try and shape it from -- approach it from kind of shaping behavior type end, you know, kind of working and accepting the language and what you're seeing on there, but working from there.

Sometimes you'll see youth who are great at expressing themselves in a written format versus verbally, and that's fantastic to encourage because you can work from that. But the policy end for us that made -- that made it able for us to do a lot of postvention efforts actually through Facebook was really great.

We did early identification work through Facebook, and that's how we were able to really identify the young people who were desperately in need and who were actually posting up, you know, actual intent of trying to take their own lives. But it was hard for the adults to adopt in the community.

I mean, it's embracing new technology, and that's really tough. Plus, most people didn't have smartphones, and so it was all computer-based. So, yeah, it's tough work.

MR. MATTHEW AUMEN: Okay. Great comment.

So I just want to finish off quickly with talking about next steps. I think as we have heard from the presentations of our young adult members of the councils, there is so much to talk about, and there is opportunities to follow up on this. And I want to ask the panel what you think may be appropriate next steps?

MS. LACY KENDRICK BURK: I think appropriate next steps kind of depends on what SAMHSA's next steps are with the development of the strategic initiative. I think definitely including young people and youth voice in whatever way you can throughout the development until you get to the final draft is really important and key.

And so, any way that we can offer, you know, if it's written feedback or if it's just conversations like this or what have you, I think that's the kind of information we would need to know how to give feedback that could be potentially incorporated into the document.

And then I'll pass to somebody else.

MR. CHARLES OLSON: I guess I would just like to say that maybe before this draft becomes final that some of the youth would have the opportunity to kind of make a couple of small edits. I don't want to be too nitpicky, but I did notice a couple of things that I think would be valuable to change.

And then, obviously, just keeping youth involved throughout the process.

MS. JOHANNA BERGAN: There is an increase of youth infusion across the councils. I wonder and know from my experience that coming here and being comfortable talking took about until my last meeting. And so, this, the calls that we just had for information purposes prior to this panel were -- went a long way in helping us, I think, all understand how our voice is important and can be heard at these tables.

Moving forward, if there was a possibility of us working together, the youth voices that are on each of the councils, if somehow we could work together in a

subcommittee or in a panel presentation like this before, I think would provide a synergy across -- across the councils and maybe better inform SAMHSA. And then I'd also just voice I interact with young people on a daily basis, and oftentimes, organizations want to hear from young people, SAMHSA included, and they don't know how to ask, right?

So I spend a lot of my time as a translator from here's the bureaucratic language in this grant requirement that says there must be young people. Let me transfer that into the conversation we're having today. Here is how you can help, right? What they mean to say in long paragraphs is whatever you say is right because it's your experience and you're the expert in your life. So we'll help you share that.

So if we could be helpful in appropriately reaching out to young people and providing the guidelines around that to make it a safe experience for the youth would be good.

MR. MATTHEW AUMEN: Terrance?

MR. TERRANCE A. RANGE: Yeah, moving forward, you know, I had a suggestion. The Clinton Global Initiative, for folks who've heard of CGI, he has several things that are happening. And in fact, his daughter, I think, has actually taken over CGI now.

But what they've done, they've done a really great job at identifying and engaging young people and youth across the country in the form of ambassadors. And so, I just offer as a suggestion to SAMHSA that maybe moving forward, you think critically about maybe identifying ambassadors or student leaders or youth just in general who can also articulate and serve as stakeholders for SAMHSA in different communities.

CGI has sent out a call for nominations for ambassadors in several communities to engage stakeholders at different levels. So moving forward, maybe thinking about a task force or a youth committee even beyond us on the panel today to begin to make this thing come to fruition. I'd really like to see that because I think that's how you're going to begin to engage young people using some of the vehicles that we've talked about today with social media.

Because I think we have very specific perspectives, but there are thousands and millions of young people beyond the room today who probably also have powerful narratives.

MR. MATTHEW AUMEN: Great. Thanks. And again, I want to be respectful of everyone's time. I would have loved to open it up for council feedback.

But what I can do, I don't want to speak for Geretta either, but there's an

opportunity that we can follow up with you on possibilities moving forward.

So, with that, I would like to thank each of our panel members today, just a phenomenal job and great session. And Pam, do you want to say a few words leading to lunch?

MS. PAMELA S. HYDE: Yes. Thank you, first of all, to the panelists and thank you, Matthew, for leading, getting us together about this.

[Applause.]

MS. PAMELA S. HYDE: This is a great lead-in to the afternoon because we're going to spend time on the Leading Change this afternoon. So, hopefully, this has generated some head space for you to think not only about the youth involvement and the youth issues, but also about the strategic initiatives and the paper itself.

It will go out for public comment, and we will use an electronic approach to response. But I think some of the things that the folks on the panel have said may be part of what we want to have a conversation about this afternoon about things you see that could be different, that are missing that need to be added, et cetera.

So that's what we will do after lunch. Geretta, we need the logistics about lunch so people can eat. It is about 10 after 12:00 p.m. by I'm watching that clock over there. So every one of the clocks is different, but that's the one I'm watching.

We will try to start right at 1:00 p.m. again because we are going to get you into some groups that are going to be really very quickly -- it's kind of like speed dating on the SIs this afternoon. So there will be a lot of intense discussion really quickly.

So, Geretta, what about lunch?

MS. GERETTA WOOD: For those of you who ordered lunch, it should be available right outside the room here, and feel free to spread out, eat in that area or in here, wherever you want. And I understand there's also a cafeteria across the street if you didn't order lunch, and there's vending machines here in the building.

So please take advantage of your lunch hour.

MS. PAMELA S. HYDE: All right. We will see you back here at 1:00 p.m.

[Break.]

MS. PAMELA S. HYDE: Okay. Can we get you to get seated quickly, get where you're supposed to be? Oh, I see. Well, can we just move them a little bit like over in that area or something?

All right. I'm going to hand this over to Elizabeth quickly, but I'm going to just talk a little while, while you're still finding yourselves where you're supposed to be finding yourself. We wanted to keep you awake after lunch.

So as you all know from the call that we were on -- does anybody not know where they're supposed to be? Oh, Kathryn, you don't know where you're supposed to be?

[Pause.]

MS. PAMELA S. HYDE: Okay. Is everybody situated? All right. So let me -- let me just remind you what we're doing here, and then I'm going to turn it over to Elizabeth.

First of all, I want to thank Elizabeth Lopez and the people working with her. Elizabeth, raise your hand. Elizabeth is over here taking care of things.

Elizabeth is the Acting Deputy in the Center for Mental Health Services, and she's done a number of things. But one of the things that she's doing for us right now is leading the work, getting our Leading Change 2.0 out there and on the streets and where it needs to be.

So Elizabeth may tell you some of this, but just very high level while you're finally getting yourselves seated and where you need to be. You know we've had a plan for 4 years. We're in the fourth year of that 4-year plan called Leading Change. Leading Change 2.0 will be our strategic initiatives governing the next 4 years, from 2015 through 2018.

We're also in the process of developing an accomplishments document. So that's coming as well.

The document that you have, you only have. So right at the moment, only advisory councils -- council members have. The public has not yet seen it. What we want to do today is have some conversation with you about each of the initiatives, and then there will be a Number 7 to talk about things that you think are really missing that we need to do something differently about.

And there will be a way that you all get to stay seated, but people are going to move around and talk with you in increments about these areas. So each of you will get to touch each of these areas before we're done here.

So I also just want to say, and again, I think Elizabeth will repeat this, but I think

all of this bears repeating because it's a little confusing. Since you have the document that's in draft, but we are going to go out for public comment. So once we finish this work with you, we're going to finish up a document that will go out for public comment.

And we may need to follow up not only with the youth advisers, but with others of you who, you know, if you want to hold a local community group discussion about the Leading Change 2.0 and then give us feedback, feel free. I mean, there's lots of things that we all might think that we could ask you to do in terms of getting input.

I can tell you, if it matters to you, that the first time we did this and we did the public comments, we got lots of public comment by our electronic process. There was a little bit of voting quickly and voting often among some groups that wanted us to hear certain things. So we're going to be really interested in having a wide range of opinions and people providing input so it's not just one thing or two things that people want to sort of get the point across about.

So that's the process. We're going to talk with you today. We're going to finish up a document that will go public for public comment, and then we will finish the document after we get the public comment in.

All right. I think that gave people time to sort of sit down enough and get settled enough, and I'm now going to turn it over to Elizabeth and all the strategic initiative leads to talk a little bit about where we are in this process and then set you off or start you on the process.

Agenda Item: Update -- SAMHSA's Current and Future Strategic Initiatives (SIs)

DR. ELIZABETH LOPEZ: Pam, thank you.

Oh, okay. Can you hear me? Yeah, okay. Thank you. Thank you, everybody. Thank you for sort of milling through the challenges of the logistics here.

I just want to say a super thanks to all the staff people and the contractors who have worked so hard to kind of turn this meeting around and get it here at ARC from SAMHSA and our kind of fire exercise. So I just want to give a really round of applause for those guys. They've worked very hard.

[Applause.]

DR. ELIZABETH LOPEZ: So just really quickly, Pam has said a lot of what I'm going to share. We're going to talk a little bit in this session about just an update

on where we are with Leading Change, the current strategic plan, and then a plan for our new strategic plan, which is going to be the bulk of what we do today. And then a process for how you guys are going to give us feedback.

You should have the goals and objectives in your book. Does everybody know where those are? Yes? Show of hands. Does everybody have them? No.

Can folks take a minute to make sure that they have a copy of the goals and objectives in their book? It should be under the Session 7.

[Pause.]

DR. ELIZABETH LOPEZ: Okay. These are our current, as you all know, our current strategic initiatives. Just a reminder -- prevention of substance abuse and mental illness, trauma and justice, military families, health reform, recovery support, health information technology, data outcomes and quality, and public awareness and support.

Just to give you an update of where we are right now. We're, as you can see, in the final year of the strategic plan implementation. All the SI leads are closely tracking their final sets of goals and objectives for each of these eight areas with an eye towards how -- where we are in terms of a status check on completing lots of the proposed action steps would inform the development of the Leading Change 2.0. SI leads are managing their work plans and providing quarterly briefings to the Administrator and the Deputy Principal Administrator on the status of those things.

What we're going to do for next steps with the current strategic plan is to develop an accomplishments report, which we've been working really hard on the last several weeks, very close to a draft for our internal review clearance process. And it will highlight some of the key four to five main, high-level accomplishment areas for each of these eight SIs that we've been working on for the last 4 years, and it will also have some recommendations for not only where we would go forward inside of SAMHSA, but also how that might inform some of the priority focus areas in Leading Change 2.0.

We're planning to release it by the mid summer timeframe. So be on the lookout for that.

Leading Change 2.0 is going to be our second strategic plan developed under our current Administrator, and it's going to move -- at the moment, it's proposed to move from eight to six strategic initiative areas. It's going to embed military families, data outcomes and quality, and public awareness and support across all six of those areas, and you'll note that those three areas that are embedding are in our current strategic area plans. And I know there's been some discussion about how we're making sure that we're not forgetting these three areas, and

you'll see, hopefully, in the draft document that, indeed, we are not.

It is seeking to be responsive to current and emerging opportunities addressing gaps in the behavioral health field, and we're working to identify particular metrics for each of the goal areas.

So these are our six strategic areas, and again, you should have them in your folder. You should have the draft document with goals and objectives in your book. Have people located them now? These were also sent to you a couple weeks ago in advance of the advisory council call that Pam had with you to discuss this document.

So we are retaining prevention of substance abuse and mental illness, healthcare and health systems integration, trauma and justice, recovery support, health information technology, and we're adding a new SI area, which we've been talking a little bit about over the last day or two, workforce development. These are going to be the proposed set of draft goals and objectives that we are going to be receiving your feedback on today during our facilitated feedback process.

But before we kind of explain how that process is going to move, I wanted to take an opportunity to ask each of the SI leads for these proposed six areas to give you a very quick, high-level overview of what the purpose of their SI area is in this particular Leading Change document.

So I'll start with Fran.

MS. FRANCES M. HARDING: Okay. Good afternoon. I'm glad you all made it back from lunch.

So the SI Number 1 focusing on the prevention of substance abuse and mental health disorders has been altered a little. You'll see that when we get into our discussion. Our first goal is to focus on emotional health and wellness -- we heard a lot about wellness today -- preventing or delaying the onset of complications from substance abuse and mental illness, and identifying emerging behavioral health issues.

You'll see when we have a conversation what those issues are. If you read ahead, you can also look at them. Our feeling was so much has changed in the last 4 years when we had the 1.0 of Leading Change. So we wanted to be able to have a goal that captures the changes that we'll see between 2015 and '18.

Our second goal remains to be reducing underage drinking and young adult drinking. You heard from the youth panel, which I was very happy to hear, that we may be on the right target on this one. We will be focusing on all of the risk factors for both in college, students that are attending college and students of the

same age group that are not in college so we don't lose them. And we're also going to be looking at increasing our collaboration with other Federal agencies.

Our third goal is the suicide goal that we had before, changing it ever so slightly. Reduce suicides among and nonfatal attempted suicides among populations at high risk, especially -- and this is the big change -- working-age adults ages 25 to 64, men in mid-life crisis ages 35 to 64, suicide attempt survivors, military families -- military service members. Sorry. I got the old language in my head. Reservists, veterans, and their families. And American Indians, Alaska Natives, and the LGBTQ population. We'll get into that.

And last, but not least is our fourth goal. Reducing prescription drug misuse and abuse. I can really sum this one up. It's a combination of prevention programming for the overall education and awareness of the problem with prescription drugs and what communities can do, and it's also a specific focus on opiates and prevention of opiate overdose and use -- abuse, rather.

DR. ELIZABETH LOPEZ: Thank you, Fran.

Suzanne, do you want to go second? Number 2.

MS. SUZANNE FIELDS: Terrific. Thank you.

So the second strategic initiative that we want to discuss with you has to do with healthcare and health system integration. We had the luxury of nearly an hour and a half discussion this morning on that very topic. So we'll have a tremendous opportunity to reflect what you shared with us earlier on this material that we had prepared before today's discussion.

But you'll hear again the intent behind this particular focus is a very broad base around healthcare, well documented, the costs of persons and the quality issues, the health issues for persons with mental health or substance use and physical health. And what we really are proposing is to look at how systems need to shift to improve care and move us away from the fragmented system we have currently.

With a particular eye towards moving beyond just a focus on physical healthcare, but again, that broader public health perspective, thinking about prevention, thinking about whole health for individuals.

Within that, we have five specific goals that we are looking at. The first has to do with fostering integration. SAMHSA specifically, as we talked about earlier, has our PBHCI initiative, our PCASI proposal related to substance use, and then the work we mentioned specific to HIV this morning. Lots of lessons learned from that that we can apply to other issues more broadly. Also looking at how we can improve and incentivize care coordination differently to move the system forward.

Our second set of goals has to do with States, counties, territories, and tribes and their specific efforts to develop and implement health integration approaches. And so, with that, we're focusing on various training and TA opportunities we could provide to those entities and organizations. A specific look at how CMS is looking at State plans, alternative benefit plans, as it relates to mental health and substance use. Again, that lever that we talked about this morning about influencing and supporting our sister agencies. And then, finally, continuing our efforts around the ever-important enrollment and outreach into the various public insurance options that people now have.

A third goal relates to various financing and delivery models and influencing those. We have enormous opportunity with our partners to be looking at Medicare, Medicaid, TRICARE, and other kind of commercial insurance options that are available. We certainly have lessons learned from our various sister agencies -- ASPE, CMMI -- related to accountable care organizations and other models that they're looking at, that particular lessons related to behavioral health need to be understood. And then, finally, again our work, specific with CMS, around duly eligible and the State implementations that are happening for that population.

Our fourth has to do with parity, the Mental Health Parity and Addiction Equity Act, both in terms of further advancing the commercial regulations that were released November 8th, but also with an eye towards the application of MHPAEA within Medicaid and the regulations that we anticipate by the end of this year.

And finally, our fifth, but not last goal has to do with quality. As we look at other healthcare systems, there is an enormous emphasis in those systems on quality, the identification of quality indicators, and through our National Behavioral Health Quality Framework, led by CBHSQ, many other activities we're doing with our partners. It's our opportunity to continue and advance a specific focus related to behavioral health.

Thank you.

DR. ELIZABETH LOPEZ: Great. Thanks, Suzanne.

Larke?

DR. LARKE HUANG: Good afternoon. I'm Larke Huang, and I lead the trauma and justice strategic initiative. There are three primary goals in this particular initiative. The focus of is it's a little bit of a bifurcated strategic initiative in that one piece is really focusing on trauma and our work on trauma and how trauma connects with mental health and substance use issues.

We -- a key piece we did this past first part of Leading Change was really to get a better sense of our understanding of what we mean by the concept of trauma and the concept of trauma-informed approaches. So we have a SAMHSA framework for that now, and this is a preview of it, which this will be getting out to you as soon as it's formatted. And that's going to be the foundation for a lot of the work that we do in the next part of Leading Change.

So we're looking at trauma across service sectors, across age ranges, and look at what we mean and how we can measure trauma-informed approaches in different public health, public institutions, and service sectors. We've done a lot of work in child welfare, a lot of work in behavioral health. We have interest and requests to do more work in primary care. We've done quite a bit of work in the criminal and juvenile justice system as well.

We also have developed a measurement strategy or the beginning of a measurement strategy so we can look at that in terms of population health, client-level data in our own grant data, and also in our facilities information, our facilities data.

So we'll be continuing to do that work around trauma. Our major thrust for this next iteration of Leading Change is really working with primary care and developing a strategy approach to look at screening assessment, trauma-specific services or referral in public health and primary care settings.

The second, and then we also fund a number of technical assistance centers around trauma. We're trying to do a better job of coordinating some of that work, and so that's also building on the foundational work we've done this first iteration on defining, providing a framework for trauma and a trauma-informed approach.

The second goal focuses on, and this is one of the few strategic initiatives that pulls out a particular service sector, and that is the criminal and juvenile justice system, given the high rates of people with mental health and substance use issues that are criminal justice or juvenile justice involved and also that have significant histories of trauma.

So we have a number of activities that are focused on how do we reduce the contact with the criminal and juvenile justice system for people who have behavioral health issues or reduce their going further or deeper into the system? We have grant programs. We did a number of grant programs this year to look at more earlier diversion upstream. We're going to continue to focus on those as well as look at some other reentry issues.

We are also doing more work around opportunities for the criminal justice population in terms of also health insurance, in terms of enrollment issues, in terms of best practices for outreach enrollment and getting them covered through Affordable Care Act.

We have joint programs that we do with the Department of Justice. We have a joint solicitation that's going out in a week, we hope, and then we are developing more collaborations also with the Office of Juvenile Justice and Delinquency Prevention. They have a vested interest in the justice system and actually looking at trauma and how addressing trauma may reduce criminogenic factors and reduce potential for recidivism.

We have a lot of work going on there. We try to also look at what we are already doing and how we can innovate within our current grant portfolio. So as we go around to your tables, I would love to hear what you think we should be doing in terms of what should our drug courts be looking at?

We've done four or five cohorts of them. We've put new risk needs, screening assessments in those. We're looking at medication-assisted treatment into those programs. But we'd love to hear from you what do you think we should do with that, with our juvenile portfolio as well, and with our offender reentry work.

And then the third goal is really reducing the impact of disasters and the traumatic reactions associated with those and the impact on the behavioral health. So communities, children, individuals, and families. We're looking at how we can do more on the readiness piece, on the preparedness piece that aligns well with our framework around trauma. We're looking at community trauma and trauma-informed communities, how can we take what we developed in our service systems and also think about it in terms of community readiness and community responsiveness.

We have some measurement systems, measurement studies going on within our disaster portfolio of work, and we're looking at how we can build more of the evidence-based skills for both preparedness and response in that portfolio of work. So that's it for trauma/justice.

DR. ELIZABETH LOPEZ: Great. Thanks, Larke.

We'll move to Paolo, recovery support.

MR. PAOLO DEL VECCHIO: Good afternoon. Several years ago, SAMHSA released a unified definition of recovery from mental illnesses and/or substance use disorders after consulting with people in recovery, family members, researchers, providers, other experts, as well as our Federal partners. This definition indicates that recovery is a process, process for improvement where people try to improve three things -- one, their health, including behavioral health and wellness; second, for people to improve and live a self-directed life, to be self-reliant, independent, to really take control of their lives; and third, for individuals to try to reach their full potential and contribute fully to American life.

SAMHSA has identified four major dimensions that we believe support a life in recovery, those of health, home, purpose, and community. For health, people need good access to affordable, accessible, and high-quality health and behavioral healthcare. This includes overcoming or managing one's disease or symptoms and abstaining from the use of alcohol, illicit drugs, and nonprescribed medications, as well as the need to access clinical medical treatment for mental illnesses. For everyone in recovery to make informed, healthy choices that support physical and emotional well-being.

Second, regarding home, people need stable and safe places to live.

Third, purpose, people need meaningful, productive, worthwhile activities, things like jobs, school, volunteerism, family caretaking, creative endeavors, and the income and independence that those things bring.

And lastly, that people need community, that people recover in the context of relationships and the important role that social networks, families, peers provide in terms of support, friendship, love, and hope.

We believe that the journey of recovery is for all people with behavioral health conditions, including those with serious mental illnesses and/or severe addictions. We see recovery providing the common and motivating goal for all of us. For consumers, people in recovery, families, providers, service systems, that message that people and do heal, that people can overcome behavioral health problems and live full and productive lives, this message of hope that these disorders are not a lifelong sentence, a life sentence. That people, families, and communities can improve and get better.

Our goals map to the health, home, purpose, community domains. So for the first goal about improving physical and behavioral health, specific objectives include identifying and adopting wide-scale evidence-based practices that facilitate health, behavioral health, wellness, and resiliency; helping to promote recovery-oriented service systems; helping to do outreach and engagement with individuals and families through a variety of approaches.

Particular focus that we have an interest in looking at crisis response systems, and for individuals with both mental health as well as for those who have substance use conditions as well.

Data, how do we measure recovery? We have got work going on in that area, too. The second goal regarding housing. Specific focus on increasing access to permanent housing as well as mainstream housing and benefits, recovery housing, and other home and community-based service systems and approaches.

Third, regarding purpose. Goal here is to increase competitive employment and

educational attainment. Specifically to work both on adopting evidence -- expanding the adoption of evidence-based practices like supported employment and supported education, working with employers, and addressing other legal and regulatory and attitudinal barriers.

Finally, regarding community, several objectives here, including again helping to expand the peer workforce, addressing issues of social supports for individuals and families, and finally, importantly, helping to decrease negative attitudes and discrimination.

Look forward to hearing your feedback.

DR. ELIZABETH LOPEZ: Thank you, Paolo.

Okay. Dr. Clark?

DR. H. WESTLEY CLARK: Thank you.

SI Number 5 is on health information technology, and several council members have raised this issue this morning, the importance of health information technology. And this strategic initiative will continue to evolve from the first iteration to stress the importance of health information technology. If we are to fully participate in a healthcare delivery system, to fully participate in health reform, with specific focus on the ACA, we need interoperable electronic health records.

We need to understand that EHRs offer a potential for assessment, treatment, monitoring, and recovery support tools to ensure high-quality, integrated healthcare, appropriate specialty care, improved patient/consumer engagement, and effective prevention and wellness strategies.

We also need to keep in mind that when it comes to HIT, there is the issue of privacy and security of health information. Privacy, confidentiality, security are critical to the behavioral health construct, as many view the information compiled as information of a sensitive nature.

We are working with ONC and others, and we're committed to developing standards and technologies that will enable health information exchange while supporting the principle that all health information should be secure and controlled by the person receiving the care. Several people -- several people have mentioned a number of issues, and I just met with Carole Warshaw to talk about the impact of domestic violence in health information technology.

Some of these issues we haven't really fleshed out, but it's clear that HIT and EHRs surface in many areas. Our goals are five point. One is to promote the development of technologies and standards to enable interoperable exchange of

behavioral health data while supporting privacy and confidentiality. If you can't talk to primary care, if they can't talk to you, then that's a problem.

Second goal is to promote the adoption of electronic health records and other HIT tools with behavioral health functionality by States, healthcare providers, patients, consumers, and others to improve prevention, treatment, and recovery for behavioral health disorders. The behavioral health field is not -- it has not been as welcoming with electronic health records and HIT, and part of our objective is to get people to understand that we don't need to be afraid of electronic health records, and we don't need to be afraid of HIT.

The last panel of the morning was composed of a bunch of young people who are very adept, as you heard, in terms of their discussion of social media, very adept at using electronic forms of communication to express feelings and also to intervene, and we need a delivery system, a behavioral health delivery system that's willing to work with the primary care delivery system in the same vein. And we can also use other strategies, including apps, mobile approaches, telebehavioral health in order to reach hard-to-reach communities.

But we all need to be comfortable with this. And as I'm fond of saying, I was very adept at electronic typewriters, but I had to give it up.

[Laughter.]

DR. H. WESTLEY CLARK: So we need to give up the old technologies and favor the new ones. There is a commercial on TV where the man talks about not rewinding the DVD, and the other woman talks about putting her pictures on the wall. So we actually need to be more adept at this.

Our third goal is to enhance capacity of secure collection and use of data in electronic health records and other technologies to support quality improvement and effective outcome tracking. Core to the transition to health reform is people want to know what we're doing. They want to know whether what we're doing actually works, and they want to know are we accountable. And so, these are themes that go under 5.3.

And the last one, promote the broad dissemination of technologies for improving behavioral healthcare prevention and wellness. Larke and I were just talking about drug courts and the exchange of information between drug courts and primary care and social services and housing. You'll be surprised how many entities our clients interact with that want information about the clients, and what we need to make sure is that the consumers and others have an awareness of this information flow so that we can enhance their care in our recovery-oriented environment.

So there are a lot of things that health IT promises. I say -- I argue it's the glue

that binds all these disparate systems together, and we're looking forward to hearing your concerns or interests or ideas.

DR. ELIZABETH LOPEZ: Thank you.

Okay. Last, but not least. Anne?

MS. ANNE HERRON: Aw, I don't like being last.

DR. H. WESTLEY CLARK: But you're not least.

DR. ELIZABETH LOPEZ: Workforce development.

MS. ANNE HERRON: This is not a new issue, not a new issue for any of us. There have been an awful lot of agencies and organizations and groups that have been working on improving our workforce for an awful long time.

But this provides us, SAMHSA, with an opportunity to really look at how are we going to influence the impact and the outcomes and the performance of our intent to improve the behavioral health of the Nation if we don't have an adequate supply of well-trained staff and workforce in order to do that?

So that's really the focus and the purpose for this strategic initiative is to provide a coordinated opportunity for us to work with our colleagues in order to accomplish this. We've set out four basic goals. One being the dissemination of training and education and core competencies, again looking at kind of the existing workforce.

The second being the support and deployment of peer providers in all public health and healthcare delivery settings. So not only recruitment and retention, but dissemination.

The third is increasing the workforce capacity to address behavioral health issues, and this is an opportunity for us really to influence some of the other workforce activities and workforce programs that our Federal partners and State partners are involved in as well.

And then the fourth goal really supports those other three, which is looking at kind of what do we know about the needs of the workforce? What do we know about pay incentives and barriers? What information can we provide and can we give and share about best practices for hiring staff in particular settings and areas?

So it really is information, again, to support that coordinated effort. And because we're new, we're energetic. So we're looking forward to all of your thoughts and ideas around how to do this.

Thank you.

DR. ELIZABETH LOPEZ: Thank you. Thank you all very much.

It's so nice to have an opportunity, kind of being in this all the time, every day, to just listen to each of the leads' kind of very high-level discussions. And from this perspective, I really appreciate how connected all six of these areas are and how each of you are making very clear how each of the others are overlapping and related to what you're doing.

We're now going to move to kind of the really exciting active part that's going to keep everybody awake after lunch, which is our breakout sessions. And really, the main purpose of this session really is to get all of your feedback.

So Pam talked a little bit earlier about making sure that we were all logistically where we needed to be. For folks who may have come in late, if you look on the back of your ID badge, it should be a number there, and whatever number that is, you should find what group that is. There's 1 through 6, it should be. You can find that group and join that group, and you'll be part of that particular breakout session.

And again, the purpose of this is really to get your feedback on those draft goals and objectives of these six SI areas that we just heard about. You should have a table -- at your table, you should have a guide to help formulate and structure your comments. Should be a one-page draft feedback form for your strategic initiative area.

The SI leads, as Pam said, are going to move to you. So you're not going to have to move around yourselves. They're going to move to you over the course of the next 90 minutes or so. So it's going to be like speed SI dating. So get names and numbers when people are with you.

So starting with Fran, she's going to start at Table 1. And then Suzanne will start at Table 2. Larke will start at Table 3. Paolo will start at Table 4. Dr. Clark at Table 5, and Anne at Table 6.

Each of them will have with them a scribe or writer who's going to be writing down your feedback on this kind of large post-it board here, and we'll be timing each of the times that they're at each table. So we'll give you a 5-minute warning before you're ready to get up and go to the next table, and then we'll give you the kind of the sign when it's time for you to move to your next table.

So you'll go in sequential order, starting with 1 going to 2, all the way until you've covered all of the tables. It's going to be about 15 minutes with a 5-minute warning.

I also want to mention, and I think Pam mentioned this as well, there is a seventh table, which is the table that the SI leads won't be rotating to, and you haven't been assigned to sit at as memberships here. But it's a table to go to discuss any other policy or other related strategic initiative ideas that you want to share with SAMHSA. And Mary Fleming, our SI lead -- or excuse me, our policy lead, policy director, will be there, along with Kana Enomoto, as well as Kathryn Power and Dr. Delany to kind of dialogue and receive any of the feedback you might have outside of these six areas.

Okay? So, with that, I will say let the breakout sessions begin.

Agenda Item: Breakout Sessions (with SI Leads)

[Breakout sessions.]

DR. ELIZABETH LOPEZ: Okay. People should be reconvening for a few minutes, but then we're going to take a break. We've got about 5 more minutes before we take a very well-deserved break. So if folks can get settled? Yes, break is coming really quickly. Okay. Really fast.

First off, thank you all for going through that very, very, very demanding, but from what I heard very, very rich process of sharing information with all the SI leads. I appreciate the time. I know folks are tired. We saw people to wind down, but we also heard some really good information.

I first wanted to just take a minute to see did anybody want to share anything that they either heard, reflected? Don't have a lot of time. We're wanting to take a few minutes for Pam to close out this part of the session over the next couple of minutes, but does anybody want to share any thoughts of what they heard or what they shared or want to make sure that the larger group hears? We could probably take a couple comments.

DR. INDIRA PAHARIA: Yeah. Is that -- that's on?

DR. ELIZABETH LOPEZ: That's on, yes.

DR. INDIRA PAHARIA: I just wanted to say what a great use of the time I thought this was, to have us all involved. Even though it was kind of like speed dating, I felt like it was very energizing. The time went fast. We all got to contribute, and oftentimes, you go to things like this where you're just sitting and listening, and it was great that you pulled from us and made us think and contribute. So great job.

DR. ELIZABETH LOPEZ: Great. I'm glad. Thank you all for being so patient with some of the logistical confusion.

MS. JUANITA PRICE: Hi. I would like to say, and I said it in the small group, I heard two people today talk about SAMHSA and how small it is. And I just want to challenge that thinking because I understand the smallness in terms of the staff and the budget compared to some of the larger agencies. But I happen to think that SAMHSA's staff and budget may be small, but the audience -- the people who really care about what we do and if they don't care, certainly they are touched by what is done here -- is very broad and very far-reaching.

So I think in terms of the impact and the influence that SAMHSA can have, I'm hoping that we're thinking that it's not limited to our budget or the budget or to the staff, but expanded to the vast number of people who, if we look at the one in four statistics or whatever, there's a vast public out there that at some point in their life will need one of the services or many of the services that is supported by SAMHSA.

DR. ELIZABETH LOPEZ: Great. Thank you so much, Juanita.

Okay. Any other comments? Do any of the SI leads want to share any reflections, thoughts?

DR. H. WESTLEY CLARK: Well -- Wes Clark for HIT.

I was joined by Maureen Boyle and Kate Tipping, and we thoroughly enjoyed the circuit from table to table. It was nice to hear that people appreciated the SI as it was written, but we also got suggestions that we could use to embellish our efforts and to clarify things from making sure we include tribes to dealing with information sharing to dealing with education of consumers as well as the providers and making sure that we continue to work with ONC and others interested in electronic health records and health information technology.

So I really appreciated that opportunity. So thank you all. You were very engaging and engaged, and I thought that we got good feedback.

DR. ELIZABETH LOPEZ: Great. Thank you.

Any other comments?

DR. LARKE HUANG: Yeah, this is Larke Huang.

I want to say a couple things. One, I don't think I ever want to speed date in my life.

[Laughter.]

DR. LARKE HUANG: That's exhausting. Secondly, Suzanne Fields can't count.

[Laughter.]

DR. LARKE HUANG: And she's our health finance.

MS. SUZANNE FIELDS: That's why we have so much money in behavioral health. I can't count.

DR. LARKE HUANG: You just skip around wherever you want to pay. So --

MS. SUZANNE FIELDS: We do need a yellow brick road.

DR. LARKE HUANG: Yeah, yeah. So I guess the other thing is if there was a theme that I want to share with Pam, actually, is that on the trauma and justice, there were probably about three of the tables who thought, well, maybe should we deyoke those? How did we come to put those together and gave a little bit of history of that. I don't know whether we will deyoke them, but there was some interest in thinking about that.

DR. ELIZABETH LOPEZ: Okay. Great. Thank you.

Paolo, did you want to say something?

MR. PAOLO DEL VECCHIO: Just really quickly, I think we had really great conversations as well. Two issues at least that I heard throughout the tables. One was around issues around evidence and data as it pertains to all the recovery supports, including looking at cost data.

And then the second piece around messaging and communications. We had a lot of great discussion and contributions on that topic as well.

DR. ELIZABETH LOPEZ: Okay. Great. All right.

Well, just as you can see, our next steps is to take all this really rich and valuable information that we've compiled over the last couple of hours, and we're going to be reviewing it internally at SAMHSA. And our plan would be to get out another set of revised goals and objectives when the document goes out for public comment, and it will hopefully reflect as much of the recommendations as possible that we heard here today.

And so, with that, I'm going to turn it over to Pam to kind of close out our session.

DR. LARKE HUANG: I just want to say one more thing. A couple of the tables, the discussion around disparities, which was a TBD, it was kind of blank there,

was brought up. And that we should not scurry around around race, and we should just address it right on.

DR. ELIZABETH LOPEZ: Great. Thanks, Larke.

MS. PAMELA S. HYDE: I don't know if you remember on the call, those of you who were on the pre-call, we told you why that was blank. But just let me underscore it, for those of you who don't know. We had a section about disparities in Leading Change 2.0 -- or the original one for each of the strategic initiatives. And rather than just use that same language, we wanted to talk with you first before we populated that area.

So we had some very specific commitments or priorities or statements about disparities the last time around. If you want to see what we had, go back to the original Leading Change -- it's on the Web site -- and look at what the disparities language was in each one of the strategic initiatives.

And certainly, Larke, with one of her many hats, has been leading us well in that area of disparities. But we wanted to make sure we sort of started with a blank slate in the sense that we didn't want to start with last year's language. We wanted to start with the new language or with your new thoughts.

So, okay. So, yes?

DR. VIJAY GANJU: Area 7?

MS. PAMELA S. HYDE: Uh-huh.

DR. VIJAY GANJU: When were we going to talk about area 7?

MS. PAMELA S. HYDE: Well, you were supposed to go to the corner. Okay. Do you want to report --

Vijay, you're between the group and their break right now.

DR. VIJAY GANJU: Okay. Well, I was going to say that, you know, I also just appreciate everything that SAMHSA does, but one of the things that I feel it does so well and so strongly is advocacy, and I think a role that you've spelled out very clearly in some of the presentations this morning is the sort of emerging stronger role of coordination of behavioral health. And I did not see that explicitly in the plan.

And it seems to me, as we're moving towards all these initiatives related to integration and this whole change process really that we're talking about, there is a lot of work that I think I heard where SAMHSA is going to be pushing more administrative efficiency that's going to take on more off of change management

function.

And as we talked about this, I think Kana was saying, well, that's going to be part of our internal operational plan. I am not -- you know, and what I was arguing for is if that is such a primary function of SAMHSA, why would it not sort of have a goal in its own right? And that's really sort of the broad thrust of what I think we were discussing at our table.

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

Yeah, that's an interesting point because collaboration and coordination is throughout every single SI with any multiple players. So it's kind of hard to know whether to make that a cross-cutting issue or whether to make it a goal of its own. So good point.

All right. I do want to get you all to a break. All I wanted to do is say thank you and also to let you know that just to remind you that we will be doing this, a revision and then out for public comment, which means there will be another revision after that. And again, for the youth folks and anybody else, if you had specific edits that you want to give, please do give them now or before you go home, hopefully. If not, as soon as you get back, give them to Elizabeth and/or to the SI lead, whatever. So we can make sure we have that when we make that decision.

All right. So I don't want you to lose your energy because we're going to give you a break here. We've got to give you a 10 -- let's do a 15-minute break. So until 25 till, and then we want to spend just a few minutes talking to you about how we're thinking about changing SAMHSA.

You remember last time we talked about the future of SAMHSA or the SAMHSA of the future? We've done a lot more thinking about that, and Kana is going to walk us through that so you can be ready to give us a little feedback about that.

So, and then we'll get you home. All right. Break until 25 till by that clock over there.

[Break.]

MS. PAMELA S. HYDE: Okay. We are going to hold you here for just about another hour and 10 minutes, and in about 55 minutes, we are going to open it up for public comment.

Part of your role is listening to the public. We don't always have a lot of comments, but there are sometimes a couple. So we like to ask you to stay for that if you can possibly do so. And our plan is to get out of here no later than 4:45 p.m.

So, with that, I want to turn this back over to Kana, who's been working on the SAMHSA of the future.

Agenda Item: SAMHSA'S Internal Operating Strategies (IOSs)

MS. KANA ENOMOTO: Thank you, Pam.

Okay. So some of you heard about this on the pre-call that we had last month, but in the last year and a half or so, SAMHSA's executive leadership team has done a great deal of work in trying to understand what does this organization need to do to achieve the many lofty goals we have set out for ourselves?

So in the last session, you really talked about the "what." What is it that SAMHSA should be striving to do for and with the field to advance behavioral health? And as we have struggled over the last few years with the weight of the level of activity. Leading Change 1.0 had a lot of goals, a lot of activities, a lot of objectives. We have accomplished so many of them. The vast majority of them we've either achieved or made great progress on.

But in doing so, we did that on top of our regular work. We did that on top of, you know, managing $3.6 billion worth of grants and contracts and all of our other partnerships and activities, and doing it in the same way we had always done it for the most part. And what we realized, as we started to kind of burst at the seams with opportunity and activity, was that we probably need to take a look at how we were doing our work and what skills our workforce had and who we had onboard so that we could do work in a way and align the agency so that it would, in fact, by 2016 be the agency that leads public health efforts to advance the behavioral health of the Nation.

And in doing that, we changed the denominator for our focus. We aren't just focusing on the grants and the communities that we currently have programs in, but we really are taking responsibility for improving behavioral health everywhere. And so, our executive team, and collaboratively working with our staff and our managers, identified seven areas, seven areas that we would do some of this reengineering of SAMHSA.

One of which is the first one, business operations, where we would have agile, innovative, and efficient business operations to position the agency to advance the behavioral health of the Nation.

In communications, that's sort of graduated from being an SI, strategic initiative, to being one where we really are looking at how SAMHSA communicates

internally, how we use our communications resources strategically, and how we're partnering with the field and other Federal agencies to make the use of our communications resources so that we would have timely, creative, and accurate and broad-reaching communications to position our agency to do the things that we've identified.

On data, we have talked about building SAMHSA's capacity to use data in a comprehensive and integrative manner that would help us achieve our public health goals. That includes developing our own data, as well as using outside sources of data and using it in a very purposeful way.

In health financing, that we realized that, for example, if you're going to be a manager of a discretionary grant, where in the discretionary grant, we've said you must use these -- you must use third-party payment wherever possible. You cannot use these grant funds to pay for a service that could otherwise be paid for by insurance.

Well, in order for a grant manager to understand -- to be able to understand whether their grantee was doing that, they need to understand what is covered by insurance or could be covered by insurance or who could be covered by insurance in that particular State or community. So that means increasing the knowledge about health financing across the board for SAMHSA and its workforce. And there are, obviously, many other ways in which we would need to do that, but that is one example.

We have a public policy group, which is to increase the public policy knowledge, experience, and influence positions so that we could influence not only our own policy and as it carries out through our own programs, but influence the policies of others.

Resource investment, and that, we had at one time called it grants and contracts, and we realized that our resources go far beyond our grants and contracts. Our resources include our personnel and our time and our energy, as well as how we do -- how we invest our overall programmatic portfolio.

And with our program portfolio, we want to invest in innovation, translation, dissemination, implementation, as well as wide-scale adoption activities so that we can really move the field forward and think, consider our portfolio in a more dynamic fashion rather than a single program gets stuck in time and sort of does the same thing over and over again, even though the practice itself has evolved or the needs of the Nation have evolved.

And finally, staff development. SAMHSA's development and optimization of staff skills and abilities will also help position the agency to take advantage of the opportunities that are before us.

So each of our SIs has an executive sponsor and a team leader. Executive sponsors are among our ELT members, and today, I have three of our ELT members to present. So we're having public policy is co-chaired by Mary Fleming and Fran Harding, and their team leader is Brian Altman, our leg director.

And staff development is led by Mike Etzinger, who is our -- the head of our Office of Management, Technology, and Operations. And his team leader is Kevin Hennessy, the Deputy at CBHSQ. And I'm going to ask Mike to lead off and give you a little bit of an update of what the staff development group is doing so that you get a flavor of how we're operating and how we're using these teams and these efforts to change SAMHSA.

MR. MICHAEL E. ETZINGER: Great. Thanks, Kana.

I'll tell you, I really believe I drew the long straw here from the standpoint of the opportunity to work with our staff that we have at SAMHSA, incredibly dedicated to the mission of SAMHSA, and it's my privilege to be able to work with them and, again, try to hone those skills.

You look at the seven IOSs or the six others besides the staff development, and it's going to be our job and our work ahead of us to make sure that we're well-versed in the others to, as Kana talked about it, Pam's challenge to change the denominator, to broaden the reach of SAMHSA and the positive impact on the behavioral health of the Nation.

So, you know, by no mistake, we gave folks the choice of which IOS they wanted to work with, and most of them wanted to work in the staff development, to be expected. So we had great turnout for the staff development, and we were able to sit down and talk about what that meant. When you looked at the other opportunities that are up on the board, you look at things like health financing and all the changes that are going on across the country right now.

When we start talking about the data management, people started getting excited about, you know, trying to put together compelling cases for how we would do and what we would do, moving forward. So we sat down and thought, you know, it's really we broke it out into three parts.

We started one of our tiger teams is looking at the SAMHSA staff as it exists now and the current skill sets that they have and trying to catalogue, if you will, the skill sets that we have, looking forward, again working with the other IOSs, keeping in mind what they're looking for. But actually, just cataloguing what we have.

We've got another tiger team that is actually reaching to the other six IOSs and saying what are the gaps that you see with respect to the -- you know, Kana

talked a little bit about what you could call the static way that we've been doing things, you know, we've been managing the grants. What are the gaps you see with the opportunities that we're presented now in the staff, and what would the ultimate staff member look like for you? What kind of skills would they have? You know, political savvy, when we talk about the policy portion, be familiar with health financing and those things, such that when they were in situations when they're working either with their grantees or with folks from other organizations, they could see those connections that might provide that opportunity to expand that reach.

You know, we have X number of dollars that have in the past touched, positively affected 10,000 people in the behavioral health. But with this little bit of knowledge, they can see that nexus that says if we did it a little bit differently, we could touch 100,000 or 200,000. So it's looking for those gaps. So we've got the tiger team working across the IOSs to help us understand what those gaps are.

And of course, the third piece is to take B minus A and say what would the ultimate person look like, skill set wise, and what do we have now? And then to engage with the staff and say, you know, who's up for something a little bit different? Who's up for an exciting new opportunity? Or nothing wrong with it, who enjoys exactly what you're doing right now? Because the work that they do right now is, in and of itself, very important as well.

And then looking at those opportunities and saying we will put together curricula, if you will, training opportunities for folks to help them develop and broaden their knowledge, to be ready for when those opportunities are there for them to see as they go about doing their daily business, to see those opportunities and be ready to jump in.

A couple things that came out, sort of spinoffs, if you will, that came out of this. A couple themes started coming up. One of them was, you know, we've got a new -- looking at a more agile workforce, and one of the things that people talked about were the soft skills required on the management side that says, okay, now we're going to have supervisors that have supervised the same old way for 5, 10, 15 years, whatever that is. What can we do to work with our supervisors, managers, the leadership to prepare them to work with the new staff?

So that was actually a task that I'm working with our OM team members, the Deputies from the centers, and the office directors to put together a plan to help put together, again, trainings for our managers to prepare them with a new way of doing business 2016 -- what are they going to need to know, what are they going to need to be a little better versed at? And to help them, we've talked about sort of a almost a university model that says let's get some continuing education type thing so that each year people are being refreshed.

I use as a case now, we're in the day and age of telework. Well, we've got a lot

of supervisors that, one, aren't comfortable with that. And not surprisingly, they haven't had to do that in the past. How do you manage that staff?

So, continuing education wise, we'd come in and try to help them understand some of the tricks of the trade, if you will, or bring experts in to talk to them about what's worked well elsewhere to sort of best practices and baseline ourselves against that.

The other spinoff that I would say, and we're working on it at the ELT level, and that really has to do with talent management. And it's really sort of a two-track thing. It's looking at the talent that we have right now on staff and sort of cultivating that and, again, looking out a little further ahead for those folks that are up for the challenge. How do we keep them interested in what we're doing as we go through this transition? How do we provide opportunities for challenging positions within the organization? And again, sort of groom them as the next leaders of the future.

But the other part of it that we're going to be focusing on has to do with sort of the structure and how you make this all go. It's the physical how are we going to hire people? Who are we going to hire?

You look up on the board, and you talk about health financing and because it's so new and the opportunities that came with health reform and the Affordable Care Act, we really need some folks that are a little bit different, have a completely different skill set. We have a great example in Suzanne that's worked for us for a while and would like to have 10 more of her, and so that's part of this challenge maybe is how do we get 10 more Suzannes to come in and help us understand again how to expand that reach? How to see those opportunities out there across organizations.

So how are we going to bring them in? Who are we going to bring them in? So those are just some of the things that we're doing at all the levels within the organization. Engage the staff sort of at the grassroots. We've got the senior level working, both the second-level management side as well as the overall talent management. So that's what we've been up to.

So if you have any questions, I'd be happy to try and answer those for you.

DR. LORI ASHCRAFT: I love everything you said, and I'm wondering if is this a plan you could share with all of us as we go back to our organizations that we could maybe try this out ourselves?

MR. MICHAEL E. ETZINGER: I will defer -- the overall plan is Kana's that she's been working. From a staff development side, I'd be happy to sit down and chat with anybody about what we're doing. Again, you know, I say it only half jokingly, there was a lot of interest in the staff development portion, and we had some

folks in there.

And I mean, they're diving into it. I mean, because they see this, rightfully so, as their futures, their careers, and their opportunity to have a piece of reshaping SAMHSA. So there's a lot of excitement around it, and I'd be happy to, from a staff development, certainly share anything that we have and, again, from the overall IOS perspective, I would defer to Kana on that.

DR. LORI ASHCRAFT: I'm interested in the staff development part.

MR. MICHAEL E. ETZINGER: Oh, happy to do it anytime.

MS. KANA ENOMOTO: We do have -- we have an overarching logic model, and we also have a logic model for each of these seven priority areas. So we could probably share the logic model.

DR. LORI ASHCRAFT: Great. Thank you.

MS. KANA ENOMOTO: And I didn't mention that we did have an open house. We invited -- the person power to do this work is coming from the SAMHSA staff. So we did an all-hands invitation. So we had about half of the staff volunteer to be on one or more of the workgroups, and so that is how we are driving this is with all staff.

MR. JOSEPH A. GARCIA: Yeah, I'm sorry. Relative to the slide, military families are included in the left column, but on the new initiatives, strategies, military families are left out. Are they included within one of the other items?

And specifically, I'm thinking about not so much military at this point, but veterans.

MS. PAMELA S. HYDE: We actually -- and Kathryn Power was here earlier, but I think she literally is at the White House as we speak because we are majorly immersed with the White House and DoD and VA on military family issues, ranging from active service members now to veterans to everybody in between and their families, Reservist, Guard, et cetera.

What we figured out is that some of the strategic goals and objectives that we had for the last 4 years we have actually accomplished. Now what we're doing is incorporating that population into everything we do. So they're really incorporated throughout at this point.

MR. JOSEPH A. GARCIA: Yeah, I kind of assumed that, but thank you.

MS. PAMELA S. HYDE: Yeah.

MS. MARY FLEMING: Well, the story of the policy IOS is a bit of a different story than the staff development IOS. So I think that's why we were asked to present today.

The policy IOS has followed a rather messy route to get to where we are, and as Mike's group did, we had a very large group of people who joined us during our kickoff. What generated from that meeting was sort of several issues, including people not understanding what a policy is, not understanding how in their daily work that the decisions they make either implement or affect policy or make policy. Folks having an interest more in a specific program than in the policy of the agency.

Sort of a lack of understanding of the sort of complex set of environmental factors that impact the policies that SAMHSA operates under. The legislation that we operate under, the priorities of the Secretary, the Administrator's priorities, reports, data -- there are just a myriad of things that impact -- that impact policy.

So we really began to regroup and think through what did we -- what were the tasks that we needed to be working on? So our logic model at this point is probably ready to be fine-tuned. We moved from -- from a focus -- we moved onto a focus of understanding how policy is made at SAMHSA, how does one go about challenging, questioning a policy, understanding that not everybody will always get their way.

Mike does a great piece where he talks about if there are 40 people in a room and you take a vote, and 21, say, are going to vote one way and 20 another, it doesn't really diminish the value of the 20, but the 21 might win. And I think sometimes people feel like if it's not my policy, it isn't a policy that I adhere to.

So we've really begun to think through how do we make policy? How do we affect policy, challenge it? And then how does the whole staff use public policy -- or use policy in their everyday work? How do we use it to influence the policies of other agencies and groups?

So as we began sort of down that process, we, as a management team, started thinking about the theory of change. We were in the middle of a discussion. It was sort of clear, and I don't know if you have the theory of change? Have you seen that slide yet? Good.

It became clear that this is really a construct or it's I think Kana would use the term a sort of discipline to put on the way we manage at SAMHSA in some ways. But it's a policy decision to adopt that kind of a construct to move forward, and so we -- we developed a tiger team, and you probably know tiger teams are short-term work teams that we use to achieve a specific goal.

We formed a tiger team to really attack, tackle the theory of change so that we develop a common nomenclature of what does that mean when we talk about it? What does it mean for a program or an activity to be at this stage of innovation or translation? What questions do you ask as you move programs or activities along the theory of change? And that we also then develop a way to communicate that kind of information back to staff.

So we're actually dealing with how do we make a policy? How do we translate a policy into action in an in vivo kind of environment by taking a major policy direction and working it through the IOS process?

And the other thing we find is that this has implications for every other IOS. So as Mike seeks to deal with talent management and staff development, you really have to think through what do staff need in order to implement that kind of discipline and construct on our work? What are the implications for financing?

So as we do a grant program, what questions do you ask at innovation that relate to financing versus what are the questions at wide-scale adoption? So there, it is a sort of complex picture that gets painted over the remaining internal operating strategies. The communication messages are different.

So we've been kind of on a winding path, trying to figure out how to approach this. And I might add, all the while we have other tiger teams who are working on some of those more concrete issues of trying to figure out exactly what else -- what's all those other things that really impact our policy, and how do they then play into the policymaking process?

Fran, do you have anything to add?

MS. FRANCES M. HARDING: I was sitting here looking at my notes, going okay, okay, okay. She was on a roll. No, I think I will help out with Q&A.

The only piece to let you know is that at first we really thought we were a dismal failure when all of our colleagues were reporting out their progress and when our team went in such a different direction than what the ELT actually wanted us or our leadership wanted us to go forward with.

But once we did, as Mary said, once we were able to regroup and re-recruit, by the way, by persuasion people to come back to the disorganized policy workgroup, they actually got very much engaged because they realized that what we were really talking about was the work that they do and what are the level of policy decisions that are made at every level? We have several levels, like most of you have.

And then when the ELT, Mary thought it would be smart to suggest that we had a tiger team for ELT. All of ELT now is working together. So although we're on

separate tracks, everyone appears to be rather engaged because it's about them, and they didn't realize just how many decisions were made, which I think was the point, because we were all making these decisions. And I think the most important thing Mary talked about was that this process, once we go through the exercise of mapping out which step along the theory of change and what are the policies associated that it's going to inform the other -- the other, what do we call them, the other IOSs.

And so, Mike, beware. So there may be some changes, and I think that once we begin to see that you can challenge a policy that's made, policies must be consistent in some areas and not in others, it will help out with a whole array of issues in SAMHSA, and I think most organizations, their commitment to the organization, whether or not -- the morale of the agency because they are finally feeling like they have something to contribute. So --

Dee?

MS. DEE DAVIS ROTH: This is a wonderful graphic. Oh, sorry. This is really a wonderful graphic. It is in every way. It's really good visually and explains well. I'm volunteering to review the paper that you're doing about what happens at all the stages. I mean, this is really a nice piece of work.

MS. MARY FLEMING: We hope to get it done. I mean, the other thing that it provides for is, I think, a mindful way to think about the outcomes you're trying to achieve and then try to work backwards from there to a solution. So sort of a series of "what if?" What if I wanted to change, you know, name a policy, the rate of suicide? What if I did this? What if I did that? And you can sort of work your way backwards to a starting point that is directly tied to the outcome.

And I think that's the other piece we're really trying to focus on, as Mike said, the new denominator and the new kinds of outcomes that we're measuring.

DR. INDIRA PAHARIA: I just am not good at these microphones. I got it. I got it. I got it.

Okay. Sorry. I actually think it also -- you could adopt this to any organization. So, as I was looking at this, I was thinking about all the change that my own organization is going through or others, and I'm thinking I could adopt this for my own. So I love it.

MS. THERESA GALVAN: On the tribal side, since I just got finally moved from acting status to permanent status as our behavioral health director for the Navajo Nation just March 10th, as I came back in in my acting status, I moved us toward what I call standardization. When I came in, it's like everyone had different roadmap. They were going north, south, east, and west.

And I was telling them, look, we've got to have one corridor. And within that corridor, that's what I see in your bullets up there of rest areas. We have to pull off, let's do that. Let's take a break. Let's look at it. Refuel, refresh ourselves. Get that drink, get the munchies, whatever, and then continue on.

But what I see and I agree with that is you could build this into other organizations because the evaluation and surveillance piece is really key for us. I brought on a program evaluation manager. She came from the outside, had no idea what behavioral health was, but when she looked it, she says, "Theresa, what about this, and what about that?" And I think it was really key because when I see your components up there, I'm like, wow, that's things that we've been working towards on our roadmap within that corridor.

So I think that as you call it the theory of change on our end is standardization. And it's timely because I knew a year and a half ago that the Nation allowed our division of how to move towards that State-like Department of Health. So we're embedding more public health service functions than we've ever done before, and we were doing it today, but it was never really defined.

So we got put across the board on our organization chart with other, 11 other programs, and I was glad, as we move towards and as we're moving towards the Department of Health, and hopefully, this month, our council will approve it, is that the division has allowed us to create our own Department of Behavioral Health now to be more distinct, separate from the 11 others, which is really great.

So as I see this and as a way the Affordable Care Act changes are coming in and through the six points that we just went through on the previous slides with all the workgroups with your strategic sessions -- workforce, IT, providers that we have -- I think it's all tying into what we're doing, and I really like this innovative thought because it's just right smack on what we're doing.

Thank you.

MS. CASSANDRA PRICE: I'm pretty loud.

MS. PAMELA S. HYDE: It's not about being loud. It's about the public being able to hear you on the phone.

MS. CASSANDRA PRICE: Okay. They still could probably hear me. It's Cassandra Price from Georgia.

And I just concur on the level of effort and expertise this went into where you guys are now versus where you were when you did the strategic initiatives the first time, and kind of the thoughtful process and using some really theory of change and science to really bring it forward.

I guess, I think it will be interesting how you track from a timeline, how you track each of these theories of change and how you mark progress and benchmarks of all of this. And I think -- but I think it's a great testament to really pushing it to the next level and getting also just lots of feedback and input, and it shows in the way that you've put all this together.

MS. MARY FLEMING: I just wanted to comment a second. We really didn't talk about the importance of data and evaluation in this process, but it's really key. And that's part of what we're trying to build into each stage, understanding that it probably needs to be a bit different in each stage. So, again, the questions are important in terms of what kind of evaluation and what kind of data, and does that change for a program over time?

So if you've been funding something for 12 years, you kind of know it works, do you really have to do another evaluation of it, or do you do something different with it? So we're really trying to -- again, it impacts in the way we expend our resources and the way we think about how we use data. So I appreciate your comments because I had sort of neglected to mention how important that piece was.

MS. KANA ENOMOTO: One question that we have for you is a question -- died from overuse.

So one question for council members who were here last time is whether or not you see yourselves and your feedback to SAMHSA. I think last time we talked about the SAMHSA of the future, and we've tried to incorporate some of that feedback into the IOSs and into this process because I think we've gotten great advice from you about how we need to expand our vision, our footprint, our influence.

I liked Juanita's comment, like people talked about SAMHSA being small. But you know, we live large. So I think that's what this is about. We're not going to quadruple our budget. We're not going to quadruple our workforce. But we're going to more than quadruple our impact by harnessing our resources, harnessing our energies in a really strategic way.

And I think, as you said, standardization, this is also a form of standardization. Everyone always had the same goals. We just went about it differently, and we didn't have a common parlance. We didn't have a way of saying what we were trying to do that translated easily from one program to the next. So I think we have tried to take input from the council over time, and so question for you is whether you see that reflected here?

MR. JOSEPH A. GARCIA: Yeah, part of what I see from last session and previous sessions is that I think some point in time I remember we made

comments about the system as a whole, and the delivery of the system includes all management, includes personnel, includes the operations, includes the entirety of an organization is that sometimes we can't tweak to make an improvement and we can't tweak here to make another improvement. Sometimes we've got to be innovative, that we got to start from scratch to some level and say you have to create it, and that's what the innovation part is what I see here, is that you've gone out and created something that didn't exist maybe in a different form or different way.

And so, what you all have done is created a new effort, a new look, and a new way of doing that business and improving. And so, it's going to pay for itself. You know, I've always thought that that was one of the answers to a lot of our dilemmas in Federal Government is that the things that we really need locally aren't there, and so not in the form that we need.

So our job then and the big challenge is to create something that works, and that's what I see here. So I'm really happy to see that.

Thank you.

MS. KANA ENOMOTO: Patrick?

MR. PATRICK A. RISSER: Yeah, I'm Pat Risser on the CMHS Council.

And I kind of feel like it's all been dancing around the edges. In my vision of, you know, 10, 20 years from now, what is it going to look like, I really hope that we can get away from being a mental illness system that's focused on illness and substance abuse, and we can shift the focus to being mental health and wellness.

And I see part of the integration is a piece of that. This is a piece. But it still feels like it's kind of tap dancing around the edges, at least out where the rubber meets the road, where the services are actually provided. They're still doing business old school, just like always, and we've never actually sat down and talked about what is mental health? Would we know it if it walked down the street in front of us, said, "Oh, there goes one. That's somebody who's mentally healthy?" We don't know.

Other than, you know, we know what mental illness is. It's the absence of whatever we call mental health, but other than defining it in the negative, I think we need to be looking at creating this positive. And even if you believe the most pessimistic numbers that one in five has serious mental illness, I still think you all are doing an excellent job because that means you're taking care of 80 percent of this country, and 80 percent of this country is mentally healthy.

And you're pushing those numbers up. Every time you do something like suicide

prevention or trauma help for people, you're pushing those numbers higher. But it's still, you know, it's necessary to somehow try and flip that around to look at it from the health and wellness side.

And I think this, this still for me just isn't quite getting there, and maybe we need to have that meeting where we actually figure out what it means to be mentally healthy.

DR. INDIRA PAHARIA: I'm assuming that you take the strategic initiatives and then you work with your regional administrators to disseminate into the regions. So that you can actually get feedback from the front lines and people doing that work, you know, as you were talking about. So that it does disseminate, it's not just at the Federal level. But it's really spread out through the regions. Is that true?

MS. KANA ENOMOTO: The strategic initiatives will go out for public comment online. So we get feedback nationally. I think last time Pam noted we had 2,200 unique commenters and 20,000 votes and comments.

So, and I think will also probably go out through our own mechanisms like the RAs and our own executives and staff. But the commenting period will be national. Does that make sense?

DR. INDIRA PAHARIA: Yeah, and then I was just making the point that it then goes to your regional administrators, right, down to the State level. That's what I was also commenting.

MS. KANA ENOMOTO: Yes. Yeah. Once we get to implementation, you mean, and sort of when we finalize the plan, absolutely.

MR. GILBERTO ROMERO: My name is Gilberto Romero, and I would just feel bad if I didn't -- if I went away with this thought and not expressing it. But you know, you keep talking about public health, and you're still focusing on the individual. I don't see that it's like any different from Western medicine that focuses on the individual.

Like when managed care came to visit us, I was like really happy that I discovered public health, and to me, what public health is, healthy people in healthy communities. And when I look at your strategic initiatives, I don't see like any strategies to strengthen communities because like the support that individuals need to sustain their wellness, that's what wellness is. Recovery is personal. Wellness is -- that's what wellness means. It's the community.

And so, when we say we're going to do public health, and we're still focusing on the individual, then we're not doing public health because if the community is not getting healthy along with me, you know, you guys are going to be in business

forever.

But I couldn't go away without saying that. You know, your initiatives are not strong enough on community.

Thank you.

MS. FRANCES M. HARDING: I think that we sometimes do a poor job of using acronyms instead of actual words in describing some of our programs, and I think this is one of the cases. For our prevention portfolio in SAMHSA, over 80 percent of the dollar, of all the dollar goes to communities. It's mostly distributed -- and you've heard two acronyms, PFS, Partnerships for Success. Partnerships for Success is a program that links States and communities and anyone else that touches a young person or family.

And then you've heard the SPF, or the Strategic Prevention Framework. The Strategic Prevention Framework is a five-step logic model on how States work with communities. We know, our science tells us, that communities create change, just as you're stating.

We do work in the individual environment as well. Many of our intervention programs, because the public model does -- public health model allows us to go across individuals and interventions and then universal, which is messaging to everybody. And then you add environmental, which is changing the behavior at a community level.

So I think a lesson learned is we need to talk about that more. One of the pickups when I did the round robin, because I refuse to call it speed dating, is -- I have people that may not like that. That we need to put in clearer language and back up the strategies that we have in the strategic initiatives, and I think that almost every table brought that up.

So I thank you. We in SAMHSA do both. We are focusing on communities a lot across all of our portfolio, and especially now, when we get more into integration and the community health centers, and a lot of the health services will be in the communities and the criminal justice services. But we also equally focus on the individual where appropriate not only in treatment, but also in our indicated intervention, which is that last section of intervention, and what we call pre-treatment, which is just before diagnosis.

Does that help?

MR. GILBERTO ROMERO: Yeah. Well, you've got to do a better job of articulating that, you know? And the emphasis, you know, like it has to be a balance. When I said you're focusing on individuals, that's an extreme. You know, to focus only on communities, that's an extreme.

So where's your balance? You know what I mean? And like I need to be aware of that. Like when people talk about SAMHSA, they kind of like come from, oh, we're going to provide services for our clients and so on and so on, and it's still individually focused, you know? So, yeah. And if I can help out in any way, I'll certainly do that.

MS. FRANCES M. HARDING: I think also Pam has spoken about this throughout the day, which is the need for us to increase messaging. And this is most certainly an area where we can improve and add in and emphasize in the messaging to all and the messaging to some, depending upon the issue.

So I thank you.

MS. KANA ENOMOTO: I would add, in addition to the Strategic Prevention Framework and the Partnerships for Success, we also have Project AWARE, which I mentioned is part of Now is the Time. It's Advancing Wellness and Resilience in Education. And that's about bringing communities, schools together with parents, law enforcement, you know, families, young people in exactly that, advancing wellness and resilience in educational settings and creating those partnerships and those dialogues so that we can help young people grow up to be healthy and safe.

And LAUNCH, Project LAUNCH is 0 to 8, and focusing on creating the networks that we need to make sure that that very young population grows up in a healthy and safe way.

Vijay?

DR. VIJAY GANJU: Hi. I was just thinking about sort of wide-scale adoption in our field and in general, you know? And so, you think how many of us have a smartphone? I would say a large majority of us. And so, I was wondering did they go through this process? No.

And so, why is it that we all have that? And I was thinking about new-generation antipsychotics and they've gotten disseminated pretty fast in our system, and other things have not. So, to me, at some level, I think it's worth going back to sort of even the old diffusion of innovation literature because there are characteristics of people who are uptakers, the characteristics of the innovation. All those things make a huge difference to this arrow.

And one of the issues that came up in the discussion that we had on our table a couple of times was that part of this whole process of wide-scale adoption has to be related also to creating demand. And so, this is -- this is the old, traditional sort of adoption, widespread adoption kind of thing.

But then, so one of the things I wanted to add was that somewhere out here there needs to be the marketing or the creating demand kind of dimension at the different levels. But the other is to realize that as we talk about the change, part of the challenges that SAMHSA's theory of change is partially what is going on within SAMHSA. But then it intersects with change that is occurring at State levels or at local communities that are also on this strategic tree.

So it becomes like a matrix because at some point, SAMHSA needs to be prepared not to just move along this continuum, along the special innovation where you think of integration or something like that. I think one of the discussions we had was there are different States that are going to be at different states of readiness for innovation. Some of them are going to be beginning. Some of them are more sophisticated. Some of them are better resourced.

And so, the strategy that's always been used is let's put out grants, and usually it's the early adopters, the first part, that essentially come onboard. And so, I guess part of all I'm saying is that there's a huge challenge in this model of change, especially when you start intersecting with the different strategic initiatives and then also interfacing with other organizations.

So I'm just saying that there's a lot of work and activity that's entailed just in the simple chart.

MS. MARY FLEMING: I appreciate your comments. We've talked a lot about this not being a linear process in any way, along with the fact that programs can enter at different stages. Not everything will go to wide-scale adoption. So I think your comments are right on target.

I sort of jokingly told folks, I came back from a meeting in terms of talking to research to practice, that they called that middle part the transformational valley of death and that that's really where things get messy when you try to figure out what's going to go to wide-scale adoption and how to move things along. So I appreciate your comments.

MS. KANA ENOMOTO: Thank you all for the conversation, and I thank that the ELT members for giving those examples.

MS. PAMELA S. HYDE: So thanks to this group up here and the rest of ELT, and actually, literally, a special thanks to Kana. She's been an incredible leader behind this and thinking about it.

[Applause.]

MS. PAMELA S. HYDE: Pushes me and pushes the other folks along, too, to think differently.

Let me just do a couple minutes of wrap-up, and then we will be done once we hear from the public comments. Sometimes there's public comments. Sometimes there's not. So it says I'm supposed to do closing remarks afterwards. So I'm going to close remarks now, and then we'll be done.

Agenda Item: Closing Remarks

I do want to say that Kana did a good job of picking who was going to talk today for exactly the reason Mary said. I think you can see that we have some very concrete, straightforward things we need to do about staff and other things. Doesn't mean it's not complex, but it's sort of Mike is a great one for saying we're going to go to Los Angeles. Do you want us to go through Yuma or Denver? You know, just tell us how to get there or tell us where you want us to go, and we'll get the job done.

And then the policy one is much more complex, and it's -- and the theory of change is much more complex. So I tell you that or I say that to say we are really trying to think about -- this in some ways came out of last year, the 20th anniversary -- or year and 5 months ago now, 20th anniversary of SAMHSA. And sort of some of us thinking, well, where were we 20 years ago, and what does SAMHSA look like now and then? And what it's need to look like 20 years from now?

So we've sort of set this for a 2016 goal, but frankly, we're trying to set the trajectory for a Federal agency that is leading public health efforts around behavioral health in the country and to advance behavioral health of the Nation because we want to think about SAMHSA's role for the future. And we want to do that not just because we sit in SAMHSA. We often talk about sitting here and taking our hats off. But rather to say what does the country need in an agency whose job it is to do this?

And we get what I think you can see from it, it is not just a lot of work on any particular initiative that's going on in any particular day or what's the work that's going on in any particular grant program on any particular day or what's the work that's going on down on the Hill on any particular day. But this is a whole other set of work that we've taken on, and there are certainly people who would say we're taking on too much.. And yet I think some of us in the whole executive leadership team has spent a lot of time thinking if we don't take this on, we may not be here to take it on because somebody else will, frankly.

This is going to be a trajectory that the country is going to go in, and somebody is going to take it there. So we think the Federal agency that is responsible for this should be the one that does that. So that's why we're trying to take it on with

your help, and you really were very helpful last time in helping us think about how we should think about SAMHSA differently for the future.

So I do appreciate that, and I hope, for those of you who were there last time and this time, you can sort of see how your -- how some of these conversations may seem just like good conversations. They're much more than that. They are advice. As I tell lots of people all the time, advice is a product. And you create that product and that input for us, and then we take that. And sometimes it may seem to somewhat diffuse, but it really does get incorporated into our work in very fundamental ways. And so, I hope you can see that.

So I just want to ask, we've got about 2 minutes before we're going to open this up to public comment. Does anybody have any final, last words, things that you want us to be aware of, or particularly those of you who are on the national committee that will -- council that will be meeting tomorrow, part of the way we use the national group is to reflect on what the day has been like and what does it mean for next steps for the councils and for us.

So is there anything you would like us to know or anything you would like those who sit on the national council to know for tomorrow or any final comments from anybody?

Yes, Charles?

MR. CHARLES OLSON: This is Charles Olson.

I'd like to make one last comment about your new Web site. I do think it's a lot more friendly, and it's been really cool watching it kind of grow along. It's tough to redesign your business without redesigning your storefront. So it's been very cool watching that grow.

MS. PAMELA S. HYDE: Cool. Well, watch some more because it's got another ways to go. So we have the whip out about that one. So thank you for that feedback.

Is Marla in the room? There you go. Marla. Project Evolve we call that. So you may hear a little bit more about that tomorrow, actually, too.

All right. Any other comments before we go to public comment? Pat?

MR. PATRICK A. RISSER: Yes, I've thanked you personally, but I wanted to publicly express my appreciation. For those who don't know, I'm term limiting off of these councils, and it is too bad because, you know, it's like I finally feel like I've figured it out a little bit, you know?

But thank you all, and you've got a killer good staff. You're an awesome leader,

and I really believe in what you all are doing. I appreciate that you're so open to hearing from all of us, that you've got great advisers, and it's just been a heck of a good ride.

Thank you.

MS. PAMELA S. HYDE: Well, thank you, Pat.

And all of you who are moving off, it's always sad to see you go because we sort of feel the same way, Pat. About the time we get into what you're telling us and how to get the best stuff out of you, then you have to go off. So that's too bad, but we'll keep in touch for sure.

All right. Anything else?

[No response.]

Agenda Item: Public Comment

MS. PAMELA S. HYDE: All right. So do we have the -- is there anyone in the room, anyone on the line?

MR. JOSH SHAPIRO: Jamie, is there anybody on the phone that would like to make a public comment?

OPERATOR: And at this time, if anyone on the phone lines would like to make a public comment, please press * and then 1. You may press * and then 2 to remove yourself from the question queue. Again --

[Audio difficulty.]

[Laughter.]

MS. PAMELA S. HYDE: Anyone in the room from the public?

[No response.]

MS. PAMELA S. HYDE: Okay. Well, hearing no public comment, then we stand adjourned, and we will see the national group tomorrow.

Any of you who want to stay around and come listen to those conversations, they are always fun and unique and interesting and helpful. So you are welcome.

Have a good evening and a safe flight back to wherever you are going.

[Whereupon, at 4:30 p.m., the meeting was adjourned.]