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SUBSTANCE ABUSE AND MENTAL  
HEALTH SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP)

NATIONAL ADVISORY COUNCIL MEETING

10:04 a.m.

Wednesday, August 26, 2015

SAMHSA ROCKVILLE HEADQUARTERS

1 CHOKE CHERRY ROAD

ROCKVILLE, MARYLAND 20857

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- 9 Hill Hospital in New York
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- 12 RICHARD MOORE, Acting Deputy, CSAP
- 13 CLARESE HOLDEN, Ph.D., Acting Director, Division of
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P R O C E E D I N G S

AGENDA ITEM:

WELCOME, INTRODUCTIONS, AND OPENING REMARKS

MR. AUMEN: Thank you. So hello, everyone. My name is Matthew Aumen, and I am the Designated Federal Officer for the CSAP National Advisory Council. Fran, we have a quorum, and I'd now officially call the Center for Substance Abuse Prevention National Advisory Council meeting to order.

So again, this meeting is being webcast online. It's being recorded and transcribed, so when speaking, please state your name and speak into the microphones. Be sure, folks in the room, you turn your microphones on, you'll see the red light on when they are on, to ensure accurate reproduction for the minutes and transcription.

We do have several members who are joining us remotely today. They should have a open line for discussion. So with that, I will turn it over to Fran.

MS. HARDING: Good morning, and welcome to the CSAP, the Center for Substance Abuse Prevention, SAMHSA's Center of Prevention Services, National

1 Advisory Council. My name is Fran Harding, as you just  
2 heard, and I'm the director of the center as well as the  
3 chair for this council.

4 I thank all of you for coming and spending the next  
5 couple of days with us to talk about the emerging issues  
6 that we are facing in our country in prevention and also  
7 some of the issues that we have chosen as a council to  
8 discuss today.

9 Let's go around the room -- around the table,  
10 rather, and have the staff of SAMHSA that are at the  
11 tables and the council members introduce themselves.  
12 Please, I'll remind you to use your mics. As Matthew  
13 has just reminded us, we are all being recorded. Thank  
14 you.

15 Jorielle?

16 DR. BROWN: Good morning, everyone. I am Jorielle  
17 Brown, the director of the Division of Systems  
18 Development in CSAP.

19 MR. MONTGOMERY: Good morning. I'm Michael  
20 Montgomery, retired as the director of the California  
21 Office of AIDS and the member of the NAC.

22 DR. COMPTON: Good morning. I'm Michael Compton.

1 I'm a member of the NAC. I'm a psychiatrist, and I'm  
2 the Chairman of Psychiatry at Lennox Hill Hospital in  
3 New York.

4 MS. REYNOLDS: Good morning. Kathleen Reynolds.  
5 I'm a member of the NAC and I work for Westat in  
6 Rockville, Maryland.

7 MR. LUCEY: Good morning. Rich Lucey, Special  
8 Assistant to the Director in CSAP.

9 MR. MOORE: Good morning. I'm Richard Moore. I'm  
10 currently serving as the acting deputy in CSAP.

11 DR. HOLDEN: Good morning. Clarese Holden. I'm  
12 the acting division director for State Programs in CSAP.

13 MS. HARNAD: Good morning. Dianne Harnad. I'm a  
14 NAC member and past Director of Prevention and Health  
15 Promotions, State of Connecticut.

16 MR. KEEL: Good morning. My name is Steve Keel.  
17 I'm a former director of Problem Gambling Services and  
18 Director of Prevention Services in Massachusetts, the  
19 Department of Public Health, and I'm a National Advisory  
20 Council member.

21 MR. WARD: Good morning. My name is Allen Ward.  
22 I'm a branch chief for the Division of Community

1 Programs. I'm sitting in for Charles Reynolds, the  
2 divisions director for the Division of Community  
3 Programs.

4 MS. RICHARDS: Good morning. I'm Claudia Richards,  
5 Acting Director for the Office of Program Analysis and  
6 Coordination.

7 MS. HARDING: Thank you. And now I ask, we have  
8 three of our NAC members listening in remotely, if you  
9 could introduce yourself as well.

10 MS. SATTERFIELD: Good morning. I'm Ruth  
11 Satterfield, and I'm a member of the NAC. I'm past  
12 Chief of Prevention in Ohio and current school counselor  
13 in Ohio.

14 MR. CLAPP: John Clapp. I am the associate dean  
15 for research in the College of Social Work at Ohio State  
16 and the director of the Higher Education Center for  
17 Alcohol and Drug Misuse Prevention and Recovery.

18 MS. HARDING: Thank you. We know that Steven Green  
19 is going to join us. He just wasn't able to link on  
20 right now. It's probably too early, although we try to  
21 make it a little bit more reasonable for our friends out  
22 west.

1 I think that our agenda today is very exciting.  
2 We're talking about two of the areas that are of most  
3 interest to both the NAC and to SAMHSA as well as the  
4 country as we move forward, and that is the whole area  
5 about updating you on what SAMHSA is doing around  
6 marijuana, around heroin, around other emerging issues.

7 But also, we're going to have a conversation about  
8 aligning substance abuse and mental illness prevention  
9 within the context of overall health care. That's  
10 really what today's theme is mostly about. And we're  
11 also going to take a deeper dive into some of the grant  
12 programming that we have, which you've also asked us to  
13 do, and have a discussion around that.

14 But the first thing we're going to have today is a  
15 visit from our new acting administrator. She hasn't  
16 been on the job only three days, so I have to get that  
17 into my head, the transition. And so while we're  
18 waiting for Kana Enomoto to come, let me just remind all  
19 of you the reason why Kana is here is because Pam has,  
20 indeed, retired.

21 We all miss Pam very much already. She has left  
22 her mark, not only in SAMHSA, but I think around the

1 country. Pam was a real champion of behavioral health.  
2 And I don't think that we would be in the position  
3 today, if we didn't have Pam as our administrator  
4 leading the conversation around behavioral health. It  
5 just was not something that we spoke about. It aligned  
6 perfectly with the overall mission of our country with  
7 the new health reform process. She was a champion for  
8 that, and she fought very hard for prevention.

9       And I think that I will personally and  
10 professionally miss her in this particular area and have  
11 been energized by her passion of moving agenda along for  
12 us around behavioral health and helping us discuss that.

13       So Kana, she's going to be here momentarily. I  
14 just saw Nevine, who was -- I thought I saw Nevine. I  
15 did see Nevine. And letting us know she is making her  
16 way down.

17       As you can imagine, she's visiting all the NACs, as  
18 Pam also did. But I'm sure that she's not able to get  
19 away from the commitment as quickly, because so many of  
20 us have a lot of questions for us, and hopefully, she  
21 will have a lot to say to us.

22       If I know Kana well, and I think I do, she will

1 probably speak less and ask more from you. So be  
2 prepared to ask her questions or describe -- and I'm  
3 specifically talking about the NAC members -- describe  
4 who you are, how you got here, and anything else that  
5 comes up in conversation. She's very much wanting to  
6 sort of get the flavor of what we're doing here and what  
7 the National Advisory Council for Prevention is all  
8 about.

9       Hopefully, it's not the first time you've met Kana  
10 or seen her. You might have seen her. You might not  
11 have actually had a lot of face time with her to meet  
12 her. But she has, especially this last year, been able  
13 to get out and do several presentations, and I think  
14 more exposure this year than previous.

15       Anyone who works with CADCA and the Drug-Free  
16 Communities, I know that, if I were to choose one area  
17 in prevention where she has had the most exposure, it is  
18 in that particular area. So I know our staff, she has  
19 made herself readily available. She is going to have  
20 meetings with every division in the already. Her plan  
21 is to do that before the middle of September.

22       So she really is trying to carry on the message of

1 behavioral health and health reform, prevention,  
2 treatment, and recovery as it is set forth. But we know  
3 every new leader comes with their own thumbprint, and  
4 we're always looking to improve and using these changes  
5 as opportunities.

6 So anything you want to ask, any suggestions you  
7 have, this would be the time to do it, following up, of  
8 course, tomorrow during the joint NAC of pulling her  
9 aside.

10 So how perfect could that be. Good morning, Kana.  
11 I just got through your long intro. I probably said a  
12 little bit more.

13 MS. ENOMOTO: I apologize for that.

14 MS. HARDING: No, no, not at all. It really worked  
15 out quite well, and I think it was like you were out  
16 there listening waiting for me to stop talking.

17 AGENDA ITEM:

18 DISCUSSION WITH ACTING SAMHSA ADMINISTRATOR

19 MS. HARDING: So I've said it all. I'm going to  
20 have, if it's okay, the NAC members introduce  
21 themselves, and then we have two, possibly three, NAC  
22 members on the phone, and they'll do the same.

1           So we'll start with Michael Montgomery. We will  
2 not put the two of you together again, just want you to  
3 know.

4           MR. MONTGOMERY: Hi, Kana. I'm Michael Montgomery.  
5 I'm retired as the AIDS director for the State of  
6 California. And when I joined the NAC, Pam challenged  
7 me to raise the flags of HIV and LGBT communities, which  
8 I've tried to do in my clumsy way.

9           MS. ENOMOTO: I think some of your emails have gone  
10 viral, so we're paying attention to what you've said.  
11 Thank you.

12           DR. COMPTON: Hi. I'm Michael Compton. I'm a  
13 psychiatrist, and I'm also board certified in preventive  
14 medicine and general public health. And I've been on  
15 the NAC for several years now. Good to meet you.

16           MS. REYNOLDS: Hi, Kana. Kathy Reynolds. Do a lot  
17 of work nationally with integration and my joining the  
18 CSAP NAC has led me to incorporate prevention much more  
19 into the work that we're doing across the country with  
20 integrating mental health addiction and primary care.

21           MS. HARDING: And you need to know, Kathy is our  
22 volunteer. So whenever you ask for a representative,

1 they all point to her, and she says yes.

2 MS. ENOMOTO: Thank you for that.

3 MS. HARNAD: Hi. I'm Dianne Harnad. I'm past  
4 director of prevention for State of Connecticut. I've  
5 worked in the field for over 30 years, and I joined the  
6 NAC two years ago. I think Connecticut, not only  
7 Connecticut, but just a lot of the thinking that we've  
8 incorporated was trying to bridge mental health and  
9 substance use prevention over the last several years,  
10 building state infrastructures and aligning the work  
11 that we do with federal plans as well as state plans,  
12 and so that's sort of what I bring to the table.

13 MR. KEEL: Good morning. My name is Steve Keel.  
14 This is my second year on the Advisory Council. I am  
15 the former director of Substance Abuse Prevention  
16 Services in Massachusetts and also the former director  
17 of Problem Gambling Services in Massachusetts, and I  
18 just retired this past Friday, but it's a pleasure to be  
19 here.

20 MS. HARDING: Could I have both John and Ruth  
21 introduce yourselves to Kana?

22 MR. CLAPP: Sure. John Clapp. I'm the associate

1 dean of research at the College of Social Work at Ohio  
2 State. I'm also the director for the Higher Education  
3 Center for Alcohol and Drug Misuse Prevention and  
4 Recovery and done a lot in the area of college alcohol  
5 and drug prevention and moving science to practice.

6 MS. HARDING: Thank you, John.

7 Ruth, are you still on?

8 We seem to have temporarily lost Ruth, but she'll  
9 log right back in. I mean, she was on yesterday as  
10 well.

11 So, Kana, I turn the floor over to you. They're  
12 anxiously awaiting to hear from you, and also, I told  
13 them that you like interactive conversations, so they're  
14 prepared to do that as well.

15 MS. ENOMOTO: Great. Thank you, Fran.

16 MS. HARDING: Yep.

17 MS. ENOMOTO: Well, thank you, first of all. I  
18 just appreciate all of you have fantastic backgrounds.  
19 You're bringing wisdom, experience, ideas, opinions to  
20 the table here, and it's incredibly valuable.

21 As you know, none of them are new, is that right?

22 MS. HARDING: Yeah.

1 MS. ENOMOTO: Yeah, so none of you are new, so you  
2 all knew Administrator Hyde, she really saw advisory  
3 committees as central to how we do our business. She  
4 saw your advice as a service that you were doing for us,  
5 and I will continue that tradition of visiting with our  
6 committees, listening to our committees, and trying to  
7 use you all to the best of you -- to use your time  
8 wisely in how we can leverage what you bring to the  
9 table in moving SAMHSA's mission and programs forward.

10 I want to acknowledge Director Harding and her  
11 acting deputy, Richard Moore, and the fantastic CSAP  
12 team. They are incredible. They continue to perform at  
13 a very high level. Despite changes, challenges,  
14 transitions, and so forth, it's really a stellar team.

15 The commitment that you have to substance abuse  
16 prevention with this group is awesome as well as their  
17 openness, their willingness, their thoughtfulness to  
18 bring some of that prevention technology and science  
19 across the way to our friends in mental health and as  
20 well as to spread it across the administration.

21 So Fran's got a wonderful leadership opportunity  
22 with the Office of National Drug Control Policy and

1 their Heroin Task Force, and she leads across SAMHSA on  
2 our Prevention Strategic Initiative. And so the  
3 commitment and the work and the value of what she brings  
4 to the table and her team brings to the table is really  
5 appreciated at every level of SAMHSA and HHS and the  
6 White House with our friends at ONDCP. So thank you to  
7 Fran.

8       You all received the emails about Pam, had sent out  
9 that she would be resigning, and her last day of SAMHSA  
10 was actually Sunday, frankly. In her last week, we had  
11 some going away events, and people asked Pam, when's  
12 your last day? And unlike most people, who would say  
13 Friday, our pay periods technically end on Saturday, and  
14 so Pam had a full workday planned for Saturday, which  
15 went into the wee hours.

16       And, in typical fashion, doing the work of three of  
17 four people, Pam sort of met her targets and got out the  
18 documents and the policies and controls, the  
19 correspondence that she had set out as an objective for  
20 herself. So to the last minute, she was a passionate,  
21 ardent, committed, hard-working administrator for  
22 SAMHSA, and she brought a vision and an energy to the

1 job that very few people could have.

2 I'll talk more about some of her accomplishments  
3 tomorrow at the joint NAC, but I wanted to convey to you  
4 her regrets that the timing of things was such that she  
5 didn't get to say goodbye to you in person, but I know  
6 that, again, she sends her best. She's still in town,  
7 so some of you may have a chance to see her.

8 But she left SAMHSA with a great legacy and has  
9 positioned us very well to continue on the path that we  
10 were on with higher visibility than ever for the issues  
11 of substance abuse prevention and treatment, and for  
12 mental health promotion and treatment of mental  
13 illnesses and caring for the people who need it the  
14 most, as well as looking after our young people in this  
15 nation who need good behavioral health in order to have  
16 good futures.

17 And so Pam really -- SAMHSA was on the map before,  
18 but Pam got like a flashing neon sign over our heads in  
19 terms of visibility within the department and across the  
20 administration and I think across the board in the  
21 field. So we're lucky to be in this place.

22 And my commitment, as acting administrator, is to

1 sort of see through the Agency in as smooth a transition  
2 as possible, that we will continue on the priorities  
3 that we have. We will also continue to listen to the  
4 field and be open to ideas and suggestions for how we  
5 can improve, how we can make more traction on the things  
6 that we all value as important.

7       So I'll be introducing some folks tomorrow. Mike  
8 Etzinger, with whom some of you may be familiar, was  
9 former deputy of CSAP, so Fran had the great vision to  
10 find Mike. She can pick talent. And so now, Mike's  
11 actually Fred's boss, as the acting deputy  
12 administrator.

13       But he is a fine professional, many years at DOD  
14 and bringing to us a sense of order and operations and  
15 timeliness that will be much appreciated. He's got a  
16 get it done approach that will help SAMHSA stay on  
17 track.

18       We've also asked Tom Coderre to serve as chief of  
19 staff. He is now our senior political appointee at  
20 SAMHSA and will be helping in the Office of the  
21 Administrator to make sure that we are responsive to our  
22 centers and offices as well as to the field. So thank

1 you.

2 And with that, I'm happy to have conversation.

3 MS. HARDING: I'm just going to say, any questions  
4 or comments, direction you want Kana to pay attention  
5 to? She's open to all the above. And if you don't,  
6 we're going to be asking you questions. So I suggest --

7 MS. ENOMOTO: I have a few in my pocket over here.

8 MR. KEEL: First, I'd like to say welcome, nice to  
9 have you here.

10 I have a question that actually stems -- or at  
11 least a statement or comment that stems from the  
12 discussion that we had yesterday in terms of marijuana  
13 and research.

14 I think one of the things that's made it somewhat  
15 difficult at times for us doing marijuana prevention and  
16 providing other services has been the lack of research  
17 or the lack of depth of research.

18 And I would like to encourage you in any way that  
19 you can, and I know this is happening, but I would like  
20 to also encourage you, whenever possible, to combine  
21 perhaps resources with NIDA and NIH or whoever, to try  
22 to broaden that so that we can actually use that data.

1           Prevention has worked very hard, substance abuse  
2 prevention, I know, to be a data driven field, to be a  
3 data driven service. And I think it's just very, very  
4 important that we have that depth of knowledge so that  
5 we can continue to do that. So just wanted you to hear  
6 that message.

7           MS. ENOMOTO: So we are partnering with our  
8 colleagues at CDC on an IOM report on marijuana  
9 research, for exactly the reasons that you articulate,  
10 that the administration would like to have a roadmap for  
11 what do we know in terms of the science and what do we  
12 need to know, because our nation has moved forward with  
13 the legalization and other things in a way that was  
14 driven by the populace, and that has also raised issues  
15 that we need to better understand, and we don't yet have  
16 the science to do that, so to inform policy making, to  
17 inform health care, and to inform enforcement.

18           So I think that's what -- so CDC had raised this  
19 some time ago, Pam had raised this some time ago, and I  
20 assume you talked about the BHCC committee, so Pam, as  
21 the visionary that she is, I always say, she doesn't  
22 just skate to where the puck is going to be, but she's,

1 like, thinking to the next game, she's like thinking of  
2 -- this game is already over in her head, and she's  
3 already onto the next thing.

4       So she had called this issue several years ago and  
5 said we at HHS need to get it together and understand  
6 exactly the state of the science, what the implications  
7 will be for us and for others, for FDA, for CDC, for  
8 HRSA, HHS, everybody.

9       So that work is absolutely happening. We have a  
10 cross cutting committee with HHS and the IOM report is  
11 getting going. And we've also been in conversation with  
12 the Surgeon General's Office about a surgeon general's  
13 report on alcohol, drugs, and health, which we hope will  
14 not so much provide the roadmap for the science, because  
15 the IOM piece is much more in-depth, but the piece for  
16 the SG would be much broader in its scope, sort of the  
17 overview piece to just capture for the public health  
18 field what the science is today.

19       MS. REYNOLDS: An issue that's obviously near and  
20 dear to my heart is the integration with mental health  
21 and addiction and primary care and prevention. And as  
22 Mike also eloquently talked about yesterday, prevention

1 has been outside of those discussions in some ways. And  
2 just wondering if you have thoughts on where we're going  
3 with integration and the future of that.

4 MS. ENOMOTO: Well, I think I could turn the  
5 question on its head and sort of say -- or the statement  
6 on its head, is I think integration is the future. And  
7 Fran has long been trying to, I think, increase the  
8 skills and awareness, the knowledge, the thinking in  
9 CSAP about not only community-based prevention but also  
10 clinic-based prevention and that interface with primary  
11 care, because obviously, we have SPR, but there are  
12 probably other ways in which prevention needs to be  
13 brought to bear.

14 We have our HIV Continuum of Care Grants, where to  
15 Fran's credit, she pushed, because I thought, well,  
16 that's kind of a stretched, but she pushed, and she  
17 said, nope, we want to get prevention in there. So  
18 while we're bringing a continuum of care for HIV care  
19 into mental health and substance abuse treatment  
20 settings, we're also bringing prevention there.

21 And so I think that is the vision. We've had some  
22 conversations about ecological models of health and

1 trying to understand not just the health care aspects of  
2 integration but integration in terms of other human and  
3 social services. So we're talking about being -- we  
4 need to be where people are.

5 Our issues are so ubiquitous that we need to be in  
6 the schools, we need to be in the workplaces, we need to  
7 be in the churches and the synagogues and the mosques,  
8 and we need to be with law enforcement and fire  
9 departments and housing authorities. We need to be  
10 where people are, because these issues are in their  
11 everyday lives.

12 So absolutely I think about integration in clinical  
13 settings, not only primary care but also specialty care,  
14 right, because you have a traumatic brain injury, you're  
15 vulnerable to many other things. And it would be great  
16 if your clinician could talk to you knowledgeably about  
17 those things.

18 But we also need to be in other places where people  
19 are accessing services to meet their needs, because  
20 that's a great opportunity to talk to them about this  
21 stuff.

22 So yeah, I think integration is the future.

1           MR. MONTGOMERY: One form of integration I'm  
2 thinking about is, at least in Maine now, the big topic  
3 is the number increase in heroin overdoses, and  
4 specifically people who are accessing heroin, because  
5 they can no longer get the other prescribed medications,  
6 opiates.

7           It seems to me that this is -- if anybody needs  
8 access to prevention services, it's doctor's offices.  
9 And I'm wondering, is there a connection being made yet  
10 with the medical profession in terms of offering  
11 training regarding how to prevent people from becoming  
12 addicted to the drugs they're prescribing.

13          MS. ENOMOTO: I just reviewed yesterday CDC's  
14 prescriber guidelines and our comments about them. And  
15 I'll tell you, Tom Frieden emailed me directly. I was  
16 like, oh, my God, I just got an email from Tom Frieden.

17          But he emailed me directly saying that he wanted my  
18 comments together with the staff's comments on their  
19 guidelines. And so I was very impressed, both by what  
20 CDC had already put together as well as by our staff's  
21 comments about the need to address, you know, patient  
22 responsibility, physician responsibility in terms of

1 monitoring the risks and the possible side effects of  
2 these medications, about the need to check PDMPs, about  
3 the possible of co-prescribing naloxone and other  
4 things. So I think that's definitely on the Secretary's  
5 mind.

6 Did you talk about her plan yet, the opioid plan?

7 MS. HARDING: No. We haven't gotten to that.

8 MS. ENOMOTO: Okay. And that may come up later.

9 But the Secretary has absolutely prioritized the issue  
10 of opioid abuse and overdose, and it's just front and  
11 center on her agenda. And she's bringing together so  
12 many of the parties that have skills and resources to  
13 bear, so FDA, CDC, NIDA, SAMHSA, ASPE, and others.

14 But she has a three-pronged approach, which is one,  
15 increasing access to medication-assisted treatment, two,  
16 increasing access to naloxone and reducing overdose  
17 deaths, and three, addressing prescriber guidelines and  
18 reducing sort of unnecessary prescribing of opioids.

19 So we have partnered with CDC, not only in the  
20 development of their guidelines but also we're talking  
21 to them about what kind of educational opportunities,  
22 dissemination opportunities there are to work with the

1 medical fields as well as dental and others in terms of  
2 how they are prescribing opioids and how they can better  
3 inform themselves, inform their patients, and provide  
4 options for people to reduce the likelihood of  
5 dependence growing, so yeah, abuse and dependence.

6 MR. MONTGOMERY: That's great to hear.

7 MS. ENOMOTO: Yeah.

8 MS. HARDING: John, is there anything happening in  
9 Higher Education, and particularly what your center is  
10 now doing with substance use and/or behavioral health in  
11 general?

12 MR. CLAPP: Yeah, there's a few things going on. I  
13 think on the of the things that would probably be of  
14 biggest interest to you all is the center is working  
15 with the Government Affairs Office of Ohio State and a  
16 couple of other major universities to try to get some  
17 refocus back into the Higher Education Reauthorization  
18 Act that's kind of working its way through the Hill  
19 right now, with the hopes of maybe restoring some  
20 resources for the fields that they're in. So that's  
21 part of what's going on.

22 MS. ENOMOTO: That's great to hear. There's a lot

1 of young people at Ohio State. And we just had our  
2 preview briefing of the National Survey on Drug Use and  
3 Health for 2014, and we're seeing still some very  
4 disturbing numbers in that 18 to 25 year old population  
5 in terms of their access to treatment, their increasing  
6 use and initiation, a lot of problem use.

7 We're seeing such good stuff happening in the 12 to  
8 17 age group, really a lot of progress being made there.  
9 But 18 to 25 remains the age cohort that's driving a lot  
10 of the increases that we will see, that you'll see when  
11 the data come out. So important work.

12 Want to shout out to Rich Lucey, who I know is  
13 incredibly passionate in this space and keeps all of our  
14 feet to the fire in terms of thinking about higher ed,  
15 because with the way our portfolio is, it's very easy to  
16 focus on communities and states, but Rich makes sure  
17 that we're also always thinking about, you know, where  
18 some of the biggest problems are, which is with our  
19 young people in institutions of higher education.

20 MS. HARDING: Thank you.

21 MS. ENOMOTO: So I actually, as I'm coming to this  
22 seat in the organization, have a few questions for you

1 all in terms of stuff I've seen, stuff I've heard,  
2 wondering if there are opportunities to be had, one, I  
3 think, to elevate prevention. I mean, Pam has had it as  
4 our number one strategic initiative for the entire time  
5 that she was at SAMHSA and yet I'm not sure we've seen  
6 the kind of support we would have liked in all corners  
7 in our efforts to elevate prevention.

8       So we've had some proposals, for example, our  
9 strategic -- we call it SPF Rx. I don't even know.  
10 It's hard to say all the words. SPF Rx just rolls off  
11 the tongue, and we talk in acronyms all the time, but  
12 strategic prevention framework focused on prescription  
13 drug abuse.

14       And while we saw a program for medication assisted  
15 treatment, prescription overdose and addiction get  
16 funding and Congressional support, we have not seen  
17 support for our prevention program. We also see some  
18 support for a naloxone program in the Center for  
19 Substance Abuse Prevention.

20       Naloxone, don't get me wrong, super important,  
21 really absolutely something that needs to get more  
22 uptake in the field, and it keeps people alive, but it's

1 prevention, and it's death prevention. So I think it's  
2 quite a stretch to say that's substance abuse  
3 prevention. And yet, the Substance Abuse Prevention  
4 Proposal didn't get support. Didn't get support.

5 So what do you think SAMHSA could be doing, and/or  
6 the field could be doing, or you could be doing to help  
7 us elevate the need for preventing the substance abuse  
8 in the first place?

9 And then another question that's sort of related to  
10 that is suggestions that you have. One of the things  
11 that I've heard from the CSAP staff in particular, but  
12 all of the SAMHSA staff really, is about how to elevate  
13 the role and to really leverage the expertise and the  
14 skills that we have in-house among our CSAP staff and  
15 other SAMHSA staff, because we have a lot of really  
16 outstanding prevention professionals on board

17 And they do a great job monitoring their grants and  
18 providing technical assistance to their grantees, but it  
19 feels, to me, like, we could do more to celebrate the  
20 professionalism and the skills that they bring to the  
21 table. So suggestions that you have for that would also  
22 be great.

1           MR. KEEL: Hi, Fran. I just jumped on that. Not  
2 that we're afraid, but I think you just put your finger  
3 on something that's just been a very difficult issue.

4           I know that I've really pushed hard in  
5 Massachusetts for primary prevention services. And what  
6 I run into is I can see the secondary piece happening, I  
7 can see a lot of support for intervention, even harm  
8 reduction types of issues. We start getting to  
9 prevention, though, there does not seem to be the  
10 financial support to actually carry on that piece.

11           I think we struggle with how do we put together  
12 that type of a financial support to encourage prevention  
13 when the grants and other things are pulled out. The  
14 sustainability is just not there.

15           I've come to the conclusion myself that prevention  
16 needs to be a cost of doing business, and somehow, it  
17 needs to almost be mandated, at least that's my  
18 particular perspective, so that it's something that  
19 automatically is required.

20           I do not necessarily think that's where some of the  
21 other providers, insurance companies and others, I don't  
22 think they're there quite yet. And their view on

1 prevention might not necessarily be primary prevention.

2 It's more along the lines of secondary prevention.

3       So I think you put your finger right on the point,  
4 how do we make that transition, so that we can have that  
5 primary prevention piece picked up.

6       MS. HARDING: Michael, I don't want to put you on  
7 the spot, but I'm going to. Can you give a little  
8 vignette of what you spoke about yesterday about the six  
9 areas of prevention and some of the struggles and  
10 challenges that we talked about that we sort of have to  
11 begin to start thinking about?

12       I think this aligns a little bit of what Kana is  
13 thinking. And maybe if we start looking at prevention  
14 in that direction and health reform in general, it might  
15 help us get more buy-in from individuals who are making  
16 these decisions for us.

17       DR. COMPTON: Sure. So as I was thinking through  
18 the topic of integration, in the field of psychiatry and  
19 medicine in general, integrated care in our world means  
20 primary care and mental health care in one setting, co-  
21 located, coordinated, collaborative care for primary  
22 care and mental illness treatment.

1           But I was trying to think through what are other  
2 models of integration. And so I sort of broke down the  
3 elements that could go into various forms of integration  
4 into sort of six elements, mental illness treatment,  
5 mental illness prevention, substance abuse treatment,  
6 substance abuse prevention, primary care treatment, and  
7 primary care prevention activities.

8           And so I guess I was sort of thinking are there  
9 models or best practices or theoretical sort of  
10 combinations of those six elements such that we could  
11 envision integration more broadly than just integrating  
12 primary care and mental health care in a treatment  
13 setting, and in particular, how do we get those three  
14 types of prevention bundled and integrated with the  
15 three types of treatment.

16           MS. ENOMOTO: Yeah. Are you familiar with the four  
17 quadrant model that was discussed sort of back in the  
18 day of integrating mental illness and substance use  
19 treatment? I mean, it sort of immediately went into --  
20 and I guess they're not quadrants, they're sextants, but  
21 it goes into sort of a little neatly into a table, and I  
22 wonder if there's ways to sort of shade that where

1 here's where you have specialty care of specialty  
2 professionals sort of, and then here's where you move  
3 over into more generalized settings and sort of the  
4 distribution of work and the need for allocation of  
5 services and resources could get done accordingly.

6 But yeah, it's a very interesting way and a good  
7 way to think about that.

8 DR. COMPTON: Another thought that I had was that  
9 we need more cross-fertilization between community work,  
10 such as community coalitions and treatment  
11 professionals. You know, having gone through medical  
12 school, psychiatry residency, preventive medicine  
13 residency, and a community psychiatry fellowship, I had  
14 never heard of community coalitions. And so many  
15 treatment professionals in the US are unfamiliar with  
16 community coalitions.

17 It would really be wonderful to begin to cross-  
18 fertilize and embed treatment professionals into those  
19 coalitions and coalition members into the treatment  
20 setting, so that we can begin to think and speak a  
21 common language of integration between prevention and  
22 treatment.

1 MS. ENOMOTO: Absolutely.

2 Kathy?

3 MS. REYNOLDS: And if I could just add to that.

4 This is Kathy Reynolds.

5 I'm involved in an interesting discussion with  
6 another group of professionals about the similarities  
7 and differences of the preventions and integrating the  
8 preventions in the mental health addiction and the  
9 primary care prevention, because we're talking about  
10 bringing prevention into the treatment field, but what  
11 about the similarities and differences of the prevention  
12 itself and raising that just -- substance abuse  
13 prevention but primary care and mental health, all  
14 prevention to a higher level of consciousness and  
15 funding.

16 MS. ENOMOTO: Yes.

17 Well, congratulations, Michael. I think you're the  
18 first physician I've ever heard talk about the community  
19 coalitions in that way, so that's impressive.

20 But as the folks in CSAP know, I'm a strong  
21 believer in community prevention, and I see such power  
22 in the coalitions that sometimes, as I go around, I say,

1 like, oh, we could do coalitions here, coalitions should  
2 be doing this, we could bring coalitions over here, and  
3 I think that's a challenge, you know, it's both a  
4 challenge and a blessings that sometimes when I have  
5 conversations with leadership in that space, they say,  
6 well, but we need to focus.

7       It's sort of hard enough harness the energy and  
8 bring up the skills and the funding to do, you know,  
9 community substance abuse prevention, but if we start  
10 sort of diluting that messaging or diluting the funding,  
11 then how can we assure that preventing drug use is going  
12 to maintain the focus and the energy that it needs if  
13 we're also helping to prevent diabetes, and we're  
14 helping to prevent suicide, or we're helping to prevent  
15 other things.

16       That being said, I think when we talk with  
17 coalitions, there are lots of coalitions that are on the  
18 Teen Pregnancy Task Force and on the Gang Violence Task  
19 Force, and doing suicide prevention as well as other  
20 things. So they are a multi-talented, multi-faceted set  
21 of entities that also probably have a lot to bring to  
22 clinical care and clinical care has a lot to bring to

1 them. So I think that's an interesting conversation to  
2 have.

3 You know, the commonalities across the preventions  
4 is another thing that we just had a great conversation  
5 about some of the early childhood stuff that we have  
6 coming out of CSAP, which in many ways, is universal.

7 Clearly, it helps to build the skills and the  
8 resiliency that you need for substance abuse prevention.  
9 But as you do that, you are building skills and  
10 resiliency for other things. And sometimes, that can be  
11 confusing to people

12 You know, on the one hand, what a wonderful and  
13 powerful thing to focus in early childhood to build  
14 that, and probably a very cost-efficient thing to do.  
15 On the other hand, we have our critics who would say,  
16 well, why are you doing that? What isn't someone else  
17 doing that? You know, how does teaching someone how to  
18 answer the door in a safe way keep them from abusing  
19 substances when they're 22?

20 It's hard to draw that straight line. And so whose  
21 money should be going to that? I think this is the  
22 challenge of the conversation on primary prevention, how

1 do you get that sustainable funding.

2       People have an easier time putting money behind  
3 something that they can see a very close link, like I  
4 give you the shot, you start breathing. Right? That's  
5 great. I can pay for that. But I teach you how to  
6 regulate your behavior and how to express anger in  
7 productive and healthy ways, who's supposed to pay for  
8 that?

9       It prevents lots of things. It promotes lots of  
10 good things. And yet, is that the school's job to pay  
11 for, because it promotes school success and school  
12 completion? Is that the cardiovascular people's job to  
13 pay for, because it reduces stress and prevents smoking?  
14 Is that our job to pay for, because it helps prevent  
15 substance abuse?

16       Part of the challenge of primary prevention is when  
17 it's -- even the environmental strategies are a little  
18 easier to see, controversial in different ways, but if  
19 you pass a law about that, then people don't do this,  
20 sort of A plus B. But some of the other primary stuff,  
21 if we have a well-functioning family, if we're talking  
22 about issues well, if we set boundaries, we have

1 consequences, all great things to do, but they're great  
2 things to do for lots of reasons.

3 But that's why we have you smart people around the  
4 table, it's what you're supposed to tell us, do this.  
5 Okay.

6 MS. HARDING: Before you leave, I have learned that  
7 we have three of our soon-to-be new NAC members with us,  
8 one in person, two on the phone, all waiting for their  
9 paperwork, and not as excited as some people are waiting  
10 for their paperwork to leave, which I will not out you,  
11 Michael. Just kidding. He loves it here.

12 So I thought it would be kind of fun for you to  
13 hear from them just a little bit to know who is going to  
14 be transitioning in as soon as the Secretary puts her  
15 stamp of approval and we do the paperwork.

16 MS. ENOMOTO: Oh, okay.

17 MS. HARDING: So we have Dolores and Scott on the  
18 phone, and we have Anton in the room. Let's start with  
19 in the room first and give a little bit about who you  
20 are and where you're from and what you do and anything  
21 else you want Kana to hear first time, although you  
22 might know Anton.

1 MS. ENOMOTO: I remember Anton.

2 DR. BIZZELL: Good morning, everyone. My name is  
3 Anton Bizzell. I am a former medical officer from CSAP.  
4 I'm the president and CEO of the Bizzell Group, and we  
5 do work particularly with SAMHSA around mental health,  
6 mental illness. We have technical support for the  
7 Office of the Director. We've been involved with  
8 prescription drugs since 2003. And so we've been on the  
9 frontlines for a long time.

10 I, myself, used to be over the 1,100 methadone  
11 clinics in the US. We came up with the first  
12 prescription drug strategy that is still in use pretty  
13 much at SAMHSA for the most part. And also, I've worked  
14 with ONDCP for the medical education for providers.

15 And so one of the things we've been doing for the  
16 last several years is really how to train physicians on  
17 maintaining their pharmacovigilance when prescribing  
18 drugs, because as a physician myself, we were never  
19 taught how to actually prescribe opiates. It was just  
20 something that we sort of like fell into and we learned.  
21 And so that's been our thing in what we are trying to  
22 do.

1           So I'm excited about joining the NAC as soon as the  
2 paperwork is completed, as Fran said. And so there are  
3 many other ways I think we can really approach substance  
4 abuse prevention, especially from an innovative  
5 standpoint, and so I'm glad to join the ranks of  
6 everyone around the table.

7           MR. AUMEN: Operator?

8           OPERATOR: This is the operator.

9           MR. AUMEN: Can you queue Scott Gagnon and Delores  
10 Cimini, if they are on the phone to participate?

11          OPERATOR: Sure. Scott or Delores, if you would  
12 star-zero, I can open your line at this time.

13          I don't believe either one of them are on the line  
14 at this time, Mr. Aumen. No one is star-zeroing.

15          MR. AUMEN: Okay. Thank you.

16          MS. HARDING: So Scott and Delores, I'm sorry, I  
17 didn't realize you weren't on the line, you're watching  
18 us. We just want to welcome you, and Kana will be -- as  
19 she said, one of the first things she said, that she  
20 will be here when we're here. She'll make time for us  
21 as well, so you'll meet her when all the paperwork is  
22 done, and you're around the table. So welcome.

1 MS. ENOMOTO: All right. Well, with that, thank  
2 you all very much. Thank you for your ongoing support  
3 of CSAP and the important mission of the center.

4 Oh, there's somebody.

5 MS. HARDING: Was someone trying to get in?

6 DR. CIMINI: Hello?

7 MS. HARDING: Hi, Dolores.

8 DR. CIMINI: Hi there. Can you hear me?

9 MS. HARDING: Yes, we can.

10 DR. CIMINI: Great. Would you like me to introduce  
11 myself now?

12 MS. HARDING: Yes, please, Dolores, who you are and  
13 what you do.

14 DR. CIMINI: Okay. Thank you. Thank you.

15 Hello. My name is Dolores Cimini. I am from the  
16 University of Albany. I am the assistant director for  
17 Prevention and Program Evaluation at the university and  
18 a licensed psychologist. I've been working in the area  
19 of prevention among college students for about 23 years,  
20 focusing on areas such as effort, universal prevention,  
21 as well as applying -- of the SFP initiative to our  
22 campus community.

1           And I'm delighted to be considered as a possible  
2 member of the NAC.

3           MS. HARDING: Thank you, Dolores.

4           Is Scott on the phone? I don't want to cut you off  
5 if you are? No.

6           MR. GAGNON: Am I on the phone?

7           MS. HARDING: Yeah.

8           MR. GAGNON: Yeah, I'm still here.

9           MS. HARDING: You really have to be flexible with  
10 this type of communication.

11           Welcome, Scott. Could you introduce yourself and  
12 what you do on a daily basis for prevention or mental  
13 health and substance abuse? Did we lose you?

14           We lost him. I think he's trying.

15           MS. ENOMOTO: Scott, can you hear us?

16           Okay.

17           OPERATOR: Scott, if you on the line, you can press  
18 star-zero at this time.

19           MS. HARDING: We tried. Okay.

20           MS. ENOMOTO: All right, Scott. Well, we will  
21 catch up at our next meeting in the spring, so thank you  
22 very much for being on the line and for listening.

1           So with that, I will take my leave. But again, I  
2 appreciate all of you and look forward to the  
3 conversation tomorrow. I hope you will actively  
4 participate in the pieces that we have. It's going to  
5 be a great conversation.

6           MR. GAGNON: Hi there. I'm sorry, not really using  
7 the technology here.

8           So my name is Scott Gagnon. Actually, I'm the  
9 substance abuse prevention manager for Healthy  
10 Androscoggin, so that's a Drug-Free Communities  
11 Coalition that serves Androscoggin County, Maine,  
12 although, I'm actually transitioning to a new role.  
13 Starting October 1, I'll be the director of operations  
14 at AdCare Educational Institute of Maine, which does a  
15 lot of the workforce development stuff with the  
16 Behavioral Health Workforce in Maine.

17           I'm also the president of the Maine Council on  
18 Problem Gambling, and I also head up our affiliate of  
19 Smart Approaches to Marijuana here in Maine as well.

20           MS. ENOMOTO: Great. Your advice will be greatly  
21 appreciated, so thank you very much.

22           MS. HARDING: And thank you, Kana, for taking the

1 time. We really appreciate it. Thank you, and good  
2 luck.

3 MS. ENOMOTO: Thank you.

4 (Laughter).

5 MS. ENOMOTO: I need it.

6 MR. AUMEN: Okay. So folks, we will take about a  
7 10-minute break. So Jill, if you can queue the music,  
8 and we will return in about 10 minutes. So thanks,  
9 folks.

10 (Break).

11 MR. AUMEN: We're ready to get started about with  
12 our next session, so I'll turn it over to Fran.

13 MS. HARDING: Okay. Welcome back. We are now  
14 going to go into a discussion about aligned substance  
15 abuse and mental illness prevention within the context  
16 of overall health care. I read nicely.

17 More importantly, you heard from Kana, we talked  
18 about it a little bit yesterday in our working  
19 committee, this is the future of where we're heading  
20 towards. This really is going to be a conversation of  
21 two things.

22 One is, we want to update you on what our panel of

1 experts, that we have been working with for the past  
2 almost two years to put together some, for a lack of a  
3 more sophisticated word, tools for both SAMHSA staff and  
4 for the field, our grantees, to help them maneuver these  
5 waters of what we've been talking about in the NAC for  
6 the last three NAC meetings that we have been together,  
7 and as you heard from Kana, we're actually talking about  
8 this almost daily in SAMHSA trying to push the agenda so  
9 that nothing is lost.

10       And I think that's the biggest part of this  
11 conversation. And I again, thank Dr. Compton, because  
12 without saying it that way, you were saying it, that we  
13 want to be all-inclusive, and we can be. And this  
14 thought about putting prevention on the shelf is just  
15 not going to work for us any longer. We were patient in  
16 the beginning. We did the triage and made sure that the  
17 most needed people got the information of health reform.

18       Triage is over, or at least lessened, and now,  
19 we're moving into actual full programming, and full  
20 programming that we agreed to yesterday really are those  
21 six areas of prevention around substance use, mental  
22 health -- mental illness, rather, and primary care and

1 trying to work both with our treatment partners,  
2 remembering recover, and etc.

3 So without further ado, you'll hear a little bit  
4 about the update on where we are with the integration  
5 group, and then we will also begin furthering our  
6 discussion around health reform, ACA, and integration in  
7 general of taking off of what we learned a little bit  
8 yesterday.

9 And this is all going to be managed and facilitated  
10 by our very own Kathy Reynolds. And if she can get this  
11 all straight and put it all together, then my hat's off  
12 to her, and I have full confidence that she'll do that.

13 So I am going to turn this over to you, Kathy. And  
14 we are at your direction.

15 AGENDA ITEM:

16 PROGRAM UPDATE: ALIGNING SUBSTANCE ABUSE AND MENTAL  
17 ILLNESS PREVENTION WITHIN THE CONTEXT OF OVERALL HEALTH  
18 CARE -- CSAP EXPERT PANEL

19 MS. REYNOLDS: Thank you very much, Director  
20 Harding. We're excited to continue our conversation on  
21 integration and the role of prevention in the  
22 integration.

1           And pleased to have with us here today some  
2 representatives who are working with the expert panel.  
3 And we're going to start with hearing from them about  
4 the expert panel and the project that the expert panel  
5 is undertaking as part of this work.

6           So Jamie or Kevin, which one of you are going to  
7 start the conversation for us?

8           MR. CHAPMAN: I just want to briefly say that Fran  
9 has graciously allowed me to work on this project for a  
10 couple of years. I think she's going to make me work on  
11 this until we get it right. So we are looking forward  
12 to your feedback.

13           We do have an internal work group committee.  
14 Shadia Garrison and I are the co-chairs, and I want to  
15 lift up the other members, Nel Nadal, who is here today,  
16 Joyce Sebian is here also, Hyden Shen, Kenisha Bennett,  
17 and Morris Flood.

18           We are working as a small group to move this  
19 project forward. And our consultant is Jamie Hart, and  
20 she's going to review with you two documents this  
21 morning.

22           MS. HART: All right. Great. Thanks. We're going

1 to get started.

2 In front of you, you've got two things. The first  
3 document is called, "Review of Work on the Expert  
4 Panel," and this is a timeline of activities that I'll  
5 talk through with you. And then the second is and  
6 outline for a proposed community toolkit that we'll  
7 discuss as well.

8 So if we could start with the review of the work of  
9 the expert panel.

10 Just for a brief history, the first internal work  
11 group on CSAP Prevention and Health Reform started in  
12 May of 2013. So it has been a little while since it's  
13 been operating. And this work group was created to look  
14 at how substance abuse prevention really fit into the  
15 ACA. So that is kind of building on what Fran was  
16 walking about.

17 And the work group met monthly and has expanded to  
18 include CMHS as well. And so the focus has expanded  
19 beyond substance abuse to really embrace behavioral  
20 health to look at both mental health and substance  
21 abuse.

22 In April, then, of 2014, we held the first expert

1 panel meeting. And this was a really interesting  
2 meeting. It was about a day and a half that we met  
3 together. And the panelists ranged from providers, to  
4 academicians, to some community-based organizations, to  
5 federal representatives. But I think like this council,  
6 it was a representation of the key stakeholders that are  
7 engaged in looking at aligning prevention and overall  
8 health.

9       And the point was really to talk about definitions,  
10 to come to some agreement and some consensus on some  
11 definitions around prevention and some of the other  
12 issues and to look at some key messages that SAMHSA had  
13 and that CSAP had originally created.

14       And so what you see under that second bullet are  
15 the four messages that SAMHSA and then the expert panel  
16 refined. And so what the intent was to really look at  
17 what is the role, so how do you talk about mental and  
18 substance use disorder prevention as being essential to  
19 health reform, so establishing that it's a critical  
20 piece of it.

21       Secondly, looking at CSAP and SAMHSA's role in the  
22 ACA and CSAP's role about leading the inclusion of

1 mental and substance use disorder and prevention and  
2 health care, so really a proactive role on the part of  
3 CSAP.

4       And then third, to look at how this is integrated  
5 into primary care discussions and practices. And  
6 fourth, about the fact that this prevention is really  
7 vital to reducing health care costs and improving  
8 quality of life.

9       So those four messages were important for laying  
10 the groundwork and the rationale about why SAMHSA and  
11 CSAP play such a critical role in looking at prevention  
12 and integrating it into the ACA but also overall health.

13       And just a couple of comments about that meeting.  
14 I think it was a interesting conversation, because it  
15 was the first time the panel had met together in person,  
16 and it was sort of that forming/norming kind of stage.  
17 And so we went through a lot of conversation about  
18 really what are we here for, what is this conversation  
19 about. And a lot of really good and fruitful  
20 conversation around terminology.

21       We talked about broadening the issue to overall  
22 health, so it's not just how prevention fits in the ACA

1 and health reform, but overall health. Right? And that  
2 it's not just primary care. Primary care is one  
3 critical strategy, but it's part of an overall approach.  
4 So this conversation, I think, helped CSAT and CMHS  
5 really broaden the conversation there.

6 And then it was also, I think, the beginning of a  
7 concrete conversation about the role of the expert  
8 panel. So they were here in this first meeting to be  
9 able to provide feedback and talk about lessons from the  
10 field, but what would their role be over time? So we  
11 used some of that session to start to identify that as  
12 well.

13 And we did a mix of full group conversation. We  
14 had some small group conversations about how this plays  
15 out in states versus communities. So I think it was a  
16 really interactive meeting. And what we left with was,  
17 I think, agreement on some of those key messages and a  
18 real commitment from the panelists to move this effort  
19 forward.

20 So we followed up in October of 2014 with a virtual  
21 meeting. And this is where the panelists had a chance  
22 to -- I think it was an hour and a half maybe -- the

1 panelists had a chance to reflect on those messages, you  
2 know, because we really crammed a lot into a day and a  
3 half. And it was great to have a couple of months to  
4 take a step back and think about what those messages  
5 really mean and then for the panelists, what their  
6 experiences could help inform.

7       And we started talking about models from the field  
8 and really thought that that was a critical role that  
9 the expert panel could play about talking at these  
10 different levels, what are the things that people are  
11 doing in the field.

12       And then we also used that call to talk about the  
13 content and the format for the next meeting. So we got  
14 feedback about what worked, what didn't work, and what  
15 they wanted to see as objectives and products from that  
16 next meeting.

17       So in December of 2015, we convened another day and  
18 a half face-to-face expert panel. And the intent of  
19 this meeting was sort of to take the conversation  
20 further. So we asked people ahead of time to think  
21 about some of the promising practices and models and  
22 initiatives that they were working on that were looking

1 at aligning prevention and overall health.

2       And so we asked them to bring that to the meeting.  
3 We did a little summary of it, but then we embellished  
4 on that during the meeting. And then we also spent, I  
5 think, a lot of time talking about the role and  
6 priorities for SAMHSA and for CSAT and CMHS in moving  
7 this conversation forward. So it was really helpful to  
8 hear from the field about what they thought SAMHSA and  
9 CSAP and CMHS could do and where they could have the  
10 most impact and influence.

11       And so what you see here as well is that the group  
12 crafted some guiding principles. This was a long and  
13 interesting conversation as well about what they really  
14 saw as -- you know, the messages, I think, helped frame  
15 the conversation and give it rationale. The principles  
16 were the things that you need to think about when you're  
17 designing efforts to look at alignment. Right?

18       So here, I'm not going to read through all of them,  
19 but I think what really came across here was the  
20 importance of prevention. Obviously, prevention is  
21 prevention is prevention. But also the importance of  
22 having that community and cross-collaboration across the

1 different sectors, that people were thinking about and  
2 valuing measurement, that common measurement was a  
3 really critical piece, and that evidence-based decision  
4 making was something that everyone was really interested  
5 in, that you should look at things that have proven to  
6 be effective as models for moving forward.

7       And then also, we talked about the workforce as  
8 really being a vehicle for change, so training,  
9 standards, other kinds of things that would influence  
10 workforce development.

11       And then lastly, we spent quite a bit of time  
12 identifying a range of priorities during the meeting. I  
13 think we had, like, 20-some priorities that sort of came  
14 out of that conversation.

15       And then what we did was, we took that, again, and  
16 reflected after the meeting, sort of condensed that list  
17 a little bit, sent it back out to the panelists, and  
18 asked them to do a prioritization exercise. So we asked  
19 them to rank, you know, from your perspective, what are  
20 the top three things or the top five things that you  
21 think are most important to move forward as part of this  
22 expert panel, as part of the work of SAMHSA and CSAP.

1 And so as a result, there were three priorities that  
2 were identified.

3 One was communicating with coalitions to figure out  
4 what kinds of resources they have, and what are some of  
5 the issues that they face, and what can they bring to  
6 the table.

7 The second was identifying a role for those  
8 coalitions, so how do you encourage buy-in with the  
9 national agenda, how do you identify and translate best  
10 practices, etc.

11 And then a third was conducting sector-by-sector  
12 education, so how do you roll this out in different  
13 sectors.

14 And those weren't in any particular order, but  
15 those were the three that rose to the top.

16 So then the last bullet you'll see, we had  
17 recently, in July, a virtual meeting with the expert  
18 panel for about an hour and a half again. And what we  
19 wanted to do was reconvene them to look at those top  
20 three priorities, just to make sure that they resonated  
21 with them and that made sense.

22 And we decided ahead of time to focus on the

1 priority about the role and engagement of community  
2 coalitions. And so we phrased it as engaging community  
3 coalitions in an effort to align prevention and overall  
4 health.

5 And so what we spent time on during that hour and a  
6 half was to look at a product. So we sort of defined  
7 what that priority meant, we talked about who the  
8 stakeholders were and who we needed to address, and then  
9 we talked about what kind of product would be useful.

10 I think we walked in thinking and talking  
11 previously about maybe an issue brief and some other  
12 options, but what evolved out of that conversation was  
13 that what was really needed was something more than an  
14 issue brief and a toolkit. And so we came up with the  
15 concept of a community toolkit that could help  
16 coalitions figure out what role they can play and how to  
17 move this issue forward.

18 And so we ended that call actually with a pretty  
19 good outline, initial outline, of what that toolkit  
20 would look like, and our next steps were to solicit more  
21 feedback from the group on the outline for the toolkit  
22 and then invite people to support the writing effort.

1 And then we also spend a little time talking about, you  
2 know, concrete engagement for the panel.

3 So the plan with the panel is to move forward with  
4 this product development, to engage them in that  
5 process. And then we've got another in person meeting  
6 scheduled for October where we'll meet together, talk  
7 about the outline and the initial draft, hopefully, of  
8 the product, and then figure out what needs to be done  
9 to move it forward, and then talk about some of the next  
10 steps for the panel.

11 So before I get into the community toolkit, I want  
12 to stop and see if anybody has any questions about the  
13 process that we just talked about, either in terms of  
14 the timeline or how we engaged the panelists or the  
15 focus of the conversation.

16 Yes, please.

17 MS. HARNAD: Hi. I had a few notes that I had  
18 made.

19 Can you talk a little bit about the key frameworks  
20 that you explored?

21 MS. HART: Sure. And I'll ask the other panelists  
22 to jump in.

1           But we looked at, I think, not only behavioral  
2 health, but we looked at frameworks that are broader  
3 than behavioral health, so what could we learn from  
4 chronic disease models, like around HIV and diabetes and  
5 other things.

6           Is that what you're asking? Or are you asking two  
7 questions?

8           MS. HARNAD: Yeah, see, that's why I asked the  
9 question, because when I read key frameworks, I think of  
10 prevention frameworks, prevention theories and models,  
11 so that's what I was wondering, if you had looked at  
12 those.

13          MS. HART: We looked at those as well. I don't  
14 know, Richard or Fran, if you have other comments about  
15 frameworks. But I think what we were trying to do is  
16 present some of the concepts, and we asked the  
17 participants to talk about the frameworks that they used  
18 in their work and then tried to integrate some of that  
19 thought and that theory to move the conversation  
20 forward.

21          MS. HARNAD: I'm a little bit confused.

22          MS. HARDING: If I can channel Kathy, that we're

1 going to accept these types of suggestions to go back  
2 and look at the framework. So if you think there is a  
3 weakness here that, when I ask the question, or not even  
4 a weakness, but it could be broadened, then I'm sure  
5 Kathy has a way to gather all that information and send  
6 it back, so we can bring it to the panel.

7 MS. HARNAD: Yeah, because for instance, when I  
8 think of prevention frameworks, and I think we've  
9 discussed this at previous meetings, when you go back  
10 and you look at the public health framework of --

11 MS. HART: Definitely. Yes.

12 MS. HARNAD: -- primary, second, tertiary  
13 prevention and how that fits, and then, of course, the  
14 national prevention strategy, if we're talking about  
15 overall health, I'm not sure if you guys integrated that  
16 into your work.

17 MS. HART: We did.

18 MS. HARNAD: Okay.

19 MS. HART: Yeah, absolutely. So you're right. We  
20 did. We talked a lot about the public health framework  
21 and forming it and about the public health strategy.  
22 Absolutely. That was part of the conversation.

1 MS. REYNOLDS: And I think our purpose here is, if  
2 you'd like more information on the actual work of the  
3 expert panel, I think that we can get that for you. I  
4 think what we want to try to do here today is learn  
5 about what they're doing and not a ton of details on the  
6 how, but just accept that the expert panel has done that  
7 and then see if there's a space in what they have done  
8 and what they're recommending for the NAC to consider  
9 doing something.

10 So just other questions about the expert panel,  
11 because I know, from our perspective, we've talked about  
12 them a couple of times, so it's really nice to have the  
13 internal work group and Jamie here to do that. So  
14 anyone else with questions about the process to date for  
15 the expert panel?

16 OPERATOR: (Operator instructions).

17 MS. HART: I think the other thing I'd say, too,  
18 just about the process is that when the panel came  
19 together, it was very much about learning from the  
20 field, having them help inform the process, and I think,  
21 over time, we've come up with more concrete deliverables  
22 and a more concrete role for the panel to play. So

1 that's been really helpful.

2       And I think people were extremely interested in  
3 giving feedback on the outline for the community toolkit  
4 and contributing to the writing and development of it.  
5 And I think, down the road, there are other priorities  
6 that the panel would be interested in addressing. So,  
7 you know, the piece of the toolkit, ideally, will be  
8 done within a short time frame, and then what's next for  
9 the panel, are there other things that the panel wants  
10 to tackle.

11       So the other thing that you have in front of you is  
12 the outline for the toolkit. And I think as Kathy said,  
13 we're not going to really digest and dissect all of  
14 this. But what I want to do is just give you an  
15 overview of what the expert panelists and what the  
16 SAMHSA team has suggested might go into this.

17       So the audience would be community coalitions that  
18 are looking at prevention of substance use disorders,  
19 and the secondary audience would be the state  
20 leadership, so that they can provide effective technical  
21 assistance to the state coalitions. And the purposes is  
22 to create an interactive product that's really going to

1 introduce coalitions to the topic and provide resources  
2 as they begin to get engaged or to enhance the  
3 activities that they're already doing as well.

4       And so it will start with an introduction that will  
5 provide a rationale and help set the stage. The second  
6 section really is intended to talk about the background  
7 of ACA and health reform and to help coalitions identify  
8 their role. So it is about where some of those  
9 activities are happening, why the coalitions are so  
10 critical and important to the alignment effort, and then  
11 offer some hands-on sort of interactive activity.

12       So a coalition could use the toolkit to say,  
13 really, this is where I fit. Here's the work that we're  
14 doing in our coalition. Here's how it relates to this  
15 efforts, and here's some ideas for activities to move it  
16 forward.

17       This third section is models for collaboration. I  
18 think, you know, we hear over and over again that people  
19 are really hungry for strategies that have been  
20 successful or that maybe haven't been as successful but  
21 to understand why they aren't successful. But we talked  
22 about models for looking at working with community-based

1 models, with public health models, and models for  
2 integrating or aligned primary care and behavioral  
3 health.

4       And so again, there might be some comparison  
5 exercises that look at the different types of models to  
6 help a coalition identify which one might fit in their  
7 context. Case studies, I think, are always immensely  
8 helpful, with questions and topics for discussion so  
9 that coalitions can learn from the challenges and the  
10 opportunities that we're presented in those efforts.

11       The fourth section is about collaboration needs,  
12 and I think this is so critical. So yes, you've got  
13 these models, and they're wonderful, but what is a  
14 community coalition? What do you really need to be able  
15 to implement those and collaborate? What do states and  
16 communities need to do together to facilitate this?  
17 What's needed and from whom? And helping coalitions  
18 identify who are the key players that you need to engage  
19 and the stakeholders that need to be involved.

20       But it's also talking about what are some of those  
21 barriers you might face and how do you overcome them.  
22 And so some of the activities might be a worksheet on

1 what are the perceived and known barriers that you have  
2 to address, and then what are your strategies for  
3 addressing those.

4 The fifth section would be on resources that are  
5 available, so again, looking at the key messages and  
6 audiences that the coalitions may be trying to reach,  
7 tools and strategies, if they are technical assistance  
8 opportunities that are available.

9 And so this might be a place where there's some  
10 checklists about how do you really get started, how do  
11 you start the conversation and get people engaged, and  
12 then what happens next. And to be able to talk with  
13 them maybe about messaging, what might really work with  
14 the stakeholders you're trying to engage, and what might  
15 turn them off a little bit.

16 And then sixth section, or the last section, is  
17 about forecasting and, I think, looking ahead and  
18 helping coalitions think about how do you really use  
19 these opportunities for alignment. So there might be  
20 ideas around social media, learning collaboratives,  
21 technical assistance, other kinds of things that could  
22 really spark the conversations between states and

1 communities, and with SAMHSA and CSAP and CMHS as well.

2 And then, obviously, an addendum and some  
3 additional resources. That would conclude the toolkit.

4 The other thing I should say that it would be  
5 happening simultaneously with the toolkit would be a  
6 blog series, potentially, that would have some of the  
7 expert panelists. I think Fran, perhaps, would start  
8 the first blog, and then we could work with the  
9 panelists to do maybe a monthly blog about some of the  
10 activities that they're doing to move their work forward  
11 on alignment of prevention and overall health.

12 So that's what we've got so far for the outline.  
13 Kathy, I can turn it back over to you.

14 MS. REYNOLDS: And I think we want to take just a  
15 few minutes here and then move onto the potential role  
16 for the NAC.

17 But I think, Dianne, where you were headed in terms  
18 of really specific detail about if you have models or  
19 checklists or those kinds of things that you'd like to  
20 supplement the work of the expert panelists, I think  
21 Jamie or Richard would be happy, through email, or we  
22 can send them to Matthew, and you can get them onto the

1 expert panel, if we want to advise in that capacity.

2 But I think we wanted to spend a few minutes today  
3 to see if the advisory committee members have any  
4 thoughts on the outline of the community toolkit. Are  
5 there any glaring omissions, challenges or things that  
6 you would like to provide feedback through Jamie and  
7 Richard to the panel on in terms of this toolkit for the  
8 community coalitions?

9 MS. HARNAD: I have developed a training on the  
10 national prevention strategy and how coalitions can  
11 align with that strategy. And so I do have some  
12 worksheets that I can share with you on planning based  
13 on SAMHSA's goals and then resources that are in place,  
14 based on whether it's the NPS or SAMHSA goals or SAMHSA  
15 strategic initiatives. And also like a readiness  
16 survey, whether they're low, medium or high readiness.

17 And maybe you guys can tweak that a little bit  
18 more, but I do have some stuff that I have it with me,  
19 so I can share with you later that I'd like you just to  
20 see.

21 MS. HART: Perfect. Great. That's exactly, I  
22 think, the kind of resources we're looking for. Thank

1 you.

2 MS. REYNOLDS: So anyone else with resources or  
3 thoughts on the overall structure of the community  
4 toolkit from the expert panel that you'd like to get  
5 information to them?

6 MS. HARNAD: The only other thing I'd like to say  
7 is that I think the coalitions, especially DFCs and  
8 other statewide coalitions and campus coalitions, I  
9 think they're more ready for this than you may --  
10 because when I look at the guiding principles, I think  
11 they're -- from my experience, many of them already  
12 integrate these principles, and they're beyond them.

13 MS. REYNOLDS: Okay.

14 MS. HARNAD: I think they're a little bit more -- I  
15 don't know, what do you think Fran?

16 MS. HARDING: I think that the field, they fall on  
17 all levels of acceptance and development.

18 MS. HARNAD: And readiness.

19 MS. HARDING: And readiness. So there are some  
20 that I agree with you.

21 And also, I thought, wrong assumption, a few months  
22 ago that if your state was aligned, then your

1 communities were aligned. It was that way in the  
2 partnership for success grantee sub-recipient  
3 communities, but not so much with the Drug-Free  
4 Communities.

5 And then Charles and I have just briefly begun  
6 talking about the HIV cohorts and communities, which we  
7 didn't really bring into this discussion very quickly.  
8 So I think your point is well taken that some are, and  
9 maybe at some point, when this project is over, we can  
10 do something with that.

11 But right now, we just had a workshop with  
12 communities, some of the DFCs during the DFC midyear --  
13 the CADCA midyear conference. And we had an exercise to  
14 see if they could align themselves with different  
15 people. And I wish I had your six steps here or six  
16 sections. But what we did is we put out where health  
17 and mental health and substance abuse, and tried to see  
18 where they aligned. We had exercises. Some did really  
19 well. Others really needed some guidance.

20 So we sort of have a mixture, Dianne. And anything  
21 that we can do -- we also have a mixture within CSAP of  
22 our project officers on both the state and the community

1 level. Some really get it and are ready to move  
2 forward, and others are not.

3 And we have two individuals from CMHS. And you  
4 guys are terrific and are helping us, but there are two,  
5 so it's very hard to infuse that kind of focus in as  
6 well.

7 So yeah, it's definitely a work in progress. And  
8 since I'm talking, I just want to remind people, there  
9 is the word draft on this. This has not even been seen  
10 by Kana. So this is not for distribution beyond  
11 yourselves. Because you're our ambassadors, we are  
12 allowed to share internal documents with you, and it's  
13 because it makes for a more productive conversation.

14 So we're working on it. And I think Kathy is going  
15 to bring us to a different level of conversation, and  
16 maybe you'll have some ideas of where do we go from  
17 here, would be nice.

18 MS. REYNOLDS: And I apologize was unable to attend  
19 yesterday's pre-meeting, and Fran has given me the task  
20 of trying to link really what feel like three desperate  
21 things.

22 Was there anything, Michael Compton or the group

1 yesterday who participated, that would inform the  
2 toolkit from the community coalition perspective that  
3 would like to share at this point with liaisons to the  
4 expert phone?

5 MR. KEEL: Kathy, this is just an observation.  
6 First of all, I think a lot of good work has gone into  
7 this, I just want to comment, and I think it's going to  
8 be extremely helpful to communities to have a toolkit  
9 like this to move forward.

10 One of the areas that I think I've seen communities  
11 struggle a little bit -- Fran, for instance, you just  
12 mentioned mental health and substance abuse. I think  
13 communities are fairly well connected on that. I've  
14 seen some tripping going over the change to behavioral  
15 health still.

16 So I think, at the state level and other levels,  
17 behavioral health is becoming more the norm, and people  
18 are accepting it. I don't necessarily feel that that's  
19 translated down to the coalition level with some of that  
20 separation, that has not coalesced.

21 I think that's where the toolkit could perhaps be  
22 very, very helpful going forward in terms of bringing

1 them along and defining what it is we really mean by  
2 behavioral health and why so that we sort of close  
3 ranks, if you will.

4 MS. REYNOLDS: I know it's tough to be on  
5 electronic media linked into this. I don't know if Ruth  
6 or anyone in electronic media has any comments for the  
7 expert panel before we move on.

8 (No response).

9 MS. REYNOLDS: Well, thank you very much. If there  
10 are no other further comments for this, we really  
11 appreciate you folks taking the time to come in, and  
12 you're welcome to stay for our discussion and what we're  
13 going to talk about next in terms of linking both this  
14 with the conversation yesterday.

15 And the conversation that our designated federal  
16 officer has been pushing us as a NAC to have pretty  
17 consistently is, is there something that we can  
18 contribute product-wise to this conversation around the  
19 integration of prevention into the Affordable Care Act  
20 and health care.

21 And so I don't know, Matthew, do you have the  
22 questions for the discussion? Are we ready to move into

1 that?

2 MR. AUMEN: Absolutely. Yeah, I can pull them up.  
3 They're on the slides, if you want to get started with  
4 them.

5 MS. REYNOLDS: Please. What we're going to do is  
6 we have about 10 minutes here until we break for lunch,  
7 which is actually quite nice, because we can start the  
8 conversation, and you can think about it over lunch and  
9 then come back, and we'll have a half an hour after  
10 lunch to see if we can define it.

11 And I think this is a great time for the  
12 conversation, because we have some folks who are  
13 rotating off who may have ideas about what those of us  
14 who are staying could do in terms of helping with the  
15 field in this and also linking it to that.

16 For example, one of the things that I noticed on  
17 the priorities that the expert panel has created, and it  
18 appears that CSAP has agreed to, is conduct sector-by-  
19 sector education components. And we have some  
20 physicians. We have some, I think, real expertise here  
21 on the NAC that there could be a sector that we could  
22 think about where we might be able to provide input on

1 that sector in terms of an educational component on the  
2 incorporation of prevention into that sector. Again,  
3 just building.

4 So don't know if you had ideas from yesterday. I  
5 know it was a robust discussion of ways that, given what  
6 we've heard from the panel and their scope from their  
7 work, are there gaps that you see that we could go into?  
8 Could we do training for preventionists? And not gaps,  
9 but this sector-by-sector education component, and just  
10 any thoughts from the panel on something that the NAC  
11 and those of us that are remaining could do.

12 And as I said, I'm good at being voluntold, as you  
13 know, so if those of you who are leaving have thoughts  
14 on how we might be able to do this.

15 Or Dianne, you look like you have some thoughts and  
16 ideas. Remember to turn your mic on.

17 MS. HARNAD: I wrote a note, and it says, "conduct  
18 sector by sector education component," and I said, "on  
19 what?" That was my question.

20 MS. REYNOLDS: Does the expert panel have some  
21 feedback on what that priority is about that you could  
22 inform us on before we make our own definition?

1 (Laughter).

2 MS. HART: We focused in the last call on the  
3 priority about engaging community coalitions, so off the  
4 top of my head, there isn't a lot of immediate feedback  
5 that I think we talked about around educating sector by  
6 sector. I think it was thrown out as a potential  
7 priority, but it wasn't one that was fully developed by  
8 the panel yet.

9 So I think it was part of the conversation around  
10 educating. So community coalitions are one kind of  
11 stakeholder group, but I think it's about educating the  
12 broader community about alignment of prevention into  
13 overall health, and what does that mean, and what might  
14 some models be.

15 So it could be that the community coalitions are  
16 sort of a first step of one of those sectors, but that  
17 there are other sectors like physicians that could  
18 really benefit from some of that education and training.

19 MS. HARDING: And one of the reasons why this is  
20 prioritized the way that it is, is because we were being  
21 pushed to have it deliverable by the end of the year.  
22 So we felt as the -- and you know how that goes. And we

1 felt that the prudent thing to do was to focus on  
2 something that we actually could with all of the pieces  
3 due. And we knew that a toolkit would be able to be  
4 developed, put through the approval process, and gotten  
5 out to the field pretty quickly, and used. And then the  
6 rest will go.

7 But I think that, to answer your question directly,  
8 it's exactly everything that everyone has been saying.  
9 It's what messages or level of education or information  
10 sharing, depending upon what sector we're looking at how  
11 we speak to them, what information do they need, what's  
12 the best form to give it to them, and more importantly,  
13 how are we going to message this so we don't get lost.

14 So it's everything we talked about yesterday and  
15 more, because we didn't even scratch the surface. We're  
16 focused like this. And, you know, think about we  
17 haven't even had a conversation with people who are  
18 living in long-term recovery, for instance, and what's  
19 their role with all of this, and, you know, those kind  
20 of issues, some people will lived experience, and how  
21 does that translate.

22 So we have not gotten there, because it was

1 directed to the panel that they couldn't go there. We  
2 had to focus in on the toolkit.

3 MS. REYNOLDS: So from your perspective then, would  
4 that be a gap that we could potentially focus on as the  
5 NAC as what some of those sectors might be and who needs  
6 to be engaged and strategies for how?

7 And again, I'm just trying, at this point, to do  
8 some brainstorming before lunch of ideas where the NAC  
9 could focus and maybe, as Matthew has suggested, have a  
10 couple of calls to talk about and to have something that  
11 we contribute to the field in terms of an advisory  
12 capacity or recommendations as it relates to this area.

13 (Laughter).

14 MS. SEBIAN: Coming from a little bit more on the  
15 mental health perspective, and I'm Joyce Sebian, by the  
16 way, so one of the things just to put in the hat, and  
17 Fran has talked about this, and we've talked about it in  
18 the internal committee as well as, I think, in the  
19 expert panel, kind of just the paradigm shift that needs  
20 to happen when you really do this kind of integration  
21 and alignment.

22 And just to put this out there, one of the things

1 that I think is kind of more on the definition side is  
2 the language of prevention, often, maybe more on the  
3 mental health side, and so the two of us from CMHS, one  
4 is with the Project Launch Program, which is really  
5 birth to eight, and then I work a lot with the Safe  
6 Schools Healthy Students, so we span from early  
7 childhood right through, and that has a substance abuse  
8 prevention component also.

9 But flipping back to the Institute of Medicine  
10 Report and what we know, I think we got to really put  
11 some focus on thinking of prevention from that birth to  
12 -- and everybody understands that, but I think in the  
13 field, there's a lot of practice more that begins and  
14 frames it differently.

15 So I may get run out of the room, but I'm thinking  
16 early childhood or mental health tends to focus a little  
17 more on the younger kids and the life span and a lot of  
18 the prevention efforts that are more substance abuse  
19 focused are -- is this fair to say -- often start maybe  
20 middle and up.

21 And so I think getting these coalitions to really  
22 think of their work and all the range of prevention

1 initiatives that they might do covers that whole range  
2 of young people as well as adolescents and adults, and  
3 then that recover piece which cuts across both.

4 MS. REYNOLDS: Well, I think that's a great idea.  
5 At this point, just ideas of things that we might be  
6 able to participate in or think about, but I like that a  
7 lot as the language of prevention and the nature of the  
8 life span and where the mental health, addiction, and  
9 primary care prevention, how they come together into a  
10 universal prevention.

11 Other thoughts? Michael Montgomery is smiling at  
12 me. He's like, look away, look away.

13 (Laughter).

14 MR. MONTGOMERY: As somebody from outside of the  
15 substance misuse prevention community, I have a basic  
16 question. Are community coalitions something that exist  
17 and are required to get federal funds or something? I  
18 mean, what are community coalitions? Or do they have to  
19 be formed?

20 MS. HARDING: Very good question. And I'm going to  
21 ask Charles Reynolds to do a quick review of what a  
22 Drug-Free Community Coalition is. Then I'm going to ask

1 Dr. Holden to, from a state perspective in our  
2 Partnerships for Success Grants, what their communities  
3 look like. And then anyone else, if you want to throw  
4 in HIV, you're more than welcome to. And then there are  
5 many other experiences.

6 But the quick answer is yes, so coalitions are out  
7 there and will keep applying for grants. Some DFCs, the  
8 Drug-Free Communities, they come together, and you must  
9 be a coalition, and Charles will explain that, before  
10 you can even apply, and they go for five and then have  
11 the opportunity to go for five more, so they are  
12 seasoned.

13 And Clarese will tell you the difference between  
14 the Partnership for Success Grants, which are five years  
15 and also have a community component. All of the money  
16 in CSAP that we give out discretionary -- and I'm not  
17 sure about Block Grant, Clarese can explain that to you  
18 -- but 80 percent has to go to the field in a coalition  
19 type structure. Which gets to what Joyce was saying and  
20 what we've been talking about is a restriction now that  
21 we're moving forward into an integration process, if you  
22 think about that.

1           But we just don't have time to talk about that now,  
2 but that might be something we talk about later is what  
3 do we do when the funding mechanism and structures in  
4 SAMHSA are what's going to be described in a second, how  
5 do we get around that and still be able to do what it is  
6 we want to do. So sometimes, that's both positive and  
7 negative.

8           So Charles, can you give a quick overview of what a  
9 Drug-Free Communities Coalition kind of is and then what  
10 they need to do to get their money?

11           MR. REYNOLDS: Okay. Good morning. Just flying in  
12 from San Antonio. I apologize for being a little bit  
13 late, but I bring you greetings from our grantees out  
14 there in Texas.

15           A DFC Coalition must be an established  
16 organization, established coalition, that's been in  
17 existence for at least two years. And they must have up  
18 to 12 sector members which represents the community  
19 abroad, including everything from faith-based to police  
20 to media to the schools working together collaboratively  
21 to address three substance abuse issues, or three  
22 issues, tobacco, marijuana, prescription drugs.

1           And what's the fourth? What was the fourth one?

2           MS. HARDING: Alcohol.

3           MR. REYNOLDS: I'm sorry. And alcohol. Thanks.

4           How can we forget alcohol?

5           (Laughter).

6           MR. REYNOLDS: Like I said, I just flew in.

7           And what they do, as Fran said, they apply for the  
8 Drug-Free Community. It's a total up to 10 years of  
9 funding, which they have to apply in two cycles. The  
10 cycles might not be consecutive. For example, depending  
11 upon the availability of funds, they might get the first  
12 five years, and then the number of applicants coming in  
13 the score, and they continue to apply until they get the  
14 second five years of funding. Okay? That's really  
15 brief.

16          MS. REYNOLDS: Thank you. Because we're bumping up  
17 on lunch here.

18          MS. HARDING: And we just sent a message to Clarese  
19 that she will go after lunch, so that we do not, excuse  
20 the pun, eat into your lunchtime.

21          (Laughter).

22          MS. REYNOLDS: So we have a couple of ideas that

1 have come up just in this first 10 minutes of  
2 discussion. What I'm hoping is that when we return, if  
3 we could put two or three more ideas for projects that  
4 the CSAP NAC could consider, so if you haven't  
5 contributed an idea at this point, if you could think  
6 about that over lunch and come back, we'll have half an  
7 hour to continue this and to think through how we might  
8 be able to contribute as a NAC to some of the work.

9 MS. HARDING: So now that I was nice to you, I'm  
10 not going to be so nice, because this conversation, I  
11 just sense, is going to be rich, we'd like to come back  
12 at 1:00 and not 1:15, sorry, so that we have a little  
13 bit more work time. And you are allowed to bring your  
14 lunch here, so as you're chomping on your chips, we can  
15 start our conversation. Thank you.

16 And thank you, Kathy. We can't overall thank her,  
17 but we will after lunch.

18 And thank you for the team of integration for  
19 SAMHSA, and we'll continue. Thank you.

20 MR. AUMEN: So Jill, if you want to key the music  
21 up.

22 (Break).

1 MR. AUMEN: From lunch, we are going to resume the  
2 meeting.

3 What we want to do now, while we have a quorum, is  
4 very quickly approve the meeting minutes from the April  
5 2015 meeting.

6 AGENDA ITEM:

7 APPROVAL OF APRIL 2015 MEETING MINUTES

8 MR. AUMEN: So CSAP members, you should have the  
9 minutes with you. You have all had the opportunity to  
10 review and comment on them, I sent them via email a  
11 while back, and approve them.

12 But just as a matter of public record, I'd like to  
13 request a motion to approve the April 15, 2015 CSAP NAC  
14 meeting minutes. Do I have a motion?

15 MR. MONTGOMERY: This is Michael Montgomery. I so  
16 move.

17 MR. AUMEN: Okay. Michael Montgomery motions. Do  
18 I have a second?

19 MS. REYNOLDS: Second, Kathy Reynolds.

20 MR. AUMEN: All right. Kathy Reynolds seconds.  
21 Any dissensions? Okay.

22 Hearing none, let it be known for the record that

1 the April 15, 2015 CSAP NAC meeting minutes are  
2 approved.

3 So with that, we can move back into our session on  
4 alignment.

5 AGENDA ITEM:

6 PROGRAM UPDATE: ALIGNING SUBSTANCE ABUSE AND MENTAL  
7 ILLNESS PREVENTION WITHIN THE CONTEXT OF OVERALL HEALTH  
8 CARE -- CSAP EXPERT PANEL, CONTINUED

9 MS. REYNOLDS: We broke just before Clarese could  
10 give us a description of the community coalitions after  
11 Charles had talked about the Drug-Free Communities.

12 So Clarese?

13 DR. HOLDEN: First, our evolution of the SPF, and  
14 most of you have heard about the SPF SIG Program that we  
15 funded first, and then there's been an evolution to the  
16 Partnership for Success Program.

17 The Strategic Prevention Framework State Incentive  
18 Grant Program was an infrastructure and a service  
19 delivery grant program. And the program's supported an  
20 array of activities to help state grantees build a solid  
21 foundation for delivering and sustaining effective  
22 substance abuse prevention services and reducing

1 substance abuse problems.

2 CSAP awarded at least all 50 states, 8 US  
3 territories, specific jurisdictions, as well as 19  
4 tribes with the SPF SIG Grant. And so we move from the  
5 SPF SIG Grant, there was an evolution to fund the  
6 Partnership for Success Grant Program, which bore out of  
7 the SPF SIG Program.

8 And FY 2009 is when we first started talking about  
9 and funding the Partnership for Success Programs, and  
10 they had several goals that they needed to meet. And  
11 since I'm from the state division, Charles was speaking  
12 of the community division.

13 So our grants go directly to the state and feed  
14 down to the sub-recipients or to the community  
15 coalitions. The goals of the PFS Grant Program was to  
16 reduce substance use, related problems, prevent the  
17 onset of and reducing the progression of substance use  
18 disorders, strengthen the prevention capacity and  
19 infrastructure at the state and community levels in  
20 support of prevention, and leveraging and redirecting  
21 and realigning statewide funding streams for substance  
22 abuse prevention.

1           The PFS has evolved into an initiative that allows  
2 us to address top priority needs impacting our states  
3 and impacting, on a larger scale, the whole nation.

4           And beginning in FY 2012, the PFS Program has  
5 concentrated on addressing the nation's two top  
6 substance abuse prevention priorities, which is underage  
7 drinking, which bore out of the SPF, too, because that  
8 was the top priority within the SPF SIG Program,  
9 underage drinking. And the second one is -- underage  
10 drinking among youth and young adults age 12 to 20 and  
11 prescription drug misuse and abuse among -- can't use  
12 that word, abuse, anymore, but misuse among individuals  
13 age 12 to 25.

14           And SAMHSA has awarded grants all the way up to  
15 2015. We have a cohort that we just funded. The SPF  
16 SIG grantees was expected to meet several key  
17 requirements. The states must use a data driven  
18 approach to identify which of the substance misuse for  
19 prevention -- as a prevention priority, and they had to  
20 tell us which ones they were proposing to address out of  
21 the two.

22           States also could address both of these priorities.

1 And SAMHSA recognized, you know, that states are  
2 different, and sometimes, they have an emerging issue  
3 within their state and within their communities that was  
4 not one of these two priorities, so they were also able  
5 to choose another prevention priority and target that as  
6 well, and they were to tell us which one that they were  
7 going to do.

8       They must have developed an approach that assures  
9 that all the funded communities receive ongoing guidance  
10 and support from the state, including technical  
11 assistance, and we also provide technical assistance  
12 through our CAP contract as well as with the Block Grant  
13 technical assistance as well.

14       As I said, we certainly funded some 31 grants, PFS  
15 Grants, in 2015. We have a new grantee workshop that's  
16 scheduled for April the 12th to the 13th in 2016. And  
17 the program is based on the premise that the changes at  
18 the community level will, over time, lead to measurable  
19 changes at the state, tribal, and Pacific jurisdictions  
20 levels as well.

21       Equally important, the SPF PFS Program promotes the  
22 alignment and leveraging of prevention resources and

1 priorities at the federal and state and community  
2 levels.

3       And lastly, the states learn through the SPF SIG  
4 Program that they should identify DFC Coalitions as  
5 their grantees or sub-recipients, because they should at  
6 least target the DFCs that are in the targeted areas  
7 where they found the priorities to be mostly in those  
8 areas to increase capacity among their existing  
9 coalitions as well as with the DFCs that was in their  
10 areas.

11       So as to not duplicate coalitions' efforts in an  
12 identified catchment area, they were to choose DFCs, and  
13 may of our states did do that. And so our state  
14 advisory councils also mirror the coalitions' advisory  
15 councils with the same kinds of people on the councils.

16       So that's where we are.

17       MS. HARDING: Thank you.

18       (Laughter).

19       MS. HARDING: I'm just looking at Michael. It's  
20 probably more than you ever thought you'd get back from  
21 a simple question of what's a coalition.

22       (Laughter).

1 MS. HARDING: So thank you, both Charles and  
2 Clarese.

3 See, Clarese had the advantage of having an hour to  
4 prepare.

5 DR. HOLDEN: That's right.

6 (Laughter).

7 MS. HARDING: And Charles said it. So if I were to  
8 summarize both, the big difference between the two  
9 coalitions, and there are many more out there, is that  
10 you don't necessarily have to be a coalition already for  
11 the Strategic Prevention Framework. States are required  
12 to build you. That doesn't mean that they don't go to  
13 ready-made coalitions, because that's always optimal,  
14 but they also will bring the coalitions together.

15 As a matter of fact, a matter of history, when  
16 SAMHSA first started back in the 90s of funding the SIG,  
17 State Incentive Grants, that was the first introduction  
18 to states to actually build a coalition. So the state  
19 funded money, the discretionary dollars, certainly has  
20 shaped the use of coalitions differently, because they  
21 must be attached to the states.

22 And as you heard from Clarese, there is

1 restrictions on what they can focus on, whereas you  
2 heard Charles, much more open process in one respect,  
3 but you must be a coalition to apply for coalition  
4 dollars.

5       And I don't know that -- I can't remember, our  
6 lunch was so long ago -- Charles mentioned that there's  
7 a matching requirement with Drug-Free Communities, too.  
8 So yes, they're very, very similar. Yes, Clarese even  
9 showed how they're similar but no duplicative. And the  
10 biggest, I think, challenge we have with our coalition  
11 structure is that we are now trying to link them all  
12 together.

13       And I think we're doing a good job with our Block  
14 Grant dollars in doing that. And some of the coalitions  
15 for DFC reach out to the coalitions in the state, and  
16 vice versa. But not as much as I think any of us around  
17 the table would be comfortable with. So that's my  
18 summation of what they both said.

19       That help?

20       (Laughter).

21       MS. HARDING: Thank you.

22       (Laughter).

1           MR. REYNOLDS:  If I could just add one other thing,  
2  too, we noticed lately, Ms. Green, correct me if I'm  
3  wrong, we also start to see regional coalitions forming  
4  up, where that the coalitions are actually coming  
5  together as a region to address -- and even some regions  
6  are applying as a coalition.

7           So instead of just saying, I'm going to tackle my  
8  community, I'm going to tackle my county or my  
9  geographic area to work together.  So that's something  
10 we see different.

11          DR. HOLDEN:  And also I may add that the SPF  
12 itself, the Strategic Prevention Framework, is used all  
13 the way across SAMHSA's programs, in mental health and  
14 treatment as well.  And so we're starting to collaborate  
15 as well as doing much of the monitoring of the grants  
16 across the three centers and across divisions, because  
17 now, community division and the state division, our  
18 project officers are now starting to go out to  
19 coalitions together on a site visit, and so we're really  
20 interconnected here.

21          MS. REYNOLDS:  Very good question, Michael.

22          (Laughter).

1 MS. REYNOLDS: And we were also talking, just to  
2 clarify for the council as we head into the last 20  
3 minutes or so of our conversation, is the expert  
4 panelists focusing on the coalitions, the NAC, if we  
5 were to determine a project, has not been asked to join  
6 this. Okay? So we're not looking to work with  
7 coalitions, and I think that was unclear for folks was,  
8 you know, in this conversation, are we joining the  
9 expert panel and going to work on this toolkit for the  
10 community coalitions? No. That's the expert panel's  
11 project.

12 And we can advise and assist with that, but it's  
13 not that we have to work with community coalitions. As  
14 we talk about projects that the NAC could work on, it  
15 could be -- I know as Michael and I were talking on the  
16 break, with medical practices and bringing prevention  
17 into medical practices or other places. I think, from  
18 my perspective, it would be nice if we could, since this  
19 is on aligning SAMHSA prevention with overall health  
20 document, it would be nice if we could stay aligned with  
21 that in terms of the products and the things that we  
22 discussed.

1           So I hope that answers the question.

2           MS. HARDING: Yeah, and Kathy, could I just add to  
3 your statement, I think that's preferable.

4           MS. REYNOLDS: Yes.

5           MS. HARDING: I think we're actually looking for  
6 some guidance on how we do that that would be a best use  
7 of your time, meaning the council's time, in trying to  
8 align with the expert panel.

9           When we put this expert panel together, we actually  
10 sat and thought, can we use the council for this  
11 activity? But because we knew we needed deliverables  
12 and a certain time, and it became somewhat of a -- it  
13 wasn't a crisis, but it was certainly a need and a gap  
14 that we have, and so we decided that we would inform  
15 you, and you could inform the process rather than become  
16 the process.

17           And coincidentally, we do have one overlap, so  
18 there will be some coordination on that. And I don't  
19 know that I would say that you couldn't get into the  
20 coalition area for the NAC, but I think I'm hearing it  
21 in a way of using the best of our time.

22           So if we keep you informed on every step that's

1 going with looking at coalition development and  
2 toolkits, then you will be able to build that in,  
3 because as we talked about, all of the education to the  
4 other sectors that we haven't listed but we sort of  
5 talked -- we threw them out there right before lunch,  
6 will involve coalitions of some sort, because a  
7 coalition isn't going to be very successful if the major  
8 components of that particular community, county, or  
9 environment is not a part of it.

10         And that's where we are right now is helping  
11 coalitions expand their reach into the medical  
12 community. I would think that we would be in very good  
13 space to recommend what are some of those points of  
14 contact, because you certainly aren't going to go knock  
15 on the door of the hospital and ask for the chief  
16 psychiatrist to come in and join a coalition. But are  
17 you the right person that we go and knock on the door to  
18 say, we're doing this, we need some representation from  
19 the hospital, who do you think we should go to, that  
20 kind of thing.

21         That's where we're at now with coalition  
22 development -- expansion. Not development, expansion.

1 MS. REYNOLDS: Okay. So any other questions,  
2 comments on this particular topic?

3 Because what I'd like to head into, as the  
4 facilitator, one of the things that I always take on as  
5 my responsibility is listening to the feedback from the  
6 group and then trying to frame it in terms of some of  
7 the answers to the questions.

8 And so I think I have two or three ideas that came  
9 up from the group before lunch, and then in some  
10 conversations, just in fleshing them out a little bit  
11 while we were eating, on some areas that follow along  
12 with what Fran was saying.

13 And one of them we talked about beforehand was  
14 there was something in this sector to sector education  
15 program and I think particularly in approaching and  
16 working with health care systems, I know and the whole  
17 issue of integration. I just did a training yesterday,  
18 and one of the things I said, "What will make this day  
19 successful?"

20 And somebody said, "Well, if you tell me how to  
21 approach a primary care provider successfully and how do  
22 I go about doing that and what do I do that."

1           And we have some folks on a panel through November  
2 and coming on that may be able to really do that, as  
3 that may be a place where we could be a separate but  
4 aligned product that we could take on as to how do you  
5 approach and get hospital folks engaged in coalitions.

6           Because as I talked with Michael about yesterday  
7 and the conversations that you all had, he was thinking  
8 of clinical settings and bringing prevention into  
9 clinical settings.

10           Is that accurate?

11           DR. COMPTON: {Nodding head}.

12           MS. REYNOLDS: Okay. He's nodding for those of you  
13 who can't see him.

14           (Laughter).

15           MS. REYNOLDS: Michael Compton is nodding here next  
16 to me as we do that.

17           So that could be one particular area. And then  
18 there could be a variety of activities, like, you know,  
19 maybe a small focus group or some key interviews with  
20 primary care physicians or groups that we know.

21           Or I don't know how familiar folks are, there's a  
22 whole industry emerging around practice facilitation.

1 As integration goes into primary care practices with  
2 mental health and addiction, there's something called  
3 practice facilitation, which are groups that come in and  
4 help the practice identify their workflow to accomplish  
5 integration.

6 And that I've seen in none of those practice  
7 facilitation products is there anything that speaks to  
8 prevention. So a module that might support practice  
9 facilitation and integration that includes prevention.  
10 We talk addiction treatment in that, we talk about  
11 bringing in mental health, and we talk about primary  
12 care, but there's nothing in this emerging practice  
13 facilitation field that includes prevention and how you  
14 integrate prevention into that.

15 So that's kind of 1A, 1B kind of thing as working  
16 in that primary care space.

17 A second very intriguing idea that came up, I  
18 thought, was Joyce's idea around -- and I think it links  
19 with principle number one, prevention is prevention is  
20 prevention. One of the questions there we had is what  
21 does that mean.

22 (Laughter).

1 MS. REYNOLDS: We didn't ask that. We saw it  
2 there, but the question is, what does that mean and  
3 whether or not a white paper or a discussion or a  
4 synthesis of mental health, addiction, and primary care  
5 as prevention, definitions, conversations would be  
6 useful and fleshing that out.

7 It's interesting. I think I know who said that,  
8 because I've talked with somebody who used that very  
9 term, or he must have been on the panel or heard it,  
10 because he wants to do a conference presentation for me  
11 on prevention is prevention is prevention. And I'm  
12 like, that can't come from more than one or two places  
13 in that format.

14 But that could be another potential activity for  
15 the National Advisory Council to take on that I heard  
16 talking about.

17 And then a third one, and this will be a Kathy  
18 Reynolds suggestion to this, because I always like at  
19 least three ideas to bat around and talk about, I  
20 noticed that as soon as Michael started talking about  
21 his six quadrants, Kana immediately drew six quadrants  
22 and started fussing with it, so I didn't know if there

1 was something, and I would need to defer to my  
2 colleagues who participated yesterday in the call about  
3 is there something that we could do with that model,  
4 with that conceptualization that could be useful.

5 Or even, along with that, what I had written down  
6 is identifying places, because there are places where  
7 prevention has been integrated into the integration, and  
8 you saw that in your expert panel, would it be useful to  
9 have a compendium or a case example book or places where  
10 this is actually happening to direct people to for  
11 assistance.

12 So as the facilitator, those were two things that  
13 came out of the conversation and one addition from  
14 myself, but I'm wondering if any of the advisory council  
15 members had any ideas over lunch that you would like to  
16 add to our potential list of things that the NAC could  
17 do to support the alignment of SAMHSA prevention and  
18 overall health.

19 DR. COMPTON: I just have a question, and we  
20 touched on this a little bit yesterday. I'm wondering  
21 if someone can sort of define alignment and how that  
22 differs from integration, just for my own clarity.

1 (Laughter).

2 DR. COMPTON: Because alignment, it's not a term  
3 that I've yet heard, at least in psychiatry.

4 MS. HARDING: I'm going to let the author try.

5 MR. LUCEY: So we saw struggles, both internally  
6 and externally, among stakeholders with the word  
7 integration, because it seemed to set up turf issues  
8 right away. Fran, through her speeches, helped written  
9 by Nel and me, so that's where that came from, kept  
10 talking about how the substance abuse field felt like  
11 their dollars were going to be stolen, quote, unquote,  
12 by the mental health field, and vice versa, through this  
13 whole concept of integrating services, and that there  
14 was going to be winners and losers and all of that.

15 And as I was thinking through it, again, probably  
16 from the experiences that I've had with the higher ed  
17 community, was I don't think it was really about  
18 integrating those two fields, that it was more or less  
19 trying to align mental health and services and substance  
20 abuse services, and that was born out of the whole  
21 cannot mix money because of the separation of  
22 appropriations.

1 I mean, we're required to keep four separate  
2 appropriations by Congress. And so by law, we can't  
3 integrate money, but we can align money. And so in that  
4 respect, that's kind of where that came from. So for  
5 me, it felt like we, first of all, align substance abuse  
6 and mental health, which is behavioral health, and then  
7 try to integrate behavioral health into primary care.

8 So that's, in my mind, how I try to separate it,  
9 and I apparently sold it well enough, maybe without even  
10 trying to knowing, because as we had our conversations  
11 among the senior staff, among just the staff in general,  
12 and then more with the expert panel, it seemed to just  
13 kind of get accepted as, yeah, I guess it's more  
14 alignment than it is integration.

15 So it's not a formal definition, Michael. It just  
16 was another conceptual thing that I had to work through.

17 MS. HARNAD: Rich, if I can add to that, at the  
18 state level, what we would interpret as alignment, in  
19 addition to what Rich said, is that aligning all of our  
20 strategic initiatives at the state level with national  
21 policy plans, state policy plans on substance abuse,  
22 mental health, public health, so that we come

1 collectively as, you know, state agencies and key  
2 stakeholders and we're aligned with the direction.

3 And so when we did needs assessments, etc.,  
4 everything lined up with what needs to be happening at  
5 the national level and just, like, trickle down to the  
6 coalition level. For me, that was key in everything we  
7 did, and I think most states are still doing that, I  
8 would think.

9 MS. REYNOLDS: Any other questions, comments or  
10 ideas from lunch for folks, from not what you had for  
11 lunch, but ideas?

12 (Laughter).

13 MS. REYNOLDS: Around projects that the NAC could  
14 consider?

15 And I know that we have a couple of NAC members on  
16 the phone, Ruth and John. Do either of, have you had  
17 any opportunity to think about this, of any potential  
18 projects in this area of aligning SAMHSA prevention and  
19 overall health that you would like to suggest?

20 MS. SATTERFIELD: Hi. This is Ruth. I have no  
21 necessary new--

22 MS. REYNOLDS: Ruth, we're having trouble hearing

1 you. Could you speak a little louder?

2 MS. SATTERFIELD: Sure. Can you hear me any better  
3 now?

4 MS. REYNOLDS: Perfect.

5 MS. SATTERFIELD: Okay. I just wanted to chime in,  
6 because I haven't been able to get through earlier in  
7 the day, to say I'm liking where this is going. I feel  
8 like we're finally getting something to start moving  
9 with some projects. And I don't have anything new to  
10 add on those pieces, but these clarification I find very  
11 helpful.

12 MS. HARNAD: I think, for me, it would be helpful  
13 if we could drill down a little bit better what we mean  
14 by sector-by-sector education, because I think that's  
15 huge. That's big pictures. So if we're talking about  
16 sector by sector, are we talking about individual  
17 sectors of state agencies? Are we talking about state  
18 and related state agencies and related stakeholders?  
19 Single sectors, campus partnerships or coalitions, or  
20 early adapters? I think we need to take steps. Or do  
21 we do it all at once? I don't know.

22 But I was thinking about the conversation yesterday

1 with campuses and how, if you would use the Strategic  
2 Prevention Framework approach, the need is there for 18  
3 to 25, the infrastructure is there, the substance abuse,  
4 mental health, public health, and the coalitions are  
5 there, the community coalitions are aligned with  
6 campuses, police, hospitals, things like that, so do we  
7 prioritize where we want to start with this? Like,  
8 who's most ready, or it doesn't matter? I don't know.

9 MS. REYNOLDS: And I think what we had talked  
10 about, I think both yesterday and today, is starting  
11 with the clinical setting and possibly the physical  
12 health care and/or primary care even more specifically  
13 as a segment that potentially we could link with the  
14 coalitions and help them address and approach that as  
15 well as work with just integration in that sector.

16 MS. HARNAD: I think you can do both. If you're on  
17 a campus, campuses coordinate services with hospital,  
18 community providers. I think, to me, that might be an  
19 easy start, versus having coalitions going to private  
20 practice. That's just my thought.

21 MS. REYNOLDS: No, and we need to. We have about  
22 10 minutes left, and I want to be respectful of the next

1 presenter, which I think is Ruth.

2       What I was wondering, if my colleagues would be  
3 interested in doing, is possibly taking these kind of  
4 three areas and do a little one-pager on each of the  
5 projects, one on the sectors and one on the prevention  
6 is prevention is prevention or a discussion about the  
7 prevention, and then one on the models and the  
8 compendium, and just put them together.

9       And then maybe, Matthew, can we have a call in  
10 between meetings to review those and see which one might  
11 rise to the top? I wouldn't want to wait until April to  
12 review them, because then we wouldn't, you know, get  
13 started, but we could do an interim meeting where we  
14 could possibly review the one-pagers.

15       And so I would hope that some of my colleagues  
16 might volunteer. I'm happy to write one up if somebody  
17 would be willing to write up the other.

18       And so I don't know, Dianne, if you'd want to write  
19 one up that was of particular interest to you.

20       But Matthew, is that possible to have a meeting if  
21 we put together some one-pagers?

22       MR. AUMEN: Yeah, absolutely.

1 MS. HARNAD: Is everyone on the same page?

2 MS. HARDING: With what?

3 MS. HARNAD: With agreeing with those three things.

4 I think that's what was put out is kind of the form of a

5 question.

6 MS. HARDING: Does that mean you want to take a

7 vote?

8 MS. HARNAD: No, no.

9 (Laughter).

10 MS. HARDING: Do you have more to add? I think

11 Kathy just picked three, because she likes the number

12 three.

13 (Laughter).

14 MS. HARDING: But I don't think that she's

15 restrictive to three.

16 MS. HARNAD: No.

17 MS. HARDING: And probably would entertain two if

18 we must, although you know you are aligned with our

19 secretary, she does everything in threes.

20 MS. HARNAD: In threes? Okay.

21 MS. HARDING: So you're right that.

22 MS. REYNOLDS: I didn't know now that, but I like

1 to hear that.

2 So yeah, I was just thinking I'm not being on a ton  
3 of choice, because I think we don't have a lot of time  
4 as council members to do this, and we want to be focused  
5 and have something that's done. And I'm happy,  
6 absolutely happy, to consider more ideas if anyone has  
7 them. It's been silence.

8 MS. HARNAD: What one did you want to flesh out?

9 MS. REYNOLDS: I'm willing to flesh out any of  
10 them, if there's one that --

11 MS. HARNAD: I'm not comfortable with the six  
12 buckets.

13 MS. REYNOLDS: I'd be happy to do that one. I'd be  
14 happy to put that one out there for discussion. Are you  
15 comfortable with one of them?

16 MS. HARNAD: Which one, the sector by sector?

17 MS. HART: I wonder, just based on the conversation  
18 we were having over lunch, if it's the sector by sector  
19 education that would focus on primary care providers or  
20 engaging hospitals or that second one on the white  
21 paper, the synthesis of substance abuse, mental health,  
22 and primary care, definitions and models. I was

1 thinking about that, based on the conversation we had.

2 MS. HARNAD: Yeah, I think I would do that.

3 MS. HART: The second one?

4 MS. HARNAD: Yeah.

5 MS. REYNOLDS: The synthesis of mental health,  
6 substance abuse, and primary care prevention. Joyce's  
7 idea.

8 MS. HART: Because it sounded like you had some of  
9 that developed already, because of the courses and all  
10 of that.

11 MS. HARNAD: It's like it hasn't changed, substance  
12 abuse, substance misuse, prevention, mental health,  
13 promotion, public health. There was definitions, have  
14 been in place from the beginning of time.

15 MS. HARDING: Yeah, it's not the definitions as  
16 much, Dianne. It's how do we help bring this all  
17 together so that we are seen, once and for all, as part  
18 of overall health.

19 MS. HARNAD: Okay.

20 MS. HARDING: So that we are not sitting here five  
21 years from now having the same conversation that primary  
22 prevention, nobody understands what it means, why would

1 we want to engage in a coalition that they don't have  
2 any role.

3 I mean, Connie used the example of the HIV proposal  
4 that was put on the table two years ago or almost two  
5 years ago. And I did push prevention. Everyone kept  
6 saying -- and what I mean by everyone are my colleagues  
7 in SAMHSA who are working on the program, no, no, no,  
8 we'll wait to do prevention.

9 No. I've been here long enough. I wait, I lose.  
10 So we just kept saying, no, no. If you're going to have  
11 a one-stop shopping of substance abuse, mental health,  
12 and primary care, prevention is going to be there. So  
13 what I ended up doing, and what she just was describing,  
14 is the component, no we couldn't put an office in this  
15 building with all the rest of the services for HIV,  
16 which included substance abuse treatment, mental health,  
17 not promotion, mental health treatment, mental illness  
18 treatment, HIV treatment, Hep C, and then overall  
19 health, because you can't really deal with those without  
20 dealing with the health of the individual.

21 So they didn't want prevention. So the compromise  
22 I made was fine, the coalition will remain where it is.

1 And it wasn't really a coalition, it ended up being an  
2 arm of the state, but that doesn't matter, whose work in  
3 the community -- they had one person, one body, one  
4 professional, a credentialed preventionist, who would  
5 then be part of this team.

6 So they would reside in their office, but they  
7 would be visiting, be a part of the office for  
8 referrals. And it's sort of like, in prevention, we  
9 never develop anything new. You just redo what you used  
10 to do.

11 So it was like the time when we would have a  
12 program for bringing substance abuse interventions into  
13 hospitals, and you would wait around in the hospitals,  
14 or you would bring them into criminal justice, and you'd  
15 wait around and wait for the courts, right, family  
16 courts, and then grab that when you can. Same similar  
17 concept.

18 And that's what we ended up doing. So it's not yet  
19 -- it didn't get funded, so it didn't go anywhere.

20 (Laughter).

21 MS. HARDING: But there was a model before that.

22 I'm just looking at Linda Youngman. She was in charge

1 of it. She had a hard time reminding them prevention,  
2 prevention, prevention. So that's really what we're  
3 talking about.

4 So yes. It sounds like you're the right person,  
5 because you know the systems, you've worked with them,  
6 and now what we want you to do is to suggest, in an  
7 elevated way and a one-pager, what are some of the --  
8 you know, what are the advantages of all these systems  
9 and aligning them, and what would that mean for overall  
10 health, with the ultimate goal of being one sphere  
11 rather than just pieces.

12 MS. REYNOLDS: And by no means is the conversation  
13 done. We could write up these three things. The  
14 primary care piece is essentially already written up in  
15 another project, so I can do that one. And so we can  
16 get these out. We can have a conversation and  
17 prioritize them.

18 And if folks have other ideas between now and when  
19 we talk, please, in no way is it a closed conversation  
20 in terms of ideas, but this is just a place to start in  
21 moving the NAC forward in a potential project that we  
22 could begin working on.

1 MS. HARDING: That sounds absolutely great. And  
2 Matthew will work with Kathy to set up some time so that  
3 we'll have a phone call to kind of work this through.  
4 We'll let you know whether or not this happens once we  
5 get a handle on how fast or slow these applications are  
6 going. We can maybe even be able to have it at a time  
7 when we're back to a full complement.

8 DR. HOLDEN: Fran, you brought up the prevention  
9 service provider that's not a coalition. So I think  
10 that we should probably think of how we're going to get  
11 them involved as well, rather than just thinking of a  
12 full coalition.

13 MS. HARDING: Totally agree. Totally.

14 MS. REYNOLDS: Okay. I think we're just about at  
15 1:45, which was the ending for this session. I don't  
16 know if our folks from the expert panel have any final  
17 comments or anyone from the advisory council has a final  
18 comment on this discussion here this month.

19 MS. HARNAD: Can you clarify what the two -- is it  
20 two papers or three?

21 MS. REYNOLDS: It's going to be three. You're  
22 going to write the one on prevention. I'm going to do

1 something on a sector paper that's related to primary  
2 care offices and then one which seems people are less  
3 interested in, which is sort of the models and the case  
4 studies and where this is currently happening. Seem  
5 okay? If we could put together a --

6 MS. HARNAD: I was thinking more like the approach  
7 to training and TA. You were thinking models.

8 MS. REYNOLDS: Okay. Approach to training and TA.  
9 That would work.

10 MS. HARNAD: Yeah, the sector by sector.

11 MS. REYNOLDS: Yes.

12 MS. HARNAD: I'm not sure that's fleshed out. Is  
13 it?

14 MS. REYNOLDS: Okay. I'll flesh it out in the one-  
15 pager.

16 MS. HART: And I wonder, too, if in the one-pager  
17 that you're working on about not just the definitions by  
18 the advantages of aligning, there might be space at  
19 least to say a couple of things about what training  
20 might look like around that for different sectors, but  
21 it wouldn't necessarily be the big focus of it, but it  
22 seems like you might be able to integrate in terms of

1 thinking through next steps what that could look like.

2       Yeah, no, I think this has been really helpful, and  
3 I want to say thank you on behalf of the expert panel.  
4 I think this is going to help. The next time we meet,  
5 we can bring this conversation back to them. It'll be  
6 interesting to see where you all take this.

7       MS. REYNOLDS: Thank you. And I'll turn it back  
8 over to Fran.

9       MS. HARDING: Thank you very much.

10       People stopped me when I was running around outside  
11 and were saying this is the best conversation we've had  
12 in the NAC in a long time, and we had a good  
13 conversation last time. So they're giving me messages  
14 that we're doing this right and that we're back to  
15 actually engaging.

16       I give Matthew a lot of credit for that. He was  
17 pushing us to get back into it. There was a time when  
18 we used to have subcommittees in our NACs, and you  
19 really then worked. But then the NACs changed,  
20 philosophies changed, leaders changed, things changed.

21       Now we're going back to sort of in between, because  
22 mostly, for me, there's so many emerging issues. We

1 just need to keep on top of them. And your job becomes  
2 that much more difficult, because we really need your  
3 help, as you probably have perceived.

4 That's why I like mixing the staff in with our  
5 conversations with yourselves. So we learn from you.  
6 You learn from us, but you also can then point to where  
7 some of the needs might be that you can advise us. So I  
8 thank you very much.

9 And thank you, Kathy, again for -- I don't know if  
10 you're a voluntold, or you were just being nice, but I  
11 appreciate it.

12 We're going to steal, Ruth, 10 minutes from your  
13 time. Apologize for that ahead of time. Things happen.  
14 But we will add some time to the end, Ruth, that if we  
15 have to cut you off too early, and it's at, like, a  
16 pivotal point.

17 I don't have flexibility at 2:15, because we have a  
18 guest speaker coming, and it's Tom Coderre is coming  
19 back to tell us about the new focus on -- well, not new  
20 focus, but the greater focus on recovery and a big event  
21 that's happening on October 4th. If I say anything  
22 more, then we don't need Tom here, so I'll stop.

1 (Laughter).

2 MS. HARDING: He has his own way of doing it.

3 So we have four members of the NAC that your term  
4 is -- what is it called?

5 MR. LUCEY: Rotating off.

6 MS. HARDING: Rotating off. I was trying to think  
7 of a nice way to say it. Every time I try to think of  
8 something, it sounded so negative, like retiring.

9 MR. LUCEY: Being thrown off the island.

10 (Laughter).

11 MS. HARDING: That's right. How dare they run and  
12 hide when it gets difficult?

13 So we just have a tradition here to just thank you  
14 and give you a token of our appreciation. And the first  
15 one, not because I like one better than the other.

16 (Laughter).

17 MS. HARDING: It's the first one I just picked off  
18 the pile. These two guys, I mean, you have to be  
19 careful -- is Michael Compton.

20 Michael came to the NAC through us running into  
21 each other. I don't know if it was just your book, and  
22 I wrote to you and said, "Can we make a deal?" Because

1 I wanted to buy a whole bunch of them, and they were  
2 darn expensive.

3 (Laughter).

4 MS. HARDING: And we were in the throes of the  
5 beginning conversations about bringing mental health and  
6 substance use together. I don't know if you remember  
7 the conversation.

8 And one thing led to another. It was required  
9 reading for our staff. And most of the staff, although  
10 I couldn't buy for everyone, they all have it, and they,  
11 I'm sure, have it all highlighted. And at least, you  
12 know, if you go in, it's been cracked open, so that's a  
13 good thing.

14 (Laughter).

15 MS. HARDING: And I have not had the finances to do  
16 your second book, but give me time. Give me time.

17 But more importantly, it was the engagement of  
18 speaking with Michael, the way he talked about  
19 integration. One thing led to another. We invited him,  
20 he accepted. And I haven't looked back.

21 You have been just a tremendous asset to the  
22 council. I never like letting councils retire, because

1 I want you to stay. But then I always get so pleased  
2 when we turn over. We'll invite you back. We'll be a  
3 new thing, because this conversation and you go hand in  
4 hand.

5 And so please accept a very small token of  
6 appreciation. It's just a certificate saying thank you  
7 from SAMHSA to you. Thank you.

8 (Applause).

9 MS. HARDING: And the second one goes to our other  
10 Michael. So when I said we're not putting you together  
11 again, I knew I was speaking truth.

12 I did not know Michael Montgomery when he came to  
13 the NAC. He was a part of a recommendation that came  
14 from Pam and Kana, many of you, that it trickles down.  
15 Read your information that you sent, your package. We  
16 decided, yes, we wanted somebody who was outspoken in  
17 HIV and had the kinds of accomplishments that you had.  
18 If you notice, we try to get all of the sectors and the  
19 areas and responsibilities.

20 And when Michael came, I'm going to embarrass him a  
21 little bit, he didn't think he fit. And he really  
22 questioned whether or not somebody more aligned, I

1 think, with the experiences that he didn't think he  
2 possessed should be sitting in that chair.

3 And we convinced him, I hope -- you're still here -  
4 - that that really wasn't true, because what we were  
5 looking for was what you had to bring, someone who has  
6 worked in the population. And that presentation that  
7 you gave three years ago, I think, solidified for all of  
8 us that you truly were an integral part of this council.

9 And personally, it's been a joy to get to know you,  
10 and I'm very happy for what you have contributed to us.  
11 So the quiet ones are important. So thank you.

12 (Applause).

13 MS. HARDING: So if you can bear with me, we have  
14 two more. They are not with us in the room. I have to  
15 be careful how I say that.

16 The next person who is retiring off the NAC is John  
17 Clapp. Now, John's had some difficulty, because once he  
18 agreed to come and be a part of us -- John, I hope  
19 you're on the line -- he then took a job, a new job.  
20 And his new job sort of kept him a little busier and a  
21 little crazier schedule. So we physically haven't  
22 really seen him often, but John, you do manage to always

1 get your thoughts in through the phone. I mean, you're  
2 very tolerant when it comes to calling in, and we  
3 greatly appreciate that.

4 I met John through higher education. Again,  
5 another area where we wanted to bring in some expertise.  
6 And great and wonderful things are happening. Not only  
7 is John working for one campus, now he's really working  
8 for pretty much I can say the country, of giving out the  
9 messages, keeping on top of the emerging issues in  
10 higher ed, and really being a great advisor to this  
11 council on the issues that we talk about but often don't  
12 really remember sometimes that higher education is an  
13 important sector.

14 And yesterday, I briefly spoke about the new NSDUH  
15 data that came out, and I told you that the area of most  
16 risk, and Kana also echoed this this morning, is the age  
17 cohort 18 to 25. They're sort of the lost age group.  
18 And now, September 10, when the data is released to the  
19 public, you will see very clearly on every sector, every  
20 area that we have studied and have data on, it's 18 to  
21 25, 18 to 25, 18 to 25 across the board of behavioral  
22 health.

1           So we certainly, with your help, helping us with  
2   changing strategic initiative number one, our goals have  
3   stayed the same, our objectives have changed. John, and  
4   you know this, we talked to you about this. We were  
5   able to convince our administration two things.

6           One, we need to focus on higher education, and we  
7   need to focus on the 18 to 25. And that was a hard  
8   sell, because we are about the 12 to 17 year olds, and  
9   CMHS is about the 0 to 8 and kids in elementary school  
10  in general. So we had to sell that, but now, look at  
11  us. We're in the right place at the right time.

12          So we thank you for that. And John, I just want to  
13  say thank you very much for your participation in the  
14  NAC and all the guidance you have given us in keeping us  
15  on the record with this age cohort.

16          (Applause).

17          MS. HARDING: And last but not least, I don't think  
18  that Steven is on the phone, but I feel obligated.  
19  Steven Green is just one of those professionals that you  
20  just want at your table. One of the areas that we, too,  
21  also look to cover is Indian Country, and Steven runs  
22  the, I think, premier program for tribes that covers the

1 entire, not a piece, that we all do well in a certain  
2 area, but he has the full continuum from prevention, and  
3 he was just talking to me last time we were here about a  
4 recovery connection.

5       So he has treatment, he has prevention, he has  
6 primary care, he does mental health. They do it all on  
7 one reservation. He doesn't live on the reservation.  
8 He lives off it. So that breaks that myth. And just  
9 does a fabulous job and has been, again, another quiet  
10 soul that has really brought a lot of thinking to me and  
11 I know to all of us. So I'd like to thank him, and  
12 these will be mailed to him with a little bit about what  
13 I just said to him.

14       So let's give Steven a round of applause as well.

15       (Applause).

16       MS. HARDING: So we have five minutes, if anybody  
17 would like to say anything before you leave. This is  
18 your chance.

19       (Laughter).

20       MS. HARDING: It includes you, too, John. We'll  
21 take you on the phone.

22       Michael, Michael, anything?

1 DR. COMPTON: Well, I guess I'd like to commend  
2 CSAP on the focus on both marijuana and integration. I  
3 think these are two crucial issues that are rapidly  
4 evolving, and so I commend you for really being engaged  
5 in those topics.

6 MS. HARDING: Thank you very much. Thank you.

7 MR. MONTGOMERY: Well, I came her in great  
8 ignorance, and I feel like I have learned so much since  
9 I've been here, and it's changed my perspective on many  
10 things, from John Clapp's discussions of alcohol abuse  
11 in universities and colleges and the hard discussions on  
12 marijuana, it's been a profound education for me.

13 And if I contributed anything, I'm grateful. And I  
14 certainly am grateful for the opportunity.

15 MS. HARDING: John, you still on the phone? Okay.

16 Well, thank you, all. And I look forward to  
17 welcoming in April our new NAC members or have some of  
18 you invited back to cover a need if we don't get  
19 approval by April. But thinking positively, we'll get  
20 approval by April.

21 Okay. So we're going to jump right into a  
22 shortened discussion. And if this goes on, we'll stop

1 it, we'll have our presentation, and then we will build  
2 some more time back in, since we have juggled this  
3 around a little bit and I stepped ahead and did the  
4 recognitions a little bit early.

5       So Ruth set this up so very short so that you can  
6 use most of your time. Ruth Satterfield, when we had  
7 our last -- part of your job as council members will be  
8 to review grants before they go out and before they're  
9 released.

10       During our last conversation on grant review,  
11 particularly around the HIV grants, spurred -- we  
12 learned that -- someone had brought up, and I believe it  
13 was Ruth, but it might not have been, but brought up the  
14 obvious that the scores for the HIV grants were so high  
15 and so rich of the applications that we had a discussion  
16 of, is there something that we can do as a NAC to  
17 provide that guidance to other -- because we also looked  
18 at some grants where we were really looking and  
19 stretching our resources to give technical assistance to  
20 grants that just really weren't making great progress  
21 getting their message across to us what they wanted to  
22 do, so their scores were much weaker.



1 discussion and take a look at is there something  
2 different.

3       The things that came immediately to mind for me  
4 were is there possibly a way that these grantees are  
5 prepared differently for the application process? Are  
6 they maybe more experienced grant writers? Or was there  
7 something different in the direction that might have  
8 been clearer?

9       I just didn't know, and I felt like we need to ask.  
10 And I feel like, based on our conversations that we've  
11 been having today and yesterday, it seems like it's even  
12 -- well, I guess, is it possible that we're maybe  
13 reaching out to more community entities who aren't as  
14 experience with the federal grant application process  
15 and particularly we're working to blend the real health  
16 processes, it seems that we might be seeing this even  
17 more often.

18       And with that thought in mind, leaves me with the  
19 question of, how do we lessen our barriers? How do we  
20 help them successfully apply for the grants that are out  
21 there? And I know it's a lot of questions, because  
22 that's kind of how my brain was running at that time.

1           So I was just wondering, since we brought that up,  
2 if you guys have had a chance to look at the process to  
3 do any repairing of the processes to see if anything is  
4 different. And if not, that's fine, how could we still  
5 look at making the people who have been set for all the  
6 grant application processes as they were for the HIV  
7 process.

8           MR. REYNOLDS: Hi, Ruth. This is Charles Reynolds.  
9 First, I want to thank you for bringing this to our  
10 attention.

11           Just the recap, from the community side, there were  
12 two grant applications that were reviewed this year.  
13 One was awarded to minority serving institutions in  
14 partnership with community-based organizations and the  
15 other one was awarded directly to community-based  
16 organizations.

17           The community-based organizations have phenomenal  
18 scores. And one of the things we done this year that we  
19 hadn't done in previous years was that we tried to find  
20 more organizations that have been addressing the issues  
21 of HIV and AIDS. And we reach out to associations we  
22 got on distribution lists. And I think we just did a

1 better job in getting the word out to people who were  
2 more experienced in working and writing grants than  
3 those folks -- not that the others weren't experienced,  
4 but there just had been a smaller pool.

5       It seems that the same groups of individuals have  
6 been getting the same grants over and over again. And  
7 when we open the pool up, we got quite a few new  
8 applicants in, and we'll be awarding quite a few new  
9 grantees for the first time, and we were really excited  
10 about that, which means that we're spreading the funds  
11 across the country better.

12       The problem we found with the minority serving  
13 institutions is that they are not as prepared to apply  
14 for a federal grant. They require more technical  
15 assistance in actually knowing how to fill out a federal  
16 grant application, and we haven't done a good job in  
17 doing that.

18       We realize going forward that if we do want to  
19 award such a program again, we have to provide them with  
20 TA upfront, more TA upfront on how to actually apply for  
21 a federal grant and more resources to them so that they  
22 could produce better applications.

1           The other challenge with minority serving  
2 institutions is finding the right individual on the  
3 campus to notify there is a grant, but it was just  
4 difficult -- going to the president of a minority  
5 serving institution is the wrong thing to do, and a lot  
6 of the lists that are out there, that's the main contact  
7 individual, so we have to find out who should we notify  
8 that we have this opportunity, and how do we better  
9 prepare them for it.

10           So we're looking forward to that in the future,  
11 making it a better process and educating them more about  
12 SAMHSA and what we can do.

13           MS. SATTERFIELD: Thank you for that response. I  
14 think that does bring it a little bit of clarity for  
15 those two grant processes to be able to be prepared.

16           But I know that, even previous to this review  
17 process, we ran into scores that were really quite low,  
18 I think because they demonstrated the same issues that  
19 you just identified as far as not being as prepared.  
20 And sometimes, I know when I was writing the grants, the  
21 technical assistance was everything that it could be. I  
22 mean, they really did provide a lot of information, but

1 there's also a limit to what they can say to an  
2 applicant during that process.

3       So I wonder if there are other things that we can  
4 make happen. And I will just throw out there one of the  
5 things I thought is having other successful grantees  
6 that obviously aren't applying for the bid dollars but  
7 is successful in other grant process, federal grant  
8 processes, if they would be willing to act as mentees to  
9 people that we could possibly link them up, if the new  
10 applicants could actually call and discuss their grants  
11 and how to get those concepts onto paper in a way that  
12 is palpable for the federal application process.

13       Because really, when you call your grant officers,  
14 there's only so much that they can say, because they're  
15 a part of that whole process, and that makes sense. But  
16 as you said, we are dealing with more people. And I  
17 think as we keep this blending process moving, we are  
18 going to be reaching out further and finding even more  
19 people that we want to have successful applicants but  
20 they don't have the experience.

21       I think we need to keep going broader on how we  
22 provide that technical assistance. That was just one of

1 the ideas. Are there other thoughts?

2 MR. REYNOLDS: I'm sorry, this is Charles again. I  
3 like the idea. Similar to what we do with the Drug-Free  
4 Community program, where we allow someone to be a  
5 mentee, have an experience grantee mentor them before  
6 they actually apply for the grant.

7 MS. SATTERFIELD: Right.

8 MR. REYNOLDS: So for example, if we continue with  
9 the MSI program, having the experienced, successful MSIs  
10 work with the ones who haven't applied yet, that help  
11 prepare them to actually apply.

12 But put of that is also communicating better out  
13 there the application that's available.

14 MS. SATTERFIELD: Agreed. Agreed.

15 I also was wondering about if there's a way -- and  
16 here I'm going to say that it's a dirty word, and it's  
17 language, that again, as we look at blending, we've got  
18 to deal with the whole issue of language and trying to  
19 be as simplified as possible and have the language used  
20 as commonly understood as possible, so that the language  
21 itself isn't a barrier. And I don't know whether maybe  
22 some would have sample writings available of successful

1 application. Those are just the kind of things that  
2 were running through my mind to try to figure out what  
3 else can we do to help.

4 I've never seen an applicant who didn't need the  
5 dollars, but some of them just couldn't put their pieces  
6 together in a successful manner. So how do we help  
7 them?

8 MS. HARDING: Thank you, Ruth. To your last  
9 points, we're all agreeing with you.

10 Steve, you have a comment?

11 MR. KEEL: Actually, Ruth touched on it, and I was  
12 wondering are applications, in fact, public documents at  
13 any point? And are models or examples of applications  
14 available to new applicants? Not so that they can copy  
15 them, obviously, but so that they can actually look at  
16 when an area is fully explained or the question is  
17 answered, what that really should look like in terms of  
18 providing enough information for it to qualify as an  
19 excellent or outstanding or an above average answer.

20 MS. HARDING: We've had many conversations about  
21 that, so I'll table that. But the answer is yes and no,  
22 because chunks of it -- I like your idea of section one

1 seems to give everybody some trouble, so I'll give them  
2 an example of a well-written section one. But when we  
3 give out samples, they just copy them, and that's the  
4 problem.

5 But I think there might be a kernel in there that  
6 we might be able to develop.

7 Yes, Michael?

8 Sorry, Ruth, I'm just being your eyes here for you.

9 MR. MONTGOMERY: In HIV/AIDS, when we were  
10 struggling with getting particularly minority servicing  
11 institutions more successful, we developed a whole  
12 program of capacity building grants so that  
13 organizations could come in that didn't have the skills  
14 and have one or two years to develop those skills, and  
15 the funding was specifically for skill development. It  
16 was very successful for us.

17 The other question I have is what do you -- in  
18 reviewing grants, we have frequently commented on the --  
19 all we see, which is the executive summary and some of  
20 the reviewers' comments, summary comments. And we've  
21 asked questions about some pretty striking criticisms of  
22 applications that get funded.

1           And in asking about that, we have been told that  
2 they will be given technical assistance to improve that  
3 part of their performance. How does that happen? Is it  
4 a project officer starts working with them with their  
5 budgeting or their information gathering?

6           MR. REYNOLDS: Right. As soon as the grant is  
7 awarded, the project officer has reviewed their  
8 application, and that's one of the things that they  
9 point out to them.

10           If it's something that requires special terms and  
11 conditions, they stated in the terms and condition once  
12 the grant is awarded, and they have to address those  
13 issues immediately. And then the project officer as  
14 well as the branch chief work together collaboratively  
15 to make sure that the grant is doing the things that  
16 they're supposed to do, so that he can successfully  
17 implement the grant.

18           MS. HARNAD: One of the strategies we used in  
19 Connecticut for the State Incentive Grant and other  
20 grants is to have a -- you may have done this -- to hold  
21 a bidders conference, where it would be almost a full  
22 day training on the application and different pieces of

1 it and what each piece meant and how you need to respond  
2 to it.

3 And also, followed by that, we would put up, on our  
4 website, questions and answers that people may have had  
5 related to the RFP and also a way to link with other  
6 people who may be interested in applying as a coalition.

7 You guys have done that in the past. I don't know  
8 if you did for that project.

9 DR. HOLDEN: There's just one thing, that we used  
10 to do a workshop, a pre-workshop before the applicants  
11 would apply to a grant application, but we found that we  
12 could not bring everybody into such a workshop, and it  
13 put those that didn't come to a workshop at a  
14 disadvantage.

15 And we found, also, that those folk who came to  
16 those workshops, asked us questions that we could not  
17 respond to, because it would give them an in to how to  
18 write the application, and we wanted them to write it as  
19 to what's happening in their state. And so we had to  
20 stop doing that.

21 But that was one thing that we did in the early 80s  
22 and 90s to help our grantees out, so that's why we don't

1 do it anymore.

2 But we do have a problem with our tribal grantees  
3 in writing good applications. So we have kicked into  
4 gear right now with our CAPT contract and with our Block  
5 Grant TA activities to actually address the tribal  
6 entities with writing better applications, addressing  
7 the applications much better.

8 MS. HARDING: So Ruth, unfortunately, we're pretty  
9 much close to time. Thank you for talking about the  
10 tribes, because under the umbrella of anything is  
11 possible in government, you just have to work at it,  
12 government has, I want to call them innovation awards,  
13 I'm not sure that's the right title for this particular  
14 award, but where employees are able to write in  
15 suggestions for something to change. And then it's got  
16 to go through an enormous amount of review. We vote.  
17 We, as government employees vote on which ones we like.  
18 It's a whole big to do. And the award actually comes  
19 with money, so there's an incentive to submit.

20 A group of individuals over at the Indian Health  
21 Service, I think they're from Indian Health Service,  
22 would make sense that they were, developed an entirely

1 new RFA process for tribes, for their agency, and it was  
2 eight pages long.

3 Now, if any of you have seen our applications, it  
4 takes eight pages for us to describe what the  
5 application is all about.

6 So they received the award. They went around, and  
7 they were able to share that with many. And SAMHSA  
8 tried to adapt it to what we have. And to be honest,  
9 then things shift, you know, responsibilities shift,  
10 tribal left me, went somewhere else, and you reminded me  
11 I should follow up to see what happened to that, because  
12 that would be a great start, Ruth, for you, if you're  
13 willing to take on a small project with the council  
14 members, we'll get you some volunteers, to maybe write  
15 some suggestions or at least write the questions that  
16 you've posed and perhaps a call with a couple other of  
17 your colleagues here.

18 And I'm not going to exempt some of the directors  
19 if they want to help you to join in on this to be able  
20 to maybe bring this up in April as well as a topic of  
21 what could we do for the next round of RFAs.

22 Is that something you'd be willing to take on?

1 MS. SATTERFIELD: Absolutely.

2 MS. HARDING: Great.

3 MS. SATTERFIELD: I love the idea of the eight  
4 page. That will be delightful. Please bring that back  
5 around.

6 MS. HARDING: Yeah, I was able to read that in an  
7 hour, I mean, because it was like I kept reading it over  
8 and over and said, this can't be all that it is, but it  
9 was. And it worked. And there's a big history to it.

10 And you can contact -- whom should she contact? I  
11 don't want to leave this hanging. I don't want Ruth  
12 hanging thinking she's got this all by herself.

13 Matthew and I will talk, and we'll get you a  
14 process of how we get out there some volunteers for you  
15 and get you going. Okay?

16 MS. SATTERFIELD: Great.

17 MS. HARDING: Thank you very, very much for  
18 bringing this up. We do a lot of communication, but  
19 this really struck you, and I admire your tenacity to  
20 continue to bring this in the forefront.

21 And I remember that, not the most recent but the  
22 conversation before, was going back and forth, and

1 finally, I said, "Guys, our job is to get money out  
2 there." So you have to sort of see it in both ways. I  
3 mean, we don't want to not get the money out, because we  
4 just have to turn that money back if we don't use it.  
5 On the other hand, we don't want to give money to people  
6 who can't use it, and they end up sending it back to us,  
7 and it ends up going back there.

8 So this is a great conversation. This is exactly  
9 the kind of advice that we could use from all that you  
10 have done from where you sit.

11 So we'll get in touch, and thank you for allowing  
12 me to steal time from you. And we will be sure to bring  
13 this back up in April, if not before. Thank you.

14 MS. SATTERFIELD: Thank you.

15 MS. HARDING: Yep. Okay.

16 Mr. Coderre is back.

17 (Laughter).

18 MS. HARDING: I will reintroduce Tom. Tom Coderre,  
19 as Kana mentioned this morning, is our acting  
20 administrator's new chief of staff. He comes, however -  
21 - and I'll let him do his own bio why he's here talking  
22 about this topic. But he does many things for us before

1 his new position, and I assume many of the things that  
2 you were doing, you'll probably continue to do.

3 One of the things that -- I first met Tom -- it's  
4 always about me. I first met Tom when I working in New  
5 York, so he's older than he looks.

6 (Laughter).

7 MS. HARDING: And he was teaching the State of New  
8 York, I'm going to use the word new, it may not be  
9 totally correct, the new way of helping our country, or  
10 in that case, our state, about what is recovery, and at  
11 that time, so you know, I worked in a substance abuse  
12 only agency, and how do we bring people in recovery to  
13 the forefront of our state and get them more actively  
14 involved in the movement, back then is what we used to  
15 call it. What do we say, what are the words, what are  
16 the activities, etc., etc., etc.

17 And this was Faces & Voices of Recovery that came  
18 with -- oh, my gosh, I can't believe I forgot her name.

19 MR. CODERRE: Pat Taylor.

20 MS. HARDING: Pat Taylor, the Faces & Voices, and  
21 this young man who came to us, a total unknown to the  
22 State of New York and to myself.



1 back.

2 MS. HARDING: And I'm younger than I look.

3 MR. CODERRE: Exactly.

4 MS. HARDING: You're older than you look. I'm  
5 younger than a look.

6 MR. CODERRE: I don't know about all that. I feel  
7 really old. And I just had a birthday, so I feel even  
8 older, I think, as a result.

9 But the organization Fran was talking about is  
10 really how I got started in doing recovery advocacy  
11 work. Many of you know, I'm a person in long-term  
12 recovery, and for me, that means I haven't used alcohol  
13 or drugs since May 15th of 2003.

14 I'm a former state senator from Rhode Island, and  
15 then I went to Faces & Voices, then I went back to work  
16 in the state senate as chief of staff to the senate  
17 president there, and then I had this wonderful  
18 opportunity to come to Washington to work at SAMHSA as  
19 Pam's senior advisor and now this new role as of  
20 yesterday.

21 So things happen very quickly, but the point is  
22 that none of it would have happened without my recovery.

1 My recovery has been the catalyst for all the change in  
2 my life. And I really appreciate the work that you all  
3 do, whether it's in prevention, treatment, or recovery,  
4 because you've really given me that se chance at life.

5 And I think you know that the stories of recovery,  
6 mine is not unique, that there are many of them, and  
7 that's what I wanted to talk to you about today. I want  
8 to talk to you about how far the movement has come since  
9 that Our Stories Have Power training I was asked to come  
10 up to New York and do a decade ago.

11 So should we go with the slideshow, Matt?

12 So we have a little slide show. Is that the  
13 slideshow?

14 MR. AUMEN: That's the slideshow.

15 MR. CODERRE: Okay.

16 (Laughter).

17 MR. AUMEN: We updated it.

18 MR. CODERRE: Great. We put it on SAMHSA slides.

19 All right.

20 (Laughter).

21 MS. HARDING: You got worried, didn't you?

22 MR. CODERRE: I did for a minute.

1 MS. HARDING: We didn't tell you had to act it out?

2 (Laughter).

3 MR. CODERRE: I didn't know. I did know.

4 So am I going to switch slides, or are you?

5 MR. AUMEN: I can do it.

6 MR. CODERRE: Great. Well, we're ready to rock and  
7 roll. Let's do.

8 So there's this project that we're working on  
9 called UNITE To Face Addiction. And I have been asked  
10 to be the federal liaison for that. That basically is  
11 just a designation that the federal government gives  
12 somebody when they formally ask you to work on a  
13 project.

14 So there are rules involved, obviously, with  
15 government involvement in anything like this, and I'm  
16 able to bring information from the government to this  
17 organization that's putting this event on, and then I  
18 can bring information back to the government about what  
19 the event is, the goals and the details about the event.

20 So on October 4, there's going to be a large  
21 recovery rally on the National Mall, and that's what I'm  
22 here to talk to you a little bit about.

1           Next slide. So what is UNITE To Face Addiction?  
2 Many of you know, there's this grassroots constituency  
3 that's developed over the last 15 years, and they've  
4 organized to speak out about a bunch of different  
5 things, addiction, prevention, treatment, and recovery,  
6 of course, criminal justice reform, a lot more lately,  
7 right, and we've heard the administration's policies  
8 changing on that, health equity and the epidemic that  
9 we're in right now regarding prescription drugs and  
10 overdose deaths.

11           Next slide. This is actually updated. These are  
12 old numbers, but there are now over 500 partnering  
13 organizations that are part of UNITE To Face addiction,  
14 and there's tens of thousands of individuals that are  
15 going to come together, we're hoping somewhere between  
16 50,000 and 100,000 on the National Mall to unite to face  
17 addiction. And they're going to be from all walks of  
18 life, and they're going to be all together in one place,  
19 thinking, talking about those issue items that were on  
20 the previous slide.

21           Next slide. And this is a lot broader base group  
22 of people that are coming together. When I first met

1 Fran, I mean, I was working with people in recovery  
2 pretty much solely. We had some family members, we had  
3 some friends, we had some allies, but we hadn't really  
4 broadened the base of people working on this.

5 And as you know now, I think people are starting to  
6 work together a lot more. We still have work to do.  
7 There's a lot less splinters, though, that are out  
8 there. There's a lot more recognition that by working  
9 together, we can achieve more.

10 So we've broadened the base for this even as well  
11 to reach outside of the normal people that attend  
12 recovery rallies and recovery events in the states, and  
13 some of you, I know, are active in your own states in  
14 these types of events. But we've reached out to  
15 communities of faith, the LGBTQ community, Latino  
16 community, the African American community, labor,  
17 organized labor, and a lot more groups.

18 The organization has 12 field reps that are on the  
19 ground and have been for the last three to four months  
20 organizing people in six regions around the country.  
21 And also, with each of these, special communities we'll  
22 call them right now.

1           Next slide. Why 2015? Well, this has been  
2 building for over the years. And I think people had  
3 this dream of having our own million-man march or  
4 something or some type of cultural moment on the  
5 National Mall. You know, everyone remembers the AIDS  
6 quilt and what that did to galvanize the AIDS movement  
7 in that country. And this is kind of creating our  
8 cultural moment.

9           And why 2015? Well, the Affordable Care Act  
10 clearly has ushered in a new era. There's recognition  
11 across the political spectrum that we can't incarcerate  
12 our way out of this problem, that we need a lot more  
13 prevention, treatment, and recovery support services.  
14 There is this heightened awareness because of the  
15 overdose epidemic. And there's this growing recognition  
16 that discrimination is occurring, and that's preventing  
17 people from finding and sustaining their recovery for  
18 the long-term.

19           Next slide. We also know that addiction is  
20 preventable, treatable, and that people can and do get  
21 well, right, that they recover. And unfortunately,  
22 because of that prejudice and discrimination that

1 occurs, a lot of people the recovery community have  
2 chosen to remain silent. They haven't come out. They  
3 haven't talked about their recovery. And because of  
4 that, there are these negative public attitudes that are  
5 allowed to persist and that prevents people from finding  
6 recovery.

7 I know Fran shared some of the data from the NSDUH  
8 with us, but there's still this group of people who  
9 won't seek treatment, who won't get help, because  
10 they're afraid of what it will do to their relationships  
11 with their family, with their employer, etc.

12 So now, we want to give people a platform where  
13 they can come out and speak about their recovery. And  
14 clearly, the overdose epidemic and the situation that's  
15 occurring in our country with prescription drugs, has  
16 really galvanized policy makers to come together. We're  
17 hearing a lot more from Congress about this issue.

18 There is legislation every day that we find out has been  
19 introduced by one Senator or one Congressman or another,  
20 and they're really engaged in trying to find solutions.

21 Next slide. So I have a short video I want to  
22 show. This just came out this morning. It's a brand

1 new trailer for the event. And a picture is worth 1,000  
2 words, a video is worth 10,000. So we're going to show  
3 it, and then we'll come back and wrap up.

4 MR. AUMEN: So it will take me a second here to  
5 start it up. But if you're in the room, you can see all  
6 the crazy equipment that we have here. So I am not  
7 making any specific guarantees at this time, but I'm  
8 going to try to set it up for you.

9 MR. CODERRE: It worked at the CSAT NAC, so they  
10 made it work, Matt. Pressure is on.

11 (Laughter).

12 MR. AUMEN: Okay.

13 MR. CODERRE: Pressure is on. You're not going to  
14 let CSAT outdo you, are you?

15 (Laughter).

16 MR. AUMEN: I'm going to blame it on the IT folks,  
17 if it doesn't work.

18 (Laughter).

19 MR. CODERRE: He's got it, or he almost has it  
20 here. Here it is. The video is going to lag a little  
21 bit behind the voice, but you'll get the idea.

22 (Video presentation).

1           MR. CODERRE: So that's the new event trailer that  
2 just came out today. If anybody wants to see that or  
3 use it in anything, it's on the UNITE To Face Addiction  
4 website, which is facingaddiction.org.

5           On that website, you can sign up. Am I hearing my  
6 echo?

7           (Laughter).

8           MR. AUMEN: I have to re-mute the speaker.

9           MR. CODERRE: Oh, good. You can also sign up for  
10 the updates, so that you get updates. You can sign up  
11 that you're going. You can sign up to volunteer there.  
12 You can post your story, if you have a particular story,  
13 if you're a person in recovery, a family member, or a  
14 friend, or an ally of recovery and you want to talk  
15 about it, there's an opportunity to do that on the  
16 website as well.

17           And I'm going to get back to the presentation,  
18 because I want to share with you -- you all heard the  
19 song "Dream On" in there. You know that song was  
20 donated to us by Steven Tyler.

21           And Steven has agreed to participate in the rally.  
22 So he's going to be actually -- can you hit the next

1 slide -- he's going to be performing along with Joe  
2 Walsh from the Eagles and Sheryl Crow, Jason Isbell, the  
3 Fray, Johnny Rzeznik from the Goo Goo Dolls and more.  
4 There's going to be a lot more announcements. These  
5 announcements were made last week.

6       When I talk about trying to assemble 50,000 to  
7 100,000 people on the Mall, you really need some kind of  
8 star power. And the great thing about the star power  
9 that's listed on this slide is that they're all in  
10 recover. They're all people in recovery. They all have  
11 the careers they do today because of their recovery  
12 journeys.

13       And then there's going to be, in addition to them,  
14 a lot of politicians and sports figures and actors and  
15 other types of celebrities that have had similar  
16 experiences with their own personal journeys in  
17 recovery. So it's going to be quite the event. It's  
18 not going be something you want to miss.

19       Next slide. So I think this gets to the point of  
20 what you can do. There is three ways you can help. You  
21 can help us, obviously, spread the word.

22       Ancillary events, there's going to be other events

1 on the days leading up to it and the day after it, so  
2 you can find out all that information on the website.  
3 There's going to be a special VIP event the night before  
4 at the Warner Theater in downtown D.C. There's going to  
5 be an advocacy day that we're not involved with, but  
6 it's attached to this event on the day after the rally.

7       Some of you may have heard of the FED UP! Rally.  
8 That's going on at the same time. I know 12-step groups  
9 are organizing. There is faith-based groups that are  
10 organizing, an interfaith service. So there's going to  
11 be a lot of different things around this event that take  
12 place.

13       When you bring that many people to town, they're  
14 going to be looking for stuff to do, because the concert  
15 or event itself, the rally is only 4:00 to 8:00 on  
16 Sunday, October 4. So that would be great if you guys  
17 can help us spread the word and then show up.

18       And the last slide, I think this is the last one.  
19 Yeah, that's it. This is my contact information. As I  
20 mentioned, I'm the federal liaison to the event, so I've  
21 been working hard with our SAMHSA folks, folks  
22 throughout HHS and then throughout the administration.

1 So we've had a lot of help from the White House Office  
2 on Faith-based and Neighborhood Partnerships, for  
3 instance, have had help from the Office on Public  
4 Engagement, ONDCP is very involved in this with us. So  
5 this is a real partnership.

6 And the thing that's been really impressive to me,  
7 because I've been doing this work for a long time, and  
8 trying to get across the barrier of federal government  
9 and getting people to participate and to help out in  
10 this stuff, before it used to be really difficult.  
11 SAMHSA was the key agency, right, that did that, and  
12 everyone kind of just pushed you towards SAMHSA.

13 Now, everybody else is wanting to be involved. And  
14 in some way, they have either taken on something to do  
15 in conjunction with the rally or their own personal  
16 work, and it's been really, really easy to engage them  
17 in this process. So I guess we're seeing a new day,  
18 which is great.

19 So thank you. And I'll answer any questions  
20 anybody has.

21 MR. REYNOLDS: Tom, is there something we can send  
22 out to our grantees about this that's already been

1 developed, or do we develop something?

2 MR. CODERRE: Sure. So I did a SAMHSA blog, which  
3 would probably be appropriate to send out to grantees.  
4 The SAMHSA blog is called Stand Up for Recovery UNITE To  
5 Face Addiction, and it came out, I think, two weeks ago,  
6 so that might be -- because that's already been cleared,  
7 and so you would have less trouble getting clearance to  
8 send it out. But that would be up to whatever the  
9 center wants to do.

10 MS. HARDING: We'll look into that and get it out.

11 MR. CODERRE: Good. Any other questions? Great.  
12 Thank you, all for your help. Appreciate it. It's  
13 great to come back. All right. See you later.

14 (Applause).

15 MR. CODERRE: I got to run to CMHS and tribal. All  
16 right.

17 (Laughter).

18 MS. HARDING: Bye-bye.

19 MR. CODERRE: Thank you.

20 MS. HARDING: Sometimes I wonder what keeps that  
21 many going, because he's always that fast, that excited,  
22 and no matter what time of day he's presenting or he's

1 in a meeting with you, you just sit there and go, wow,  
2 am I a slacker or what, because this guy just doesn't  
3 stop.

4 (Laughter).

5 MS. HARDING: So all right. We are going to take a  
6 break, unless you don't want one, of course.

7 (Laughter).

8 MS. HARDING: It's that time of the afternoon. So  
9 we actually, I think, are going to give you a long one,  
10 15 minutes where you can stretch your legs.  
11 Unfortunately, this is all the good news. The  
12 cafeteria, coffee shop, whatever we call that, is not  
13 open I don't think, or does it close at 3:00? It closes  
14 at 3:00. Your chances of getting coffee is pretty slim  
15 to none, but everything else is available.

16 So we will see you back here in 15 minutes,  
17 whatever 15 minutes is on your watch. That way, I know  
18 you'll all be back on time.

19 Ruth, take a break.

20 (Break).

21 MR. AUMEN: All right. Welcome back, folks.

22 We're going to get started with the next session. So

1 next, Fran will be talking to you about the National  
2 Heroin Task Force.

3 So Fran, whenever you are ready.

4 AGENDA ITEM:

5 NATIONAL HEROIN TASK FORCE

6 MS. HARDING: Okay. Welcome back. This is the  
7 last stretch. This is the last two miles of your  
8 marathon, and you just have to engage, and we'll go.  
9 Hopefully, it will not be as painful

10 Every time we meet, it always seems like we have a  
11 new initiative that's added to our plate. So the newest  
12 initiative that--along with you'll hear tomorrow about  
13 the Secretary is having another 50-state meeting on  
14 opiates in September.

15 The Secretary has her opiate strategic plan that  
16 being rolled out, and we have staff here that are  
17 working on pieces of that, because every agency and HHS  
18 has a piece of that success, which SAMHSA or CSAP is  
19 involved with, because if you remember, I'm responsible  
20 for prescription drugs, what Kana was alluding to, both  
21 budget and across the board. It doesn't matter if it's  
22 treatment or if it's prevention or treatment or

1 recovery.

2           So we have the 50-state is prescription drugs, the  
3 budget items that we've been working on that Kana was  
4 saying that we're just having a hard time getting them  
5 to see the role of prevention in the opiate issue,  
6 although they're very happy to put a budget and money  
7 into CSAP, even thought CSAT, with a T, is doing the  
8 work. Interesting. It's just a different level of  
9 management that I've become expert in for survival sake  
10 only.

11           The other newest member of the drug family that  
12 we're looking at is heroin. As you know, I'm not sure  
13 that I spoke yesterday--let me just check real, real  
14 quickly. Yes, we are seeing an increase in heroin use,  
15 even in the NSDUH survey, but it is minor compared to  
16 the increase in opiates and in increase in--well,  
17 alcohol still remains, in case anyone was thinking  
18 differently, still remains the drug of choice for our  
19 country and the one that is the largest representative  
20 reason for people going into treatment is because of  
21 alcohol addiction, believe it or not. It's not all the  
22 rest, although the second is marijuana. So that's even

1 surpassed some of our other illicit drugs.

2 So I get a phone call in April or March saying  
3 that, in April, the Attorney General has decided to  
4 start up a new task force on heroin, because he wants a  
5 report for Congress and the President by December of  
6 2015. Yes, I did say '15.

7 So the two individuals, I've given you--and I mean,  
8 you could share it, I don't know why you'd want to share  
9 it, but it's not--it's public--the letter from our  
10 Attorney General explaining what this task force is,  
11 explaining what he wants out of the task force.

12 And our two co-chairs leading this task force is a  
13 Mr. David Hickton. He's the US Attorney for the Western  
14 District in Pennsylvania, and the federal co-chair is  
15 Mary Lou Leary.

16 For those of you who have not yet met Mary Lou, I  
17 always tease her, because I introduce her this way,  
18 she's the new Ben Tucker. I don't know how long Ben  
19 Tucker has to be in New York City before I stop saying  
20 that, but people do remember Ben, and that puts  
21 immediately in their mind what Mary Lou does. She is or  
22 deputy director for state, local, and tribal affairs,

1 and for SAMHSA, she is the person who oversees the Drug-  
2 Free Communities. That's why we have such a good  
3 interaction.

4 And you can see in the letter there is many other  
5 partners, and obviously, SAMHSA is. One of them was  
6 Pam, obviously, will now be Kana. So you can read that  
7 at your leisure.

8 The bottom line is we are required to develop a  
9 report that is due to the Attorney General in November  
10 that will be then--the action will happen in December or  
11 January, whatever they decide. Our deadline was August.  
12 We met our deadline.

13 I gave you four task forces. So there is four task  
14 force committees, one on education and committee  
15 awareness, one on law enforcement response, coordinated  
16 community response, treatment and recovery treatment,  
17 and recovery support.

18 If you look at it, we have two out of the four  
19 committees being coordinated, run, facilitated, led by  
20 SAMHSA employees, myself with education and committee  
21 awareness and our very own Dr. Melinda Campopiano, who  
22 resides in treatment in CSAT.

1           We talk a lot about the negativity of SAMHSA, how  
2 we're small, people don't often come to us. We're  
3 always in the shadows of CDC, FDA, and then all of our  
4 research agencies. But when it really comes down to the  
5 work and when they need collaboration and they need  
6 people to pull something like this together in an  
7 impossible timeline, it was no surprise to me that they  
8 asked SAMHSA to help out in this.

9           So my other two colleagues is Rod Rosenstein. He's  
10 a US Attorney for the United States District Court for  
11 the District of Maryland, is leading the law enforcement  
12 response, and Jason Cunningham, who is from the National  
13 Narcotics--he's the National Narcotics Coordinator of  
14 the Office for the United States Attorney's Office.

15           So just a small little picture of what it's like to  
16 sit at this table. Not only do you have all the  
17 partners that are listed here, all the big--you know,  
18 the administrators and leaders and directors and all  
19 their fancy titles, you have your four chairs of the  
20 committee.

21           And I have two staff are working with me directly,  
22 Mike Muni and Barbara Howes, who was here, is here.

1 Barbara is here. Hi, Barbara. Who, without them, of  
2 course, this could not have been accomplished in the  
3 time frame that we had getting soliciting information.

4 So I'm only telling you this story to show you that  
5 we are making strides, because we're here, and we're  
6 leading these groups. And we will be with them all  
7 throughout. And SAMHSA's name and Kana's should be  
8 front and center if there is a bill or a structure or  
9 something for the signature. So we're there.

10 That being said, I have the education and community  
11 awareness committee. Now, as always, when they started  
12 talking about this--now, remember 75 to 80 percent law  
13 enforcement, little old prevention sitting over here,  
14 two people, and then my partner in crime, coordinated  
15 community response guy, Jason, who really, I think got  
16 roped into this.

17 So setting it up, and they're talking about  
18 prevention first, and prevention always has to go first--  
19 -I want my next profession to be something that I'm  
20 tapped on last, because whenever there is an  
21 announcement or someone has to start talking, it's  
22 always prevention first, and that's a bit uncomfortable,

1 prevention first, talking about what we're doing.

2 People are doing this, talking to their neighbors,  
3 and I'm trying to look at the co-chairs, and I'm trying  
4 to be my enthusiastic self. People are looking up at  
5 the ceiling, because we're in a beautiful room in the  
6 White House on the side. So I mean, the environment was  
7 good. And I'm just sitting here trying not to be  
8 distracted, going, they don't want to know.

9 MS. HARDING: They don't want to know what I have  
10 to say at all. And when Michael Compton said earlier,  
11 what is a coalition? I mean, that's all I could think  
12 of, because someone's saying, well, okay, this is really  
13 nice, but we don't really understand what the IOM is let  
14 along the IOM steps.

15 And so we knew immediately we had a lot of teaching  
16 to do in a short amount of time. The good news is, we  
17 were there. And I think for the people that we serve,  
18 and the people we give grants for, and all the work that  
19 you have been doing throughout your careers, that's  
20 really what the big thing is. We're there. We're at  
21 the table. We're in the door. We're coordinating, and  
22 we know how to coordinate.

1           And I say this all the time, too, when I speak, is  
2 the skill sets that the prevention work force have are  
3 adapted to almost everything and will get us far in  
4 life. And one of those is collaboration and  
5 coordination. We know how to collaborate with the best  
6 of them. And that's really, when you think about it,  
7 what we do very, very well and what carries you.

8           So long story short, we had our first subcommittee  
9 meeting. We got four people to show up. Four, just  
10 four. And I said, oh, lord, this isn't going to work.  
11 And so we tried to solicit more excitement from our  
12 colleagues.

13           And the bottom line is, I said to Mike Muni, who  
14 was working with me, and I think I dragged Rich into the  
15 conversation, and we decided what we needed to do was  
16 prime the pump. I assembled quickly a small  
17 subcommittee within SAMHSA, mostly CSAP but a couple of  
18 our other colleagues, just to put meat on the bones of  
19 what we were going to do in our part of this report.

20           And that's how Barbara got involved, because now,  
21 we have to have somebody collect all this. And we sent  
22 it out to the full list, not just the four that showed

1 up, the full list. And then what happened, they started  
2 to react to it, because for whatever reason--and then we  
3 obviously got all our work done.

4 I have to commend Barbara. She came in from the  
5 outside so to speak, not knowing what she was getting  
6 into. I don't know if she volunteered or she was  
7 voluntold by Charles. I'm not certain, but she has done  
8 a spectacular job, and I'm glad she is here to hear this  
9 and help answer questions.

10 So the report, once we get a draft, our next  
11 meeting is September 10, as I said, all of the drafts  
12 are in. We had to get those in early in August. So  
13 each of the four chapters are written. We've already  
14 received our first level of edits from the leaders in  
15 ONDCP, and we've turned it around, and it's back in  
16 their hand. So by September 10, the plan is we should  
17 have a working draft.

18 As soon as I get permission to share with my  
19 colleagues, remember, you are all ambassadors. And you  
20 didn't take an oath, but I did ask somebody why you  
21 should take an oath when you take these jobs. But we  
22 will then share them with you, not for publication, not

1 for sharing, but then you'll see where we're going.

2 And then we can then talk about if you see  
3 anything, and you say, you know what, you missed  
4 something, you really should think about adding this,  
5 because we will have some time between September 10 and  
6 the end of October to make our last screening edits.  
7 And that will mean from my colleagues in SAMHSA, Kana,  
8 and then whomever else she wants me to share this with.  
9 So you will be in the loop with that.

10 So I didn't want this to come to you, even though I  
11 can't share anything with you now, I didn't want to come  
12 to you cold, and you say, what is this? So you know,  
13 this is not a huge document. We were limited to--  
14 Barbara, was it up to 30 pages, 20 or--

15 MS. HOWES: Was it 20 to 30 or 30 to 40?

16 MS. HARDING: No, I think it was 20 to 30. All  
17 right. It's either 20 to 30 or 30 to 40 times 4. So  
18 it's not huge. I mean, but government standards, it's  
19 not huge.

20 (Laughter).

21 MS. HARDING: So it's an easy weekend read. And if  
22 you want to just go to the important section, which is

1 the education and community awareness section, I'd be  
2 happy to take your comments.

3 (Laughter).

4 MS. HARDING: So I'm happy that we're doing this, I  
5 guess. I'm a little bit scared, because some of the  
6 conversation and some of the recommendations that are  
7 coming out of some of my colleagues from a law  
8 enforcement perspective really needs some molding a  
9 little bit and shaving off the edges.

10 How many times have we said we cannot just regulate  
11 this and throw people in jail? I mean, it's just not  
12 going to work. So I think that this balance of four  
13 committees is interesting what you get a chance to read  
14 it. And I'm anxiously waiting to see the whole  
15 document, because the only chapter I've seen, besides  
16 ours, is Melinda's, of course, because she and I both  
17 shared. The mystery is the other two and what is their  
18 angle. I know what they say in the meetings. I don't  
19 know what they're going to write.

20 So I'm very excited that SAMHSA--that I had the  
21 honor to be a part of this, so we could get the  
22 prevention message in. We certainly have done that. We

1 go the gamut. We're into HIV. We're into--of course,  
2 whenever it's HIV, it's always Hep C and the like.  
3 We're into several different populations.

4 What else, Barbara, would you say that our chapter  
5 expands into? It's not just a straight heroin, opiates,  
6 PDMPs, anything else? Pretty much, that's it, right?

7 MS. HOWES: There was some marijuana in there, but  
8 it got too long, I believe.

9 MS. HARDING: Yeah, yeah. Well, you know, when  
10 you're working by committee, you've got to be fair with  
11 the comments. And yeah, it was stricken.

12 SPEAKER: (Inaudible).

13 MS. HARDING: I don't think we got specifically,  
14 but I know in treatment they had mentioned some of that,  
15 so the treatment component, and when you see it, you'll  
16 see the whole piece, you might be interested in the  
17 treatment piece.

18 Of course, there's your obvious, even in treatment,  
19 naloxone and medicated assistant treatment, which we had  
20 in our chapter, as well, right? Sarah, remembers, one  
21 of the readers. I don't know if it's still there or  
22 not, because I also know our colleagues in treatment are

1 putting it in there.

2 So it goes to our earlier discussion, what is  
3 prevention. I mean, when you're talking integration  
4 with health reform or health care rather or just health  
5 and primary care, you're also--and people are looking at  
6 preventive care. So having medicated assist in  
7 treatment can be seen as a prevention tool to some.  
8 That's not necessarily where we would like our money  
9 focused on entirely, but it might stay in prevention.

10 So it's a very--for the short amount of time we had  
11 to put this together, we, meaning all the committee, and  
12 I would say, Barbara, about 100 people at most in that  
13 room, so it's a small committee relative to government.  
14 And that includes our leaders.

15 So that's it. Any questions?

16 It's mostly just a heads up. Didn't have a lot to  
17 show you. Wanted you to know it was happening, and  
18 wanted you to know as soon as I get the go ahead to send  
19 it to you, I will. And I know you'll hate the  
20 turnaround time. So do what you can. Read it. Don't  
21 send us anything. It's not an assignment. It's just a  
22 courtesy share.



1 would like to make a comment is invited to address the  
2 council.

3 For anyone in the room, please state your name and  
4 make sure that you speak clearly into the microphone so  
5 your comments could be heard and, most importantly,  
6 recorded. Please also limit any comments to five  
7 minutes or less.

8 I will hand this over to Matthew from this point  
9 on.

10 (No response).

11 MR. AUMEN: All right. So there are no comments  
12 from the room.

13 Jill, can you open the phone lines up for public  
14 comment for anyone who is on the phone?

15 OPERATOR: Certainly. And if anyone on the phone  
16 would like to make a public comment, please press star,  
17 one at this time and please record your name. Once  
18 again, it is star, one, and please record your name.

19 (No response).

20 MR. AUMEN: Okay. Hearing none from the phone, we  
21 do have one from the room.

22 So go ahead.

1           MR. HOFFMAN: Hi. Thank you. My name is Julian  
2 Hoffman. I work as a government affairs manager with  
3 the National Safety Council, over 100-year-old  
4 organization, we work on a variety of safety issues.  
5 We're employer-based, 14,000 US companies, and I handle  
6 our prescription drug overdose efforts.

7           First of all, thank you for having us here today,  
8 and thank you to SAMHSA for your continued work on this  
9 issue. I know, as Director Harding just said, some of  
10 it blurs the lines between treatment and prevention, but  
11 we are very pleased with CSAP's funding for grants to  
12 prevent prescription overdose regardless. It's one of  
13 our requests going up to Congress in our own advocacy  
14 effort. So thank you for that.

15           Speaking about events that are going on, we also  
16 just wanted to take this opportunity to let you know  
17 about a couple of things that we're doing. In just a  
18 few days, I'll be heading to Chicago as part of  
19 International Overdose Awareness Day, which is on August  
20 31.

21           There will be rallies around the world. It's an  
22 event that was started in Australia, but at our Chicago

1 event, we will actually be holding several legislators,  
2 and we're hoping to train 200 to 300 people outside in  
3 the use of naloxone and distribute them all at once.  
4 Think it's a great opportunity for some awareness around  
5 the issue.

6 We also look forward to participating in the UNITE  
7 To Face Addiction Rally, which we were informed about  
8 this afternoon, and the day before, the FED UP! Rally,  
9 which is centered around opioid addiction, which we're  
10 also happy to sponsor.

11 We recently released a community action toolkit,  
12 which I encourage anybody who is interested in that to  
13 go to our website and find. It has various parts that  
14 are targeted at different stakeholders, be you  
15 legislators or community representatives, people who are  
16 interested in hosting your own events.

17 We're also working with the American Academy of  
18 Family Physicians and the American College of Physicians  
19 on prescribing guidelines for the treatment of pain. We  
20 think a lot of the prevention comes from making sure  
21 that people who don't need opioids don't get them,  
22 especially for acute pain.

1           And then finally, we just wanted to thank the  
2 center for sending Ron Flegel to our upcoming annual  
3 convention in Atlanta. He's going to be presenting on  
4 Weed in your Workforce to our 14,000 members who will be  
5 in attendance. We're very excited to have him there.

6           So thank you, again, for having us today.

7           MS. HARDING: Thank you. So we're good, right?  
8 I'm just checking to make sure there wasn't any other  
9 comments that came in.

10          Thank you. So the public comment period is now  
11 closed, and we'll close our session.

12   AGENDA ITEM:

13   CLOSING REMARKS

14          MS. HARDING: I will close by one more time  
15 thanking our council members that have given us their  
16 time, their efforts, their thinking, taking the risks  
17 when needed, and just being here and sharing who you  
18 are, what you've done, and working so tirelessly for us.

19          So I think both Michaels fondly, Michael Montgomery  
20 and Michael Compton, and John Clapp, and Steven Green.  
21 We're going to miss you and hope that we will find a way  
22 to tap into you every now and then.

1 Michael has already told me that one of our  
2 replacements from Maine is a great person, and we are  
3 going to be in a real--educator on marijuana, so that  
4 will be a nice addition and a very timely one. So we're  
5 very happy with that.

6 And I also just want to say thank you for the rest  
7 of the council and look forward to expanding our  
8 council, hopefully, by April.

9 And, I mean, we know what it's like to have to deal  
10 with the travel, have to work through all the federal  
11 government restrictions and guidelines and paperwork.  
12 And we do appreciate it. We get kind of numb to it  
13 here, but we do know when you're not having to do it on  
14 a daily basis, it is sometimes very difficult, and we  
15 appreciate that.

16 I most have appreciated our last two years of this  
17 council, because you have been very engaged, willing to  
18 work with us. We've had committees. We've had many  
19 more conversations on the phone. We've worked through  
20 problems. You've been very vocal during the grant  
21 review, and there were times when that process went  
22 pretty quickly, because nobody asked any questions.

1           You guys are very much on top of it. You take your  
2 jobs and responsibilities very seriously, and we greatly  
3 appreciate that and just thank all of you around the  
4 table.

5           How about some logistical information for tomorrow.  
6 Do you have that?

7           MR. AUMEN: So the various councils are meeting  
8 tomorrow in the Sugarloaf conference room. That is from  
9 8:30 a.m. to 4:15 p.m. at SAMHSA, again, and the  
10 conference room is down the hall.

11           So for the members present, there is the shuttle  
12 that will leave at 7:45 tomorrow morning to bring you  
13 here.

14           (Laughter).

15           MS. HARDING: See, and you thought it was rough  
16 yesterday.

17           (Laughter).

18           MS. HARDING: We're kind.

19           MR. AUMEN: I don't know. Maybe if you stall,  
20 then you can wait on it.

21           MS. HARDING: It's not that early. Been up for  
22 hours before that.

