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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION (SAMHSA)

Center for Substance Abuse Prevention
National Advisory Council Meeting

10:00 a.m.

Wednesday, April 2, 2014

Gaithersburg Marriott Washingtonian Center
9751 Washingtonian Blvd
Gaithersburg, Maryland 20878

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PARTICIPANTS:

4 MATTHEW AUMEN INGRID DONATO

5 FRAN HARDING MARK JACOBSON

6 KATHY REYNOLDS MIRTHA BEADLE

7 MICHAEL MONTGOMERY RON FLEGEL

8 LEI MCCABE

9 NEL NADAL

10 PATRICIA WHITEFOOT

11 ROBERT VINCENT

12 RUTH SATTERFIELD

13 PAM HYDE

14 MARLA HENDRICKSSON

15 MICHAEL COMPTON

16 DIANNE HARNAD

17 STEVE KEEL

18 RICH LUCEY

19 JOHN CLAPP

20 RICHARD MOORE

21 STEVEN GREEN

1 JORIELLE BROWN

2 CYNTHIA RUBIO

3 RICH MCKEON

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

5 AGENDA ITEM: CALL MEETING TO ORDER

6 MR. MATTHEW AUMEN: All right, folks. We're
7 going to get started. So can everyone hear me pretty
8 decent?

9 Okay. We're working on the webcast portion of
10 today's meeting. As soon as we get that up, we will
11 have that available to those who are participating
12 virtually. We have the phone line set up. It has two
13 small mics near the phone, so it'll pick up the
14 conversation in the room as opposed to the table mics
15 which will pick up for the transcription.

16 OPERATOR: [Off audio.]

17 MR. MATTHEW AUMEN: All right. Thank you,
18 everybody. So my name is Matthew Aumen, and I am the
19 Designated Federal Officer for the Center for
20 Substance Abuse Prevention National Advisory Council.
21 I'll now officially call the meeting to order, and I

1 do want to provide notes before we get started.

2 Please speak clearly into the microphones as we
3 have participants who are on the phone and who will be
4 watching the webcast that we have set up as well. And
5 again, I have the speaker phone in the middle of the
6 room. That'll capture everything in the room, so try
7 to keep side conversations down or at a minimum. And
8 then with the microphones, please state your name for
9 the transcription purposes before you speak. That'll
10 be very helpful.

11 I also want to before I get started really send a
12 thanks to a number of folks who helped put this
13 meeting together. We had a change of venue last
14 minute as our office building was closed. And I
15 really want to thank a few SAMHSA staff, most notably
16 Tia Ames, Eliza Jones, who helped a lot with
17 logistics. Our logistics contractors, Karen Braxton,
18 Berna Robinson, Tina Scott. They did a heck of a job
19 with logistics. Our travel coordinator in-house, Anju
20 Sardana and Trish Rice, as well as Patty Runyon
21 helping out with getting members -- our new member on

1 board, also Kevin Forkov with Ethics. A tremendous
2 amount of work that goes into this.

3 So without further delay, I will turn it over to
4 Fran, and we will get started.

5 AGENDA ITEM: WELCOME AND OPENING REMARKS

6 MS. FRANCIS HARDING: Thank you, Matthew. Good
7 morning, everyone. Everyone looks alive, awake, ready
8 to go. You've adjusted your time zones, and we're on
9 our way.

10 I want to remind everyone, especially our new
11 members, not only to welcome you, but this is a
12 recorded meeting, so that just to be forewarned. We
13 want to hear what you have to say, but we also want
14 you to be mindful of yourselves and your positions.

15 So I welcome everyone here, Council members,
16 SAMHSA staff, the public attendees. I welcome you to
17 the Center for Substance Abuse Prevention National
18 Advisory Council. If you thought you were in another
19 council meeting, we'll give you directions on where to
20 go there.

21 AGENDA ITEM: COUNCIL ROLL CALL/INTRODUCTIONS

1 MS. FRANCIS HARDING: So just as we did in the
2 past, what we normally do is go around the table, and
3 I will ask everybody at the table to introduce
4 themselves, and where you're from, and whether or not
5 this is your first meeting or not. And then, SAMHSA
6 staff, identify your position. I will not be asking
7 people around -- outside at this moment to introduce
8 yourselves only because of the logistics of taping and
9 being able to record. So if we could start on my
10 right and go around.

11 MR. RICH LUCEY: Good morning. I'm Rich Lucey.
12 I'm the Special Assistant to the Director in SAMHSA's
13 Center for Substance Abuse Prevention.

14 DR. JOHN CLAPP: Good morning. John Clapp, the
15 Ohio State University. I'm the Associate Dean of
16 Research in the College of Social Work.

17 MR. STEVE KEEL: Good morning. My name is Steve
18 Keel. I am former NPN from Massachusetts, and I'm a
19 new member to the Advisory Council.

20 MR. CHARLES REYNOLDS: Good morning. Charles
21 Reynolds, the Director of Community Programs within

1 CSAP.

2 MR. STEVEN GREEN: Good morning. My name is
3 Steven Green. I'm the Executive Director of
4 Behavioral Health Services for the Gila River Indian
5 Community, which is located in central Arizona. And
6 I'm in my third year as a committee member.

7 DR. MICHAEL COMPTON: Good morning. I'm Michael
8 Compton. I'm the Chairman of Psychiatry at Lenox Hill
9 Hospital and Professor of Psychiatry at Hofstra, North
10 Shore-LIJ School of Medicine at Hofstra University in
11 New York.

12 MS. DIANNE HARNAD: Good morning. I'm Dianne
13 Harnad, a former NPN from the State of Connecticut,
14 and also a faculty member, School of Social Work,
15 Eastern Connecticut State University.

16 MR. MARK JACOBSON: Good morning. I'm Mark
17 Jacobson. I'm the Acting Director of the Office of
18 Program Analysis and Coordination at CSAP.

19 MS. LEI MCCABE: Good morning. My name is Lei
20 McCabe, Lead Budget Analyst at CSAP.

21 MR. ROBERT BOZZO: Good morning. I'm Robert

1 Bozzo. I'm a contractor, and I'm taking notes
2 throughout the meeting.

3 MR. ROB VINCENT: Rob Vincent, Public Health
4 Analyst, Materials Developer, Center for Substance
5 Abuse Prevention.

6 MS. NEL NADAL: Good morning. Nel Nadal,
7 Division Systems Development, Team Leader for
8 Materials Development.

9 MS. PATRICIA WHITEFOOT: Oh, sorry. Good
10 morning. Patricia Whitefoot, Yakama Nation, and a
11 member of the National Advisory Council. I also work
12 as Indian Education Director for the Toppenish School
13 District in Toppenish, Washington.

14 DR. JORIELLE BROWN: Good morning. I'm Jorielle
15 Brown, and I serve as the Director of the Division of
16 Services Development -- excuse me -- Systems
17 Development in CSAP.

18 MR. RICHARD MOORE: Good morning. I'm Richard
19 Moore. I'm the Director of the Division of State
20 Programs in CSAP.

21 MR. MICHAEL MONTGOMERY: I'm Michael Montgomery,

1 retired as the Chief of the Office of AIDS, State of
2 California, and I'm now living in Maine.

3 MS. RUTH SATTERFIELD: Good morning. I'm Ruth
4 Satterfield, a former NPN for the State of Ohio, and
5 also an independent contractor. And this is my first
6 meeting.

7 MS. KATHLEEN REYNOLDS: Kathleen Reynolds, Vice
8 President for Health Integration and Wellness at the
9 National Council for Behavioral Health, and this is my
10 first meeting.

11 MS. MIRTHA BEADLE: Good morning. I'm Mirtha
12 Beadle. I'm the Deputy Director for CSAP.

13 MS. FRANCIS HARDING: Okay. One of the
14 prerogatives of leading this group is I can change my
15 mind. There aren't that many people here this
16 morning, so if I could ask for your indulgence, I
17 would like them to identify who they are and which --
18 what do you do, what's your position in CSAP. You'll
19 have to come up to a microphone to do it. So if we
20 could do this efficiently and quickly, that would be
21 wonderful.

1 MS. CHARLOTTE OLSON: Charlotte Olson, Project
2 Officer, Division of Community Programs in CSAP.

3 MS. METRA AHATPOR: Metra Ahatpor, primary care
4 physician, Clinical Communication Advisor at OSEC,
5 Office of Communications, at SAMHSA.

6 COMMANDER CYNTHIA RUBIO: Hello. I am Commander
7 Cynthia Rubio, and I am the CSAP Special Assistant on
8 Health Reform.

9 COMMANDER JOSEFINE HAYNES-BATTLE: Good morning.
10 I'm Commander Josefine Haynes-Battle. I'm a Branch
11 Chief within the Division of Systems Development.

12 MS. MARIA BOBROVNYK: Good morning. Maria
13 Bobrovnyk. I'm the policy intern at American Public
14 Human Services Association.

15 MR. ALAN WARD: Good morning. I'm Alan Ward.
16 I'm a Branch Chief in the Division of Community
17 Programs at CSAP.

18 MS. FRANCIS HARDING: Anyone else care to
19 introduce themselves? It's not a requirement.

20 [No response.]

21 MS. FRANCIS HARDING: Okay. Thank you very much.

1 So welcome, everybody. The Council -- Matthew has
2 assured me that we have a quorum. Hooray. Hooray.
3 There have been times that's been a bit of a struggle
4 with weather and travel in the past. So knowing that
5 we have a quorum, I want to move forward with
6 approving the minutes of our last meeting.

7 AGENDA ITEM: APPROVE MINUTES FROM 14 AUGUST 2013
8 MEETING

9 MS. FRANCIS HARDING: The Council has -- you have
10 reviewed and commented on the meeting's minutes from
11 August 14th, 2013 -- sorry, I got the 14s mixed up --
12 at our NAC meeting. I was trying to remember when the
13 last time we came together. So at this time, I'd like
14 to request a motion to approve the meeting minutes for
15 our records.

16 UNIDENTIFIED SPEAKER: So moved.

17 MS. FRANCIS HARDING: Michael moved. Can I have
18 a second?

19 MR. STEVEN GREEN: Second.

20 MS. FRANCIS HARDING: Steven. Any objection?

21 [No response.]

1 MS. FRANCIS HARDING: Hearing none, as noted by
2 the transcriber, the August 14th, 2013 CSAP NAC
3 meeting minutes have now been approved for public
4 record. Thank you all very much for doing that.

5 So we're -- I told you yesterday that we were
6 going to keep on task, and we have an awful lot to fit
7 into the next few hours. So we're going to just go
8 through the agenda at a pretty fair clip. Any
9 questions that you have, if we're going too fast, if
10 you want to take a pause and ask more questions on the
11 products that we show you, please do. We have built
12 in that amount of time.

13 AGENDA ITEM: BUDGET UPDATE

14 MS. FRANCIS HARDING: So the first thing on our
15 agenda is to talk about -- to have our budget update.
16 In past National Advisory Councils, you have asked for
17 an update -- a very high-level update on where we're
18 at with the budget so that we get into conversations
19 programmatically, you have a little bit of a sense of
20 where we are at.

21 So I am going to ask our new Budget Director, Lei

1 McCabe, from the Office of Program Analysis and
2 Coordination, to give us a quick and high-level, but
3 detailed, analysis of what our budget is. Lei?

4 MS. LEI MCCABE: Thank you. Good morning. Let
5 me just go over the budget updates for '14 and '15,
6 and touch very briefly on '13 numbers.

7 And as you see on the slides here, in Fiscal Year
8 2015, we received about \$306 -- I'm sorry -- \$175
9 million of program of regional national significance.
10 And the breakdown of specific items are strategic
11 prevention framework, about \$110; mandatory drug
12 testing, about \$4.9; Minority AIDS Initiative, \$41 --
13 around \$41; STOP Act, \$7 million; fetal alcohol
14 spectrum disorders, \$1 million; science and service
15 program coordination, about \$4 million; Center for
16 Application of Prevention Technologies, \$7.5; and
17 last, but not least, Minority Fellowship Program,
18 which is a collaborative effort with Center of
19 Substance Abuse Treatment and Center of Mental Health
20 Services.

21 And we have also a share in SAMHSA's Substance

1 Abuse and Prevention Treatment block grant. The
2 amount is \$363, \$364 million. Just to give a
3 background of this number is calculated, CSAP takes
4 about 20 percent of the total prevention and treatment
5 block grants. So that's where we stand in Fiscal Year
6 '14.

7 And in Fiscal Year '15, everything pretty much
8 stays the same, except there is one major change. We
9 received an increase of \$10 million in the Strategic
10 Prevention Framework Program line because SAMHSA is
11 proposing to dedicate \$10 million to a new program.
12 The Strategic Prevention Framework Prescription Drug
13 Abuse and Overdose Prevention is now -- we call it
14 SPFX.

15 This program will provide funding for the
16 prevention of prescription drug misuse and abuse in
17 high plurality age groups, including young and middle-
18 aged adults to the general public. So that's why you
19 can see as a total budget number for CSAP where you
20 have a big increase due to this particular program.

21 One thing I want to note is in Fiscal Year '15,

1 the Minority Fellowship Program is not receiving any
2 funding as of now. That's the collaborative decision
3 with other centers. That's a very small decrease.

4 So as a whole in Fiscal Year '15, CSAP total
5 budget is about \$10 million more than the current
6 year, Fiscal Year '14.

7 So are there questions?

8 [No response.]

9 MS. FRANCIS HARDING: Thank you, Lei.

10 MS. LEI MCCABE: Thank you.

11 MS. FRANCIS HARDING: I do want to remind
12 especially some of the new members of the Council that
13 the 2015 President's budget is exactly what it sounds
14 like. It's the budget the President has put forward.
15 However, it's not a -- it may not look like this in a
16 few months because this is what the President has put
17 forward for us. We support the President's budget.
18 As you can see, we really support the CSAP portion of
19 the budget, but it may get changed between now and the
20 time that it actually goes into to be enacted. So
21 oftentimes the enacted budget, which is the budget

1 that we work with, it could be slightly different,
2 higher, lower, the same. We never really know. So
3 just wanted you to not walk away thinking that
4 everything is exactly the way that it is.

5 Any questions for Lei?

6 [No response.]

7 MS. FRANCIS HARDING: Okay. So our take on this
8 is that it's a good budget for us. We have fared very
9 well during these economic times. When Administrator
10 Hyde gets here, I'm sure she'll say something about
11 the budget as well, and all of the other pieces that
12 don't necessarily pertain specifically to prevention.
13 And I think most of you have found it, but in your
14 books, you have every slide that we have. I hope
15 after I say this it's right.

16 You have them in your books, particularly around
17 the budget because I know sometimes it's difficult to
18 have -- trying to retain those members, so thank you
19 very much. I should let you know that Lei has only
20 been on the job for a month?

21 MS. LEI MCCABE: One month.

1 MS. FRANCIS HARDING: One month, see? So we have
2 done a lot of changing a lot of buildings since we
3 last met, and we have brought a lot of talent to the
4 table. So I congratulate you, Lei, on your first
5 report. It was very clear, concise, and because there
6 are no questions, it must be a good thing, right?
7 We'll have to give her a bigger challenge next time.

8 AGENDA ITEM: CSAP PROGRAM UPDATES

9 MS. FRANCIS HARDING: Okay. Switching gears a
10 little bit, we're now going to go the CSAP Program
11 updates. As we discussed in our previous conference
12 call, the areas of interest were mostly around the
13 underage drinking and our National Prevention Week.
14 So I have asked Nel Nadal and Rob Vincent to give us
15 an update on both of these, and probably a couple of
16 little surprises in there as well. So, Nel?

17 MS. NEL NADAL: We'll try not to surprise you.
18 We try to make sure we always tell you ahead of time
19 what's going to happen.

20 UNIDENTIFIED SPEAKER: No surprises.

21 MS. NEL NADAL: Good morning. Actually I am

1 channeling my colleague, David Wilson, who is the lead
2 for this particular observance and hope to do him
3 justice as far as presenting features of National
4 Prevention Week.

5 Basically this is our third year. We launched
6 this in 2012, and the basic question would be why do
7 we need yet another public awareness observance. And
8 the reason that this was proposed and taken on was
9 that there is no single observance that actually
10 captures all of the behavior health issue that SAMHSA
11 is talking about. And so, that was the basic concept
12 behind it. And it gives us an opportunity to really
13 showcase prevention, and looking at prevention and
14 promotion relative to substance abuse issues, suicide
15 prevention, bullying, emotional health promotion.

16 So giving tools to communities in terms of what
17 works and to be able to show results because we have a
18 lot of things where we've told stories about we have
19 this really great prevention program. We've used it
20 for this. Being able to take it to the next level
21 where we actually explain to people why does it work,

1 why does it take all the things that go into it in
2 terms of all of the prevention science behind anything
3 that's being done at the local level or at the state
4 level, and then showing that it mattered that you did
5 something in the prevention arena.

6 In terms of selecting this particular month, May
7 was selected primarily because you're getting to that
8 period where kids are going to be off of school, and
9 we're gearing it to more youth. And you're getting
10 into a point where there would be a higher potential
11 for experimentation, and really kind of gearing up
12 something for folks to focus on as they enter the
13 summer months.

14 In terms of the themes for 2014, these don't vary
15 much from what you already know we focused on in
16 Strategic Initiative Number 1, and so, these reflect
17 those priorities. Draw your attention to May 20th. I
18 mean, each day was really just to give something for
19 communities to go ahead and connect to and decide
20 whether they wanted to pick on one, two, or however
21 many things that their particular community-based

1 organization or state wanted to focus on.

2 Because of the changing landscape with regarding
3 to marijuana use, that was added to the theme for May
4 20th. Prescription drug use was part of what we had
5 focused upon last. We put marijuana use in there.
6 Just something just to attend to. Obviously it's
7 different depending on how communities are working
8 with changes in terms of laws, ordinances, and
9 whatnot, but also looking at the data in terms of the
10 perceived risk being -- going down.

11 One thing about the -- oh, I'm sorry. Could you
12 flip back one more time?

13 UNIDENTIFIED SPEAKER: [Off audio.]

14 MS. NEL NADAL: Back to the themes. One of the
15 things that we try to do is that any of the public
16 awareness efforts that are going on across SAMHSA,
17 we're making sure to go ahead and tie together that
18 are being run by our center as well as those that are
19 being run throughout the Agency, that we have a
20 connection to them so there's a lot of cross-promotion
21 and intentional collaboration.

1 You may be aware of SAMHSA sponsoring its fifth
2 round of town hall meetings to prevent underage
3 drinking. So the theme that we have is Our Lives, Our
4 Health, Our Future. The theme that was selected for
5 this year's round, which will pretty much kick off in
6 April, is Our Town, Our Health, Our Future. And part
7 of it's just to have a consistency to make sure that
8 we're saying core messages all the time, and then have
9 communities go ahead and work off of those to tailor
10 that to the needs of their communities.

11 Okay. Jumping back to the resources, everything
12 is on the website. The idea is it's a very
13 substantive website, and for those folks who haven't
14 had a chance to go to check it out, I would encourage
15 you to do that. There's a lot of tools that can be
16 used by community-based organizations that they can
17 tailor, and there's a lot of things that are pretty
18 much ready to go. So all the things that you would
19 expect from an awareness observance that you have
20 radio scripts, you have social media examples, you
21 have fact sheets that pretty much reflect the latest

1 from our Center for Behavioral Health Statistics and
2 Quality.

3 Let's see. Jump to that one. Oops, sorry. The
4 website has a number of things that really are making
5 use of SAMHSA's use of social media. So the I Choose
6 Project, there's a place where we're listing the
7 events that different communities are holding around
8 the country. There's a prevention pledge. Anybody
9 who's been playing in the field of behavioral change
10 knows that having people have a way to go ahead and
11 engage, even if it seems fairly simple of terms of
12 being able to make a public pledge.

13 Because of social media, that is something that I
14 think has taken off, and so we're building off of that
15 and working really closely with our Office of
16 Communications to maximize the tools that we have in-
17 house, but also with our Federal partners, having them
18 basically carry the message and then add their piece
19 to it, so that you have a larger conversation. I
20 mean, the whole idea is that all of these awareness
21 events are really to keep behavioral health issues in

1 the public discourse.

2 MS. FRANCIS HARDING: Nel, would you take a
3 question or two as you go quickly through this?

4 MS. NEL NADAL: Sure. Would you jump to the
5 prevention pledge slide, please? A little bit ahead.
6 This is a brand new feature, and it's making use of
7 Facebook. And again, the same idea that you are
8 making a public pledge. But beyond that, the bricks in
9 the wall basically reflect different stories in terms
10 of people being able to tell how has prevention played
11 a role in their life.

12 And that one, I think it's been -- it's getting a
13 fairly steady interest, and it's one of those that
14 allows people to go ahead and customize and share how
15 something -- the metamorphosis in terms of prevention
16 actually made a difference to how they're doing and
17 carrying on. Flip to the next one, please. I think
18 it's the I Choose Project should be next.

19 That was launched last year. The I Choose
20 Project pretty much, with all of the attention to
21 selfies in the recent media, the idea here is, again,

1 making a public declaration. It's something that
2 communities can do. It's very easy. It's something
3 that kids get really excited about. Everybody likes
4 to see themselves out there in the public sphere. And
5 so, we're trying to contribute by having them do, you
6 know, positive messages, and it goes a lot of
7 different directions.

8 We've had folks also focus on recovery, so it's
9 not limited to just the prevention story because we
10 have a lot of people that come at prevention from a
11 lot of different ways, and it is one of the simplest
12 ways to go ahead and do customer engagement. Part of
13 it, if you're thinking and engaging with an agency --
14 because it's an agency, it's a website -- trying to
15 make it personal, this is one of the ways that this is
16 being done. Next one, please.

17 So we did do a promotional video this year, and
18 we're hoping to show you that in just a moment. But
19 really the whole point of the promotional video was to
20 come up with something that wasn't bureaucratic, that
21 had some more playful animated features to it so that

1 it would catch your attention and basically take you
2 to the SAMHSA website so that you'd be aware of what
3 all the different tools and resources are available on
4 there. Do you have the access to the link to try play
5 that one just to show?

6 MR. MATTHEW AUMEN: Nel, this is Matthew. The
7 folks who are participating virtually or on the phone,
8 they don't have the webcast yet. But we're going to
9 try to get that up by the break.

10 MS. NEL NADAL: Okay.

11 MR. MATTHEW AUMEN: We can play the video here.
12 Folks can listen in on it.

13 MS. NEL NADAL: Yes. I think that rather than
14 take up time in terms of the technical aspects, we'll
15 show that to you when we actually have it able to
16 click, or do you think you've got it?

17 MR. MATTHEW AUMEN: Okay. We do have time.

18 MS. FRANCIS HARDING: We have time.

19 MS. NEL NADAL: Okay.

20 MR. MATTHEW AUMEN: But for the slide, you might
21 have to explain it to them a little bit more just for

1 the folks who are on the phone.

2 MS. NEL NADAL: Yes. I think probably what will
3 be the easiest, rather than trying to describe the
4 video is if we can send the link out on the webcast,
5 then people can go directly to that, because it's on
6 the SAMHSA You Tube channel. And we'll give it a few
7 more seconds because I don't really want you guys just
8 waiting for a technical thing to occur. And we'll
9 just go ahead and jump ahead on some of the other
10 aspects of Prevention Week.

11 One of the key things that we are doing is
12 collaborating with Federal partners, the folks that
13 we've pretty much traditionally worked with within the
14 prevention field, such as CAC and whatnot. One of the
15 things that this observance has allowed us to do is
16 that while we know all these different agencies, it
17 gives us something to coalesce around that's fairly
18 easy. It's not a heavy lift. It doesn't request a
19 lot of program resources. And it's something that we
20 can get the SAMHSA messages out as well as messages
21 that are important to those other constituencies.

1 And I think we're buffering, and we're about to
2 show the promotional video. Excellent.

3 MS. FRANCIS HARDING: This is all just to build
4 your enthusiasm and anticipation --

5 [Laughter.]

6 MS. FRANCIS HARDING: -- of what's to come.

7 UNIDENTIFIED SPEAKER: Should we do a drum roll?

8 MS. NEL NADAL: As much as we know technology is
9 a wonderful thing, it has its moments.

10 [Video Presentation.]

11 MS. NEL NADAL: What do you guys think?

12 [Applause.]

13 MS. NEL NADAL: All right. So just to go ahead
14 and wrap this one up, as far as the partners and
15 stakeholders, it's been ongoing. The whole idea is
16 that we're really trying to connect with the people
17 that we haven't talked to before in the primary care
18 area and basically build something from there to get
19 to some of the deeper issues that we know we have to
20 address in terms of the whole alignment, integration
21 discussion and taking that a little further.

1 Bloggers are one group that we are also doing a
2 lot of outreach with, basically to have other people
3 echo the prevention messages of Prevention Week and
4 just the overall SAMHSA messaging. And we've made an
5 intentional outreach to Hispanic Latino as well as
6 other groups, such as parent type blogs and other
7 professional blogs -- well, not professional blogs --
8 folks that are interested in prevention. So there are
9 some of the folks that you may have seen that are
10 working with our Recovery Month partners. The idea is
11 that they have a different reach. They can say
12 certain things slightly differently than we can in
13 terms of presenting it. And also it won't necessarily
14 have the government tone just because there are
15 certain things that you can be a little more plain
16 spoken in talking about this issue.

17 In terms of across SAMHSA's collaboration, we are
18 connected to Recovery Month, which happens in
19 September, and it basically is an all-year piece.
20 We're working closely with the folks that are working
21 on Children's Mental Health Awareness Day, which

1 occurs in May, and connecting the things that we have
2 with Community Conversations, which is the major
3 initiative that was launched last year.

4 The idea is that if you have this thread
5 throughout all the different awareness pieces, it's
6 getting us to work more closely with our colleagues,
7 but also that you'll have a more consistent message
8 coming out about the prevention messages that SAMHSA
9 wants to put out.

10 In terms of external partners, just a quick look
11 at a lot of the logos that represent the folks that
12 we're talking to. We're working with higher ed, which
13 is NASPA, National Association of Student Personnel
14 Administrators. We have a connection with the
15 American Foundation for Suicide Prevention. The
16 Federal partners that you would expect -- ONDCP,
17 NIAAA, NIDA, NIMH.

18 We have a very close relationship, and have had
19 for the last couple of years now, with American Public
20 Health Association. Pretty much American Public
21 Health Association has a social media platform, media

1 outreach akin to what CDC does. And they're able to
2 take a lot of what we're doing and use it in cross
3 promotion with us. So we are supporting them with
4 National Public Health Week, which starts next week,
5 and then they're going to be doing the same thing for
6 us during National Prevention Week. But we're also
7 connecting them to the other observances that SAMHSA
8 has, so it's not exclusive to just this one observance
9 that we're doing.

10 And then just the formal list of all the folks
11 that are there. CDC in en espanol. One of the things
12 that's new for this year, which we're very proud of,
13 is that we're able to go ahead and put the tool kit
14 into Spanish, which is a huge deal for us. And also a
15 large part of the website has got Spanish language
16 access.

17 And other than that, you now have the
18 coordination person, David Wilson. And if you have
19 any questions, let me know.

20 MS. PATRICIA WHITEFOOT: I have a question. My
21 name is Patricia Whitefoot, and I'm looking at the

1 list of partners that you had and the intentional
2 outreach that you did. I don't see an area where
3 we're looking at American Indian and Alaska native
4 goals that we're working toward

5 And also, since today the final four basketball
6 games are going on, I also am thinking about sports
7 mascots that use Native American characters to depict
8 Native Americans in negative stereotypes, such as the
9 Washington Redskins. And so, just the whole sport
10 arena I think needs to, you know, really provide some
11 support to prevention. I think we've all been to the
12 various types of games, and we know the use of alcohol
13 advertising, particularly in these types of arenas, at
14 the national level.

15 So I really think that we need to seriously take
16 a look at that and see what we can do to support, you
17 know, families in that environment and children that
18 go to those events -- those national kinds of events.
19 So that's the comment that I have. Thank you.

20 And thank you for this presentation. I enjoyed
21 it, and because I'm at the school level, you know, we

1 don't go just the one week prevention. We're gearing
2 up for the full month in our school district on
3 prevention work with our young people that are in, you
4 know, on the Acoma Indian reservation, low income
5 community, rural, those kinds of things.

6 And I also just want to say, you know, thinking
7 about rural isolated communities, outreach to rural
8 communities. And I forgot to mention that with regard
9 to partners, I would take a look at outreach to the
10 National Congress of American Indians, which is made
11 up of the tribal leadership. And I think that would
12 be a good venue for us to consider in the future.

13 MS. NEL NADAL: Thanks, Patsy. Some of the
14 groups that we actually reached out to, what I didn't
15 really bring out, would be including all of our
16 grantee networks and also working closely with
17 SAMHSA's Office of Indian Alcohol and Substance Abuse.
18 So we have been making sure to reach out to all the
19 Federal partners that belong to that, and haven't yet
20 had an opportunity to go ahead and do a little bit
21 more with regard to some of the other groups that you

1 must mentioned in terms of the National Congress or
2 our National Indian Health Board and some of the other
3 folks.

4 MS. PATRICIA WHITEFOOT: Thank you.

5 MS. FRANCIS HARDING: And thank you, Patricia,
6 for your comments. Are well stated and we'll take
7 them under advisement.

8 Now, we're going to move on if there are no other
9 questions. We're going to move on to Rob Vincent, who
10 is going to enlighten us on our campaign. We're so
11 very proud of our campaign for underage drinking. Rob
12 will also remember at the end to tell you where we're
13 going to expand to. I don't really know how many show
14 and tells you're going to do, but we'll -- I'll find
15 out in a second.

16 We have -- it's been such a long time since
17 SAMHSA has been able to bring some tools like this out
18 to the public, and it can be used in any venue -- at
19 the community level, at the school level, at board
20 meetings. I've used them at speeches when I'm out
21 speaking. It's just a good way to grab attention.

1 We know in this room the value of this exposure,
2 and we also know it's not the only thing that we use.
3 It's one of several strategies or tools, depending
4 upon how you want to classify them, which is a
5 criticism we get often. You're doing a campaign. Why
6 would you do a campaign, you know, if they remember it
7 for five minutes? Well, that's not why we do
8 campaigns. They're a part of a continuum of services.

9 So, Rob, if you will take us through what we did,
10 why we did it, and some of the feedback we received,
11 and then take questions also at the end.

12 MR. ROB VINCENT: And no surprises, Fran. It's
13 the same NASADAD presentation.

14 Thank you. My name is Rob Vincent. I'm a public
15 health advisor, and I've got the privilege of really
16 leading the development for the Talk. They Hear You
17 campaign in conjunction with our contractor and the
18 rest of my team. I'll often refer to David Wilson as
19 my dancing partner, who's my alternate on this.

20 We fondly refer to as we poach each other what
21 we've been trying to do is draw a thread through

1 virtually everything we do in all of our campaigns.
2 So you'll see Talk. They Hear You show up in National
3 Prevention Week, which is on May 13th is where we
4 actually did our lunch at the National Press Club, and
5 then on the same Alcohol Awareness Day. So you'll see
6 that same thread as we try to build, for lack of a
7 better word, brand recognition to sort of permeate the
8 messages in every venue we can.

9 Talk. They Hear You as a national campaign is a
10 part of the STOP Act, Sober Truth on Preventing
11 Underage Drinking. So I want to put that out, as you
12 were looking at budget numbers, to make sure you
13 understand its relationship to that. It's a million
14 dollar piece in the campaign.

15 Our primary target is to reduce underage drinking
16 among youth nine to 15 by engaging parents in
17 prevention. And I just want to underscore that. This
18 is not we're going to the youth to provide prevention
19 messages. This is enlisting parents as
20 preventionists, if you will, for lack of a better
21 word, to encourage them to be a part of the

1 conversation and to help strengthen their ability to
2 have natural conversations or have good ongoing
3 conversations in natural context ongoingly.

4 Sometimes we've -- in days of old we used to do,
5 I refer to it as the one big 60-minute message. The
6 idea here is 61-minute messages. We're trying to
7 continue this. Or sometimes I'll say "rinse and
8 repeat." We want to keep this process going as often
9 and as frequently as we can with parents and our
10 community members and coalitions.

11 As you well know, in prevention parents are king.
12 We know that they're important. They're the primary
13 messengers for underage drinking. To be successful
14 parents really, through our focus groups and a number
15 of other venues, told us, we need some prompts. Help
16 us get some language that this feels comfortable and
17 easy to do, and not the one big talk. So that really
18 has been the idea here is how do we help you not have
19 the big moment, but how do we help you have little
20 moments that feel comfortable and casual and in a way
21 that you can communicate the message?

1 And also, to help parents find some prompts and
2 conversation starters, but also to take advantage of
3 opportunities to discuss the issues and present
4 themselves. Also feeling comfortable and confident in
5 how they do that.

6 So we have two primary PSAs -- video PSAs. Let
7 me just first caveat that. Let me first introduce you
8 to Lucy, who is a wonderful 10-year-old actress who is
9 incredible, and you'll get a chance to see her
10 shortly. Lucy and Anna, and then of course our
11 father/son video. These two PSAs come in a 30, 60,
12 and a 15. Fifteen is new. We inadvertently
13 discovered how popular 15-second videos were for
14 different venues, mostly social media. So we're
15 trying to optimize on the social media platform,
16 instant message or Facebook, those kinds of things.

17 Let me just briefly go over the conversation
18 goals that we had for parents. The idea here is to
19 show that they disapprove, show that you care about
20 your child's happiness and well-being and to
21 communicate that in a way that's ongoing and

1 consistent, show that you're a good source of
2 information about alcohol, that you understand that
3 this is an adult beverage product, and that you're
4 aware of all of the things that go on with that, if
5 you will. And mostly to show that you're paying
6 attention, that you're aware and you're watching, and
7 you're engaged in that idea there. So we're trying to
8 sort of -- and you'll see that come through in both
9 the print PSAs and the video PSAs. And I'd be very
10 interested in your feedback on the video PSAs as well
11 once we get to that time.

12 And then, of course, to build skills and
13 strategies to avoid underage drinking, how do we put
14 in lots of little things that sort of -- as the old
15 adage goes, we want to increase protective factors and
16 reduce risk factors for young people.

17 So this is *Father/Son*.

18 [Video Presentation.]

19 MR. ROB VINCENT: So we tried to get what I refer
20 to as a two-for. We've tried to do that in all of our
21 video PSAs. Did anybody catch the second prevention

1 message?

2 [No response.]

3 MR. ROB VINCENT: There for a long time, there
4 was a time in prevention where we -- in other groups
5 we were promoting bicycle helmets as well in our
6 community coalitions, so I thought that was very
7 ingenious of my colleagues that actually worked on
8 this piece of it. I thought it was very good, I'm
9 going to follow the same trend. It's brilliant.

10 We also tried to capture a little piece where
11 there's sort of a -- a bit of an endearing moment to
12 show the relationships. So it's the father/son sort
13 of in the garage scenario and seeing those kinds of
14 things, and then sort of get that sort of hook at the
15 end.

16 Thoughts or feedback before I press onto the next
17 one?

18 [No response.]

19 MR. ROB VINCENT: So the next one is *Mom's*
20 *Thoughts*. We just finished shooting that one, and
21 that one is getting ready to go into distribution.

1 I'll talk about distribution and the development of
2 the whole campaign once we've gone through sort of the
3 visuals.

4 *Mom's Thoughts* is -- our attempt here was to
5 capture the mother/daughter dynamic, and we'll see if
6 we did that or not.

7 [Video Presentation.]

8 MR. ROB VINCENT: Thoughts? Comments?

9 [No response.]

10 MR. ROB VINCENT: We've either taken your breath
11 away or we're still early in the morning.

12 [Laughter.]

13 MR. ROB VINCENT: Perhaps I should order more
14 coffee. Okay.

15 So let me just first talk a little bit about the
16 development of all the PSAs before I sort of launch
17 into the visual display of the rest of them. All of
18 this work really was predicated on a little over a
19 year's time of formative research. So everything that
20 you see, while it seems quite simple in 60 seconds is
21 laboriously gone over in every detail in terms of

1 framing, statement, impact, all of those kinds. And
2 it was all tested prior to with community coalitions,
3 five regional coalitions across the United States.
4 And we tried to get a good demographic dispersion
5 across.

6 These were actual local coalitions that were
7 testing the original materials, the print PSAs, those
8 kinds of things, for us as we were going and then
9 guided us ongoingly.

10 Since that time, and, Patricia, this might be of
11 interest to you, we've also engaged with -- as the
12 Tribal Law and Order Act has come available and as our
13 Director for the Office of Indian Alcohol and
14 Substance Abuse is engaged, we have new PSAs coming
15 for Indian country as well. And, in fact, just
16 yesterday we were working on the selection and the
17 concept development to do that as well. So just to
18 sort of give you a bit of a head's up, those things
19 are coming, not quite yet.

20 We did contract with a new group to help us do
21 that, Solstice in Alaska, a native-owned group who's

1 actually working with us to do that, and have really
2 amazing -- as good as this was, I actually think that
3 what's next to come might be slightly better because
4 they're a very creative team.

5 So as I was saying earlier, we were talking about
6 sort of the natural context. In every one of these,
7 you'll find this isn't the typical stats kind of
8 moment. We're trying to keep that to a minimal, but
9 sort of be more pro-social in nature.

10 So we're looking for natural places where
11 mothers, daughters, fathers, sons, et cetera, would
12 come together and have a quick conversation. So
13 shopping break, a perfect moment to talk about
14 alcohol. No, we didn't say -- you know, talk about
15 underage drinking or try to go too far. We left it
16 nice and broad.

17 And then, of course, taking them to the website.
18 The campaign is built entirely on the website in terms
19 of its distribution. We have communications groups
20 that are going out, Goodwill Communications, who's
21 doing a vast amount of work in the broader markets to

1 get PSA video, PSA and print material distribution.
2 You'll notice we're trying to drive the traffic to
3 engagement there.

4 Chores, perfect moment to talk about alcohol.
5 Now, on this one we added an alarming stats of pre-
6 teens that are drinking alcohol, which makes it urgent
7 to find every opportunity to talk to your kids about
8 the dangers of underage drinking, for tips on when and
9 how. So you'll see sort of the methodology that goes
10 there. And, of course, underagedrinking.samhsa.gov.
11 And any of you can go there and see the full suite and
12 download the full suite, as well as a partner toolkit
13 that is available to all of our coalitions.

14 And we can thank our Division of Community and
15 Division of State who have helped us embed this in all
16 of our coalitions and sort of surround them. So
17 that's been a large part of the work as well.

18 Dinner time. Oh, one thing I failed to mention.
19 We took a slight shift early on in the campaign. All
20 of the likenesses you're seeing are actual families.
21 So the first version that we used -- how do I say --

1 was a little sterile. You could just see on the print
2 material that it felt like actors and actresses. We
3 couldn't quite do that with the video PSA. We really
4 needed people who could act and hit their marks. It
5 was quite an expensive project, so you don't really
6 want to have a good there. But all of these are
7 actual families.

8 And so, that young lad there was the most
9 hilarious young man I've ever met and worked with in
10 my life. Just a bundle of joy. He was just running
11 all over this house, and it was kind of interesting to
12 watch him have a lot of fun with this. But again,
13 dinner time is a perfect moment to talk about alcohol.
14 The Woo family, a perfect moment to talk about
15 alcohol. And you can see it.

16 And *Saturday Errands* was our other version of
17 this, so that we were looking for those things that
18 moms and fathers often do, which is usually pick up
19 everything on the weekend to try to get done what you
20 didn't get done in the week.

21 So on the launch of national coverage, again, I

1 said we launched May 13th, 2013. We had a national
2 press roll-out. You can see, I'll call it, the
3 executive summary video version of that or the full
4 extended, which is one hour. I wouldn't necessarily
5 recommend going to the one hour. My guess is the two
6 young people that we bookend that did that with us, my
7 guess is they go there often, but probably for the
8 rest of the adults. The Surgeon General, Michael
9 Botticelli, the ONDCP helped us. Administrator Hyde
10 did the same.

11 We also were able to -- very fortunate that
12 within that same timeframe, we got a launch on the
13 *Today* show with Matt Lauer, and they did a nice job of
14 promoting the campaign and getting us right in public.
15 And, of course, several launch and media interviews.
16 We bushwhacked poor Fran unfortunately and got her
17 last minute, last second and said could you do a live
18 section on Fox. And so, I still apologize for that.

19 UNIDENTIFIED SPEAKER: I was jealous.

20 [Laughter.]

21 MR. ROB VINCENT: Obviously I'm not taking -- I

1 don't have a better one yet. I need to get them on
2 photo shopping something really great in there. So
3 you can see a little bit. We've actually been able to
4 penetrate blogs and a number of other things very
5 effectively through all of that.

6 Our market penetration, we're at about 1.31 as of
7 this last cycle, which I think was just last month's
8 final date number. We will have more. We've
9 generated an advertising equivalency of \$12.8 million,
10 so you should know it's a million-dollar campaign. We
11 took an earned media strategy, which means we
12 basically create the content, and then we go beg every
13 vendor out there would you please show this for us.
14 And that's the -- that's how that works. And that's
15 been the approach, and we've had an amazing success
16 with it.

17 It's been placed, of course, in Dulles. Several
18 of the key airports around, just got it in LAX, and it
19 is now in Atlanta, Georgia as well, so we tried to hit
20 the big hubs. It took us a while to get Atlanta, and,
21 of course, some of the highways. A big boon for us

1 was the Walmart, 550 of the Walmarts, and their little
2 point of sale video screens it's being shown on.

3 This will give you a little idea across America,
4 the gross rate of impressions. So red is high, blue
5 is medium, green is low. I want to make sure and talk
6 to our Delaware folks because they really -- it's not
7 like they're not doing anything. They actually just
8 don't have their own television station. Now,
9 Vermont, well, we'll have to have a different
10 conversation with them -- or New Hampshire rather.

11 Again, this is the snapshot of the website, so
12 this will give you kind of the organization there.
13 This page is -- this website is about to change.
14 You'll notice it changing in the next month or so. It
15 will be refreshed to the new beta site. And, of
16 course, our team. This is everybody that worked
17 diligently hard on everything from social media to all
18 of the key points in it. And then if you have
19 questions.

20 MS. RUTH SATTERFIELD: I'm really impressed with
21 all that you've done. My only question is, what we

1 saw was pretty middle class suburbia. Did we do some
2 different areas socioeconomically? I'm just kind of
3 wondering.

4 MR. ROB VINCENT: This is a question that's come
5 up a few times, one that's been wrestled with
6 immensely and intensely, I will tell you. One of the
7 things -- so you'll see, we tried to shoot the target.
8 Again, this is for sort of the mass. But one of the
9 things that we've been very mindful of is I don't want
10 to show any one group in anything less than a
11 flattering light.

12 So that really became the key for us that we
13 didn't want to show anybody, let's say, in a likeness
14 that wouldn't be positive. We're trying to lift
15 people up in this particular campaign in every way we
16 can. So we didn't want to show anything that really
17 was less than flattering.

18 And so, we've taken very careful conversations.
19 We've relied on our technical assistance panel, which
20 is quite an esteemed group. I apologize that I didn't
21 include them in there, but they really hail from all

1 of the top public health venues. It's been one that
2 we've had a lot of conversation about, and I don't
3 know that I have a perfect answer for, but one that I
4 think we decided to err on the side of caution in
5 every way that we could do that.

6 What you will notice in the mobile app, which I
7 failed to talk a little bit about it, but figured to
8 do it on the end. It'll be called Start the Talk, and
9 in that one, that's a little more neutral, but it's
10 more avatar based, so it won't look like actual
11 kitchens or those kinds of locations. On the Native
12 American piece, we're just in the development of that
13 concept. A similar conversation was held, and I think
14 the similar choice was decided by all the technical
15 experts within that group to do the same, so.

16 MS. RUTH SATTERFIELD: This is Ruth Satterfield
17 again. I apologize for not saying that originally. I
18 would just encourage us to look into some urban
19 settings. I don't think that they have to be anything
20 that's a negative setting because there's a lot to
21 celebrate in urban settings. And just because

1 families may look a little different doesn't mean that
2 they're negatively perceived. So I would just
3 encourage us to continue to look towards that.

4 MR. ROB VINCENT: Okay. Other comments or
5 questions?

6 MS. FRANCIS HARDING: We could -- we can put this
7 on as a discussion point for August or the call we
8 have between now and August, and we'll take any
9 suggestions. And we'll invite Rob and the team, and
10 maybe even somebody from communication, just to take
11 in some of your ideas.

12 This has come up on several occasions. So you're
13 kind of caught, right? We finally are able to secure
14 dollars so that -- and get permission, which sometimes
15 is more difficult than securing dollars, to be able to
16 put a message like this out to the public.

17 We are working on several populations, but every
18 population is another million dollars. So we are --
19 that being said, I think that the team has done a very
20 good job with our print and our mobile material that
21 reflects more of a broad stroke of America. And we'll

1 take -- because this is not the first time this has
2 come up. So we'll take suggestions.

3 And let's -- if you're still interested at the
4 end of the day, then we will record that as being a
5 topic area that we might want to discuss further
6 because we do want to get these messages out there.
7 We do want to continue to show government that we're
8 watching the dollar wisely and really getting an
9 impact that is helping everyone in the country that's
10 focusing on this problem. So thank you, Ruth for
11 bringing that up.

12 MS. PATRICIA WHITEFOOT: I just have one comment.
13 Patricia Whitefoot with the Advisory Council. Just
14 one comment has to do with, you know, some of the
15 marginalized communities, and particularly low income
16 communities where the health disparities are
17 significant. And, you know, in our communities, rural
18 communities, isolated communities, oftentimes we find
19 elders or grandparents that are raising children, and
20 foster care parents as well. So I just want us to be,
21 you know, considerate of the population, you know,

1 around the country.

2 And I don't think it's just the native
3 communities where grandparents are raising children.
4 And we see that in our schools, and we see foster
5 children that are -- and in some cases, even, you
6 know, us as educators are filling that role as well.
7 And we're not necessarily raising the students, but
8 we're there with them, and students come to the
9 classroom teachers as well. So I just want us to be
10 mindful of that as well, particularly in marginalized
11 communities.

12 I also just want to speak to President Obama's
13 initiative, My Brother's Keeper. I think that there's
14 a webinar going on, probably already occurred. I
15 think that's important to pay attention to that
16 initiative. And along that same line, I would just
17 add that I also think it's important that mothers
18 raising -- single parents raising boys is an important
19 need that we need to address as well. Parents,
20 grandparents raising young men. That's a real --
21 that's, I think, an issue that we need to pay

1 attention to. Thank you.

2 MS. FRANCIS HARDING: And thank you for that
3 comment. As far as My Brother's Keeper, Dr. Wesley
4 Clark is SAMHSA's lead working with the White House on
5 that initiative. And all of SAMHSA has -- I had
6 better say it correctly --

7 [Laughter.]

8 MS. FRANCIS HARDING: -- have pooled our -- you
9 knew immediately. I didn't even see her, but I sensed
10 her.

11 [Laughter.]

12 MS. FRANCIS HARDING: We've pooled our resources
13 and our programming so that we can align and see the
14 portfolio that we have within all of SAMHSA. I
15 encourage you tomorrow to seek out Dr. Clark and ask
16 him, and he can give you an update of where we are
17 with that. But thank you for bringing that up. It's
18 important.

19 Yes, Rob, last comment, and then we're going to
20 shift --

21 MR. ROB VINCENT: Patricia, I would just invite

1 you to look at the next set of PSAs. I think there's
2 going to be something there that's going to warm your
3 heart where we actually are using elders with both
4 boys and girls actually to try to do some of that
5 likeness is what came out of yesterday's meeting.

6 MS. FRANCIS HARDING: Any other questions for Rob
7 or Nel or anyone about the campaign and the materials
8 or anything?

9 [No response.]

10 MS. FRANCIS HARDING: Of course not. Okay. So I
11 just asked Pam, I said we are scheduled for a break.
12 Perfect timing. I want to honor that, but I also want
13 to give Pam an opportunity to say good morning before
14 we break, and then we'll do a quick -- you have to
15 promise -- quick seven-minute break and come back, and
16 then we'll then be led in conversation and have a
17 discussion with Pam. So, Pam?

18 ADMINISTRATOR PAM HYDE: Good morning, everybody.
19 Thank you for being flexible. This last 36, 48 hours
20 has been quite interesting. I woke up early yesterday
21 around 4:30 to do some early work before I got the

1 office, and immediately started getting emails about a
2 fire. So since 4:30 yesterday morning, we've had
3 quite the day. So we'll talk tomorrow about some
4 other things more substantively than the fire. But
5 nevertheless, what this is causing is obviously a
6 readjustment or adjustment for how we're doing things.

7 So thank you for being flexible about all that,
8 and what it means for me as I am now traveling from
9 hotel to hotel throughout the day. So I'm going to be
10 late to everything and will have less time with
11 everybody. But anyway, it's good to see you all.
12 It's good to see faces that I know, and I see a few
13 new ones that I haven't met yet. So the break will
14 give us a great time to do that.

15 I don't know what's happening with Marla. She
16 was -- she had some family issues today, so I don't
17 know if she's going to end up making it. But if not,
18 we can chat about her issues as well.

19 So I'm mostly here to listen today. I don't
20 really -- I didn't really come with a lot of stuff to
21 give you or say to you. We'll do all that tomorrow.

1 So whatever your conversations are, I just want to
2 listen a little bit and see where your heads are.

3 I just spent a little bit of time with the
4 technical -- Tribal Technical Advisory Committee, and
5 they were talking about integration. Already some
6 really rich discussions going on about what does that
7 mean, and how do we think about it, and what are the
8 opportunities, but also what are the challenges about
9 thinking about an integrated approach.

10 We're doing some HIV/AIDS integration work that
11 we haven't done before. We're doing some proposals
12 about substance abuse integration that we haven't done
13 before, and building on work in the mental health area
14 that we've already done. So there's just lots of
15 stuff going on about that.

16 So I know you have lots of things today, so let's
17 get to your break.

18 MS. FRANCIS HARDING: Do you want to go around
19 quickly -- Pam makes a good point. If some of you are
20 not going to leave the room and she hasn't met you,
21 she can take this time and use it -- the seven

1 minutes.

2 [Laughter.]

3 MS. FRANCIS HARDING: So if you could just
4 quickly let's go around and remind Pam if you've
5 already met her how long --

6 DR. JOHN CLAPP: John Clapp, the Ohio State
7 University. This is my second year on the committee.

8 ADMINISTRATOR PAM HYDE: Great. Spent many years
9 in Ohio. Terrific.

10 MR. STEVE KEEL: My name is Steve Keel. I'm the
11 former NPN from Massachusetts, and now I direct
12 problem gambling service for the Mass Department of
13 Public Health. I'm a new advisory board -- new
14 Advisory Council member.

15 DR. MICHAEL COMPTON: I'm Michael Compton. I'm a
16 psychiatrist in prevention -- Chair of Psychiatry at
17 Lenox Hill Hospital in New York.

18 MS. DIANNE HARNAD: Hi. I'm Dianne Harnad. I'm
19 the former Director of Prevention, State of
20 Connecticut. And I'm currently on the faculty of the
21 School of Social Work in Eastern Connecticut.

1 MS. RUTH SATTERFIELD: Hello, I'm Ruth
2 Satterfield, a former NPN at Ohio and an independent
3 contractor. It's my first meeting.

4 MS. KATHLEEN REYNOLDS: I'm Kathy Reynolds from
5 the National Council for Community Behavioral Health
6 and the former Director of the Center for Innovative
7 Health Solutions.

8 ADMINISTRATOR PAM HYDE: Great.

9 MS. FRANCIS HARDING: Okay. So we're going to do
10 a quick break. Please come back as soon as possible.
11 We're starting in seven minutes with a conversation
12 with Pam. Thanks.

13 [Break at 11:07 a.m.]

14 [Reconvened at 11:27 a.m.]

15 MS. FRANCIS HARDING: Okay. We're going to
16 officially come back to order please. Marla, we have
17 a seat for you at the table.

18 AGENDA ITEM: STRATEGIC COMMUNICATIONS

19 MR. MATTHEW AUMEN: All right, folks. Welcome
20 back from break. We are going to move forward in the
21 agenda with our discussion on SAMHSA's communications.

1 And we have Marla Hendricksson with us, who is the
2 Director of the Office of Communications. She had
3 just gotten in here, so we'll give you a minute if you
4 need it to get settled and situated, and then we'll
5 get started.

6 Marla is going to give us a short presentation on
7 the Office of Communications and some of the
8 initiatives that are going on within the office and
9 with SAMHSA. And then we'll open it up to a
10 discussion with the Council members to answer a few
11 questions that we have posed for you all. And we look
12 forward to a lively discussion. Marla?

13 MS. MARLA HENDRICKSSON: Can everyone hear me?
14 Good morning, everyone. Sorry I'm late, but I'm sure
15 you had a good deal to talk about. I wanted to use
16 this time to give you an overview of SAMHSA
17 communications. But before I do that, I understand
18 that Pam's time is limited for today, so, you know,
19 perhaps this is a good time for Pam to say a thing or
20 two about communications and why we're here
21 existentially maybe. And then moving onto -- then

1 teeing up, you know, public awareness and support and
2 the rest of the agenda for today.

3 ADMINISTRATOR PAM HYDE: Thanks for that
4 softball, Marla.

5 [Laughter.]

6 ADMINISTRATOR PAM HYDE: This is just to give her
7 time to think a little bit here. We're all adjusting.

8 Let me start by saying actually Marla joined us
9 about a year -- 15 months ago now, 14 months ago now.
10 And she has brought new life, new people, new energy,
11 and new all kinds of things, new ideas, to our
12 communication effort. So we're really, really, really
13 pleased to have her and to the team that she's
14 building in our communications shop.

15 Communications is one of three things that came
16 out of a set of issues that we met with around our
17 stakeholders -- some of our key stakeholders recently
18 in December and February. And frankly, it's good
19 timing because those of you who saw the *Wall Street*
20 *Journal* editorial yesterday, which was a total
21 surprise to us -- what was in it was not a surprise to

1 us because we know who's behind those messages.

2 But one of the things we're trying to think about
3 is not only how we message SAMHSA and its role, but
4 also how we message about behavioral health. So the
5 way people think about mental health and substance
6 abuse issues, the way I think people talk about it,
7 the way people consider it as either an adjunct
8 therapy versus an actual part of healthcare. All of
9 those things are very critical.

10 We've been doing all kinds of work around
11 communication dialogues, national dialogue on mental
12 health, mostly mental health, although frankly the
13 public doesn't separate mental health and substance
14 abuse the way the Federal government does. But
15 nevertheless, we've been doing a lot of that kind of
16 work. Some of that kind of work is being done by
17 private partners that we don't fund, and so they do it
18 on their own. There's been lots of those
19 communications out there.

20 And I think one of the things that's going on is
21 for young people, and this is really particularly

1 important in the prevention world. Young people are
2 really growing up, and the next set of young people --
3 so the nine-, 10-year-olds -- are going to grow up in
4 a completely different world about behavioral health.
5 And I don't mean to be quite so grandiose about that,
6 but if you step back and think, they're going to grow
7 up in a world where having health insurance is a
8 given, not a question. They're going to grow up in a
9 world where having behavioral health benefits as part
10 of their health coverage is a given. That was not
11 true when I was growing up. It was really something
12 you had to think about if you cared.

13 They're going to grow up in a world in which
14 their primary care docs are asking a whole lot more
15 questions about their mental health and their
16 substance use, et cetera. They're going to grow up in
17 a world in which their schools hopefully are going to
18 be talking about it a whole lot more, and they talk
19 about it a whole lot more, about suicide, about
20 substance use. They're going to -- they're seeing it
21 in the press in very different ways, and it's a much

1 more open issue. It reminds me a little bit about
2 when we never, ever, ever talked about breast cancer,
3 and then we never, ever, ever talked about prostate
4 cancer. And now we talk about that stuff all the
5 time.

6 So they're going to grow up in a world where if
7 they have a major mental illness, they're not kicked
8 off their insurance, and they don't run out at the end
9 of a year or at the end of a certain amount of money,
10 a lifetime limit.

11 So all of that -- I'm saying all that to say the
12 way I think about and the way they communicate about
13 mental health and stuff I think is going to have a
14 profound difference in the next 10 to 15 years.
15 However, we are in 2014, and the way people are
16 communicating about mental health at the moment is not
17 so nice, and the way people are communicating about
18 SAMHSA, frankly, is not so nice and not accurate
19 either.

20 But that aside, what we've asked Marla to do is
21 to put together a communications strategy that would

1 really look at the way people think about these --
2 think about and talk about our issues. We've put in a
3 proposal for something called, and I know she'll talk
4 about it, something we just barely started to put our
5 foot in the door about, the science of changing social
6 norms, because we also know that we do all these
7 campaigns, underage drinking and all kinds of stuff,
8 get great results for them.

9 But we could do better. We could do more by
10 stepping back and looking at the science and saying,
11 is there science that tells us what does it take to
12 change people's behavior about or thinking and
13 behavior about addiction and about mental illness more
14 broadly that we can bring into those great campaigns
15 we're already doing -- suicide prevention campaigns,
16 the underage drinking campaign. All of those things
17 have been hugely successful at least in terms of
18 changing people's minds about it.

19 So she's going to talk about that I think. We're
20 trying to do some strategy and strategic thinking
21 about that and trying to think about how SAMHSA can

1 position itself in the field in a messaging and
2 communications way that could be helpful to the
3 process. So I think that's enough background. That
4 should've given you enough time to think.

5 MS. MARLA HENDRICKSSON: Thank you. Yes,
6 definitely thank you for framing it in that way, Pam,
7 because, first, we're going to go through the overview
8 of communications, and then go through our strategic
9 communication plan and why this is a great time to do
10 that. It is a very challenging time, but no time is
11 better than the present. And following that, we will
12 hopefully have a longer discussion on the role of
13 prevention and what your group can do to help us with
14 that, especially in the light of the upcoming large
15 initiative that we're going to have on the science of
16 social norms.

17 All right. So here we have what SAMHSA's
18 communications role is. It's really the face to the
19 public, and doing so we are here to make SAMHSA and
20 behavioral health more relevant and more positioned --
21 better positioned.

1 When I speak to the things in the bailiwick of
2 communications, there's really four parts. It's
3 public affairs. There's web. There's social media
4 and products. So I'm sure you have the slides with
5 you. Following that, we have the Office of
6 Communications, which I lead, which is right with Pam
7 and Kana. And the role of this group is essentially
8 to be the source for news and information about
9 SAMHSA. We are, I would like to say, the first line
10 of defense, but also the offense, not to be offensive
11 or anything.

12 We hope that by improving communications, we are
13 improving the understanding and the recognition of
14 SAMHSA. And to do that, we would use services -- you
15 know, talk about our services and tools and really
16 make what we do here in communications a one-stop
17 resource for everyone in the field.

18 What you have here is -- the next slide -- is
19 that discussion about the strategic initiatives. The
20 current strategic initiatives still include
21 communications in terms of public awareness and

1 support. These are the eight that we have now, and
2 moving forward I believe you are aware that we are
3 moving to a new set of Leading Change 2.0 strategic
4 initiatives.

5 What will happen with that is communications will
6 be folded into the internal operating strategies,
7 which is the undergirding on the bottom. That means
8 that we are internalizing the work of communications
9 as core functions in all we do in SAMHSA. By doing
10 that, we are hoping to increase the internal capacity
11 of the staff. And what communications will do for
12 that is then pivot to support every other strategic
13 initiative, which are the external strategic
14 initiatives there. Next slide.

15 So moving forward with internal operating
16 strategies, what we are hoping to achieve is using
17 communications to position SAMHSA to advance the
18 behavioral health of the Nation. We have five major
19 objectives with that, and each of them has a work
20 plan. We have a body within SAMHSA, our
21 Communications Governance Council and our work group,

1 in fact, in there called the Internal Operations
2 Strategic Work Group. And what they're doing is we've
3 broken it out into different teams that focus on
4 developing the things that can be implemented in these
5 five objectives.

6 So the first one is about really looking at the
7 products we have and how do we make that more
8 strategic, how do we improve -- how do we use those to
9 improve the positioning of SAMHSA? Second to that is
10 -- a second component is the -- making sure that we
11 have strong and regular engagement with our
12 stakeholders. Third is, you know, having our tools
13 inside the ready resources, which are the web and
14 social media. Fourth being the governance inside
15 SAMHSA and creating the standard operating procedures
16 that will help carry out our work. And five is making
17 sure that our staff has the capacity inside. So all
18 together, these things are very interdependent. Next
19 slide.

20 So how do we get there? As I mentioned, it's
21 about relevance. It's about positioning. And to do

1 that, we would be going from this document, which
2 you've seen our strategic initiatives. You've seen
3 the strategic -- the internal operation strategies.
4 And from there, those things get operationalized
5 through SAMHSA's strategic communication plan. This
6 plan was developed last summer, and I believe it's the
7 first comprehensive one for SAMHSA. What this plan
8 does is then operationalize the things we want to do
9 to better position SAMHSA to the outside. Next slide.

10 So here we go. The plan focuses on four things.
11 It's about key messaging. It's about using our
12 dissemination much better for information. It's about
13 planning the awareness, building communications that
14 concentrate on Agency efforts. And then finally it's
15 really leveraging the relationships and the partners
16 we have. Next slide.

17 There are key components to this strategy which
18 I'll walk through. We have goals, objectives -- sorry
19 -- goals, objectives, audiences, strategies, tactics,
20 and evaluations. It does drill down quite deeply, and
21 I won't go over them in detail because you have the

1 slides in front of you. So if we can skip to the next
2 slide. The next slide. Okay.

3 So the plan is grounded on, as I said, the
4 strategic initiatives, the internal operational
5 strategies. And some key things that we did. We had
6 to go out and talk to the outside. We weren't going
7 to create a plan in a vacuum. So we took the pulse of
8 the outside. By talking to key informants, which are
9 really the executives from 50 different organizations
10 that we work closely. We also did an environmental
11 scan, an online scan, traditional media scan, and then
12 following that is a SWOT analysis. All together these
13 things then informed the types of strategies we
14 identified that we really need to work on. Next
15 slide.

16 So for the key informant interviews, they again
17 were the 50 executives that we spoke to who are our
18 partners, and then they were broken up into four major
19 areas. One is the service providers, policy makers,
20 advocacy groups, business and insurers. And, you
21 know, when the information came back we had some aha

1 moments, but we also had some validation of the things
2 we really wanted to do.

3 For example, we found that we knew that we needed
4 to make our documents a lot more consumable, so it's
5 one thing to have these 200-, 500-page reports, but
6 who's going to read that? So if you want to increase
7 or broaden recognition, especially by the general
8 public who doesn't -- who can't distinguish us from
9 anyone else, you know, you want to make information
10 not only available to them, but available in a form
11 that can be relevant to them. So I call that the bite
12 snack meal approach. Okay. Next slide.

13 The interviews were there to, again, identify the
14 information, the products and services that we want
15 SAMHSA to provide. We want people to be more familiar
16 with our activities. We want them to learn. We want
17 to learn how SAMHSA can best reach those audiences,
18 and then find ways for SAMHSA to be more effective to
19 the outside. Next slide.

20 For prevention, it was interesting to know that
21 ACA was the most mentioned of all, another being

1 parity. We expected to have a larger impact, in fact,
2 for that. Another one that we found another aha was
3 the access to care, good feedback from our partners
4 and stakeholders that that is a major concern across
5 all the four quadrants I mentioned, including with
6 businesses and insurers and providers and such,
7 advocate groups, policy makers. All of them across
8 the board said access to care is important.

9 Integrating behavioral health with physical
10 health is another key area, and the last being
11 workforce development. And I'm sure you know from the
12 Leading Change 2.0 that workforce is one of our six
13 strategic initiatives moving forward. Next slide.

14 So for prevention, you see here, again, just a
15 breakout. You'll see amongst the four quadrants,
16 again, the ACA is across the board there. Workforce
17 is another. Parity. That's just how it was broken
18 down, and you have the slides to look at. Next slide.

19 From the top Federal sources for behavioral
20 health information, it appears that SAMHSA and CDC are
21 the leading sources of information followed by,

1 depending on, again, the quadrant, there were some
2 that were stronger than others. Interestingly enough,
3 for the lower right quadrant on business and insurers,
4 SAMHSA didn't actually, you know -- wasn't really on
5 their radar. So that was an area that we -- that was
6 an aha for us. We really need to penetrate that
7 audience much more, and so we are doing that in our
8 strategies. Next slide.

9 So, yes, there were things that SAMHSA really did
10 well apparently. The positive things were, you know,
11 people do like our content. The clinical areas are
12 definitely very much recognized. Formats. Formats
13 like our campaign materials were great. Our alerts
14 were great. The effort on native aspirations is well
15 regarded, and the collaborative work with partners,
16 such as the policy academies, were actually also very
17 well regarded. Next?

18 So the improvement areas are, like I said, you
19 know, the material is great, the content is great, but
20 it's not very consumer driven, so we will be making
21 changes to that. We also heard that we need more of a

1 clinical or medical voice, so we are working on that.
2 We also, of course, you know already we have a chief
3 medical officer, and I also have a person on my staff,
4 Dr. Metra Ahatpor, who is a primary care physician by
5 training.

6 So we are making strides, in fact, to not only
7 make sure our content reaches its audience, but, in
8 fact, in communications we have a mindset. We're
9 working toward that mindset.

10 Okay. So the next one is something that we're
11 very mindful of. Our website is in the process of a
12 major overhaul. Not only do we have several that we
13 are consolidating into one website for multiple
14 reasons, foremost being that we have to have the same
15 voice, the same content, more consistent in our
16 approach, in our look and feel, in our tone, our
17 messaging. And again, it's all about being relevant
18 and being positioned.

19 The length of time there is to issue information
20 and products. This came up in a recent NAC call as an
21 issue. More graphics. Again, we look for more ways

1 to reach audiences, especially audiences that are not
2 familiar with our work. To do that, you need to put
3 some eye candy out there. Infographics is one, and
4 especially when you're looking at younger audiences
5 who are very used to different mediums that really
6 draw their eye. We have so much wonderful data. We
7 need to be presenting that in a way that is compelling
8 and it's eye catching to folks, and again, also bright
9 colors. Next slide.

10 So we also had an environmental scan, and I won't
11 go into it much. Just suffice to say that we went
12 through our traditional media. We had an online scan
13 of the web, and we also had an extensive social media
14 scan. The period in which we did this was late 2012
15 through middle of 2013, and we found out some key
16 drivers there. Next slide.

17 So the drivers for the media scan was reports of
18 studies were what drove people to us. Grants also is
19 very high, and a growing expertise -- a growing
20 knowledge of expertise, including our data. Next
21 slide.

1 So for positioning, we found, in fact, that
2 substance abuse -- at the time that we measured,
3 substance abuse information was double that of mental
4 health in terms of the discussion in the air waves
5 right now at the moment of the study. Mental health
6 at that time was paired largely with gun control
7 policy. That's changing now largely due to the work
8 that we were doing last year with Now is the Time.
9 But again, it's a conscious effort to make sure that
10 people understand the issues much better. Other
11 topics were treatment and recovery, and welfare, and
12 behavioral health. Those seem to be the ones that
13 most resonated. Next slide.

14 Positioning wise, what we'd like to do is make
15 sure that the work that we put out there positions
16 SAMHSA to lead the public health efforts and to
17 advance the behavioral health of the Nation. That is
18 the driver for the IOS. To do that, we want to make
19 sure our messaging, as Pam said, is credible and it is
20 broad reaching. We also want to make sure that we
21 reach the right audiences.

1 I'm going to skip through the next slides just so
2 that we have more time to have a discussion.

3 Okay. So let's see. Can we skip over to the key
4 findings on social media? There. Social media is a
5 big push that we have now, and I think we are gaining
6 good traction, especially with audiences -- new
7 audiences that we are trying to reach. SAMHSA, in
8 fact, is the most authoritative on Twitter for mental
9 health and substance use. And we are working more
10 closely this year to use that influence to better
11 increase our reach. As Pam said, we are looking to
12 change perceptions and behaviors around behavior
13 health, and to do that, we are going to be looking
14 into the science of social norms.

15 Facebook is not as strong, but it is a staple, so
16 we're looking into that as well. That is something
17 that people go to for lots of reasons, so we do have a
18 good presence there. But, again, Twitter seems to be
19 the broadest reach. What we're going to be doing this
20 year is also looking at other venues.

21 Another aha that we found was for all

1 communications types of reach, that apparently there
2 are about 26 different types of communications
3 channels, including social media, print, and web, and
4 other things. SAMHSA was found to have -- to be doing
5 24 of those channels already, to be reaching those
6 channels. The question is, do we want to use all 24?
7 Do you want to focus on fewer, but more concentrated,
8 efforts?

9 Okay. Leveraging information for social media
10 monitoring is key so that we can reach those
11 influencers out there. And we are in the process of
12 developing standard operating procedures for that.

13 All this to say that we did our SWOT analysis --
14 next slide -- and we found several key strengths and
15 weaknesses and such. So we're going to be doing more
16 information with data because it is a strength. We
17 know that we have -- and we shared this with the staff
18 already and within our Communications Governance
19 Council. And the things in the SWOT analysis is
20 really helping us craft the actual strategies in our
21 strategic communication plan. Next?

1 Okay. So what we hope to do is determine whether
2 the goal should be content based or communication
3 based for our strategic communication plan so that we
4 can better operationalize the strategic initiatives
5 and the internal operating strategies. Becoming the
6 thought leader in healthcare is another area that we
7 want to emphasize.

8 We also want to increase our visibility among the
9 workforce. And as I said earlier, there's a focus on
10 improving attitudes in the general public. And
11 finally, it's continuing to use the plan to inform our
12 activities throughout SAMHSA. So having a document
13 like this, which is our strategic communications plan,
14 is something that we will always refer back to
15 whenever we do our communications across SAMHSA. This
16 and in terms of the work plans for the internal
17 operational strategies are -- keep us going to where
18 we want to go.

19 So with that, I was going to go and open up a
20 discussion on -- how much time do we have?

21 MS. FRANCIS HARDING: Marla, may I make a

1 suggestion while we have Pam's time for a little bit
2 longer? One of the areas that the Administrator is
3 very interested in is the whole area around messaging,
4 and that's a huge part of the communication plan. So
5 before we go into the actual questions that we were
6 going to ask you, I was wondering if it would be all
7 right for us to go into a conversation about the types
8 of messaging that you as the NAC members would like to
9 see SAMHSA do more of. What are we doing well? What
10 would you prefer us doing less of? The whole gamut.
11 Yes, Michael?

12 DR. MICHAEL COMPTON: Michael Compton here. I
13 guess I have a question for Marla and Pam. What is
14 your latest thinking on the term "behavioral health"
15 and how it resonates with the American public as
16 opposed to the more traditional mental health and
17 substance abuse terms?

18 ADMINISTRATOR PAM HYDE: Actually we just had an
19 interesting conversation a week or two ago about the
20 use of the term "substance abuse," which is now
21 falling out of disfavor or falling into disfavor --

1 falling out of favor. I actually find the behavioral
2 health field to be very word conscious, so on any
3 given day whatever word you use, somebody is going to
4 argue with you about it. There was a time on the
5 mental health side where the word "consumer" was a
6 really great term. That was what the consumers were
7 asking to be called. Not anymore. They don't want to
8 be called that anymore. And that term obviously
9 doesn't resonate in the substance abuse world.

10 There was a time when the word "recovery" was
11 really the word and "substance abuse" really wasn't
12 used very much in mental health. And it is now
13 totally embraced on the mental health side. We could
14 go on, my point being, I think it's probably time we
15 quit worrying about the words as long as we don't
16 offend. And I know there will always be somebody
17 offended about something.

18 But behavioral health is a term that works in the
19 healthcare world. The healthcare world embraces that.
20 They get it. They understand it. A lot of the
21 healthcare world uses the term "mental health," and it

1 means mental health, mental illness and addiction.

2 But the addictions world hates that worse than they
3 hate "behavioral health," or at least a lot of them
4 will tell me that.

5 I've literally put that to some addictions folks
6 and said, if you had to use the word "mental health"
7 as the over-encompassing one, or "behavioral health,"
8 which would you hate the worst or which would you
9 pick, and they said we'll take "behavioral health" any
10 day over "mental health."

11 So, you know, the issue -- the reason we picked
12 "behavioral health" in the first place is because we
13 knew -- it was my choice. I'll take total credit and
14 blame. Four years ago, I knew that this next four to
15 five to six years was going to be all about healthcare
16 and health reform, and we needed to be in that game.
17 And in order to do that, we couldn't keep setting
18 ourselves apart from it. And it's like I said
19 earlier, if you look at, like, IHS, used to -- I don't
20 know if they still do, Patricia -- but used to have
21 behavioral health as an adjunctive therapy or an

1 adjunctive, so was vision, dental, behavioral health
2 was kind of over there, and health was all over here.
3 That's really changing in a lot of places.

4 So we picked the term "behavioral health" because
5 I picked the "behavioral health." And early on, we
6 put even a thing out and said what's in a term, and
7 asked people to comment on it, and tried to gen some
8 conversation about it because we were really trying to
9 say, look, we've got to pick a word that the health
10 world will get, that they understand what we're
11 talking about, and that doesn't talk just about
12 prevention, doesn't talk just about treatment, doesn't
13 talk just about recovery, but talks about all of that,
14 and encompasses emotional health development at the
15 same time.

16 So it would be really hard -- I mean, I have
17 challenged people all over this country for five years
18 now tell me another word that will encompass substance
19 abuse, substance misuse, addiction, mental illness,
20 mental health conditions, prevention, treatment,
21 recovery, emotional health promotion. If you can give

1 me a word that will encompass all of that and I can
2 put it in a sentence that says SAMHSA leads in public
3 health efforts to improve the "behavioral health" of
4 the Nation, I'll be happy to substitute a couple of
5 words.

6 DR. MICHAEL COMPTON: I personally like the term
7 a lot, but I'm a health professional. I'm wondering
8 about the American public. Do we have any evidence
9 that they're sort of catching on with our terminology?

10 ADMINISTRATOR PAM HYDE: It's a great question,
11 and I think as we do more of the work around public
12 attitudes and polling and stuff, I think we can find
13 out. My guess is just because I travel around the
14 country quite a bit, is that most of the American
15 public would use the term "mental health" and mean
16 both. Most people wouldn't say mental health is only
17 those mental illnesses over there, and addiction is
18 something else. They would actually see it as both.

19 Now, you can see we've got -- the *Wall Street*
20 *Journal* editorial is a pretty good example of that --
21 we've got a group of people who are saying you should,

1 SAMHSA, only be dealing with mental illness, not
2 addiction, not children's emotional health, not
3 prevention, none of that. You should only be dealing
4 with adults that already have a very severe mental
5 illness, that that should be our priority. That's
6 obviously like CDC saying you should only be worried
7 about people with heart disease that need a
8 transplant. You know, none of the pretty stuff, none
9 of the prevention efforts, none of the work up to
10 that, but only when they need a transplant.

11 So anyway, I think the public uses the term
12 "mental health" more. I think the healthcare world
13 gets the "behavioral health" term. I think our world
14 still struggles with that. And even on the mental
15 health side, people struggle with the word "mental
16 illness" in some cases. And the way I make that
17 distinction is you can break your leg and you have a
18 health condition, but you don't have a disease. And
19 so, there's a group of people who sort of see the
20 distinction between a condition and an illness, and
21 then on the substance abuse side there's this growing

1 conversation about do we use the word "abuse" when
2 it's really misuse or non-medical use for prescription
3 drugs, for example? Marijuana is going to get us all
4 into what is an illicit drug and what is not an
5 illicit drug. And so it's hard to make it that -- it
6 used to be real clear. There's illicit drugs and
7 there's prescription drug abuse or misuse. It's not
8 that clean. I mean, it's going to be getting
9 squirrely.

10 So terms are hard. That was a long response to
11 that, but I don't really see, given everything else we
12 have to do that at the moment, taking on that argument
13 for a while. I mean, it's just not the argument to
14 have, I don't think. Does that help?

15 DR. MICHAEL COMPTON: Yes.

16 MS. MARLA HENDRICKSSON: Okay. So speaking of
17 terms, the first question is about terms. So in terms
18 of prevention, one of the things that we are planning
19 to do with our next online media -- social media and
20 online media scan is to look at the conversations that
21 are happening around the country. Social media is a

1 great microcosm of that, and it's not just relegated
2 to the 18 to 24s anymore. It's getting much broader.

3 So in terms of what conversations are happening
4 online and looking closely at prevention aspects of
5 that, what is the conversation and where is it taking
6 place? Questions for you would be what terms should
7 we be looking for when do the scan? The last time we
8 did this for all behavioral health search terms, we
9 came up with 900 different terms. We're going to need
10 to narrow that down to the ones that are most salient.

11 So what we'd like to do is then open it up to you
12 guys. I mean, if you're going to go look at
13 conversations happening online, kind of eavesdrop on
14 them in terms of prevention, what kinds of terms would
15 you be looking at? And within those terms, also
16 looking at who's talking about it, and how do we get
17 in those conversations?

18 So we want to step away from just, here, SAMHSA,
19 here's information that's out there, but that depends
20 on our reach and how people are recognizing SAMHSA.
21 Conversely, it's more than just what we do here. It's

1 how can we get in the conversations that are happening
2 out there.

3 So if we had to think about terms for prevention,
4 what type of terms would they be, and who do you think
5 would be having conversations that would be key
6 influencers for us to talk with?

7 MS. FRANCIS HARDING: Thoughts? I think that if
8 you reflect on the conversation we had yesterday
9 around integration, there were a lot of -- we had a
10 lot of discussion around the way we define prevention,
11 where does prevention fit into integration of primary
12 care and medicine. So perhaps that will help. You
13 think about what are those -- what's the terminology
14 that sparked that conversation, and the during the
15 conversation around bringing substance abuse
16 prevention, which we kind of feel is not on stable
17 ground as much as it used to be. And we need to shore
18 it up so when we go into physical health. Does that
19 help at all?

20 Because we want to -- if you noticed or in your
21 slides tonight when you look at them for tomorrow,

1 you'll see that the scan didn't come up with the work
2 that we talk about here in this Advisory Council. So
3 did we not ask the right questions? Were we not
4 asking the right people? I think that's what Marla
5 is trying to get to so that when you see that for
6 those four pieces, that pie, that you see something
7 that's on there and you say, hmm, okay, I get it.
8 We're there, and we need to either strengthen it or
9 change it, or, et cetera. Dianne?

10 MS. DIANNE HARNAD: Hi. Dianna Harnard. This
11 was one of the most important. Things that piqued my
12 interest in this Power Point presentation was the top
13 prevention issues. When I looked at them, my question
14 was, who did you ask the questions to and what were
15 the questions? Because when I read these and I looked
16 at the four quadrants, I almost feel like maybe the
17 questions were more on -- they don't feel like this is
18 prevention at all to me. It seems like we're
19 preventing a bad communication strategy versus --

20 I'm not sure I'm articulating correctly, but it
21 doesn't feel like we're talking about the behavioral

1 health prevention or promotion, what the top issues
2 are within that content area. It feels more like it's
3 more global -- Affordable Care Act. Well, that should
4 be, well, what's the role of prevention in the
5 Affordable Care Act? That should be the top issue I
6 would think. Mental health parity, where does
7 prevention fit into the emerging act as it gets
8 flushed out. Access to care, that's a major concern
9 for prevention across all quadrants.

10 So when we're talking about top prevention
11 issues, I expect to see prevention in that, and it's
12 not there. So I was really taken aback when I saw
13 this. So I'm not sure if this was meant for just
14 prevention -- these slides just for prevention, or is
15 this for the whole SAMHSA communication strategy?

16 MS. MARLA HENDRICKSSON: So these were part of
17 the canvassing of the outside before we created our
18 strategy, and this was used -- the questions we used
19 and the folks that we approached on the outside were
20 just to see what the lay of the land was, not to use
21 it constructively to say here's where we need to be

1 going.

2 You are absolutely right to say, well, it's
3 probably embedded in here but not really teased out in
4 terms of what prevention's role is. These were more
5 general things that resonated out of those
6 conversations. But you're also right to say, well, if
7 prevention wasn't particularly mentioned in here,
8 where can we make those changes, and that's what the
9 strategies were.

10 MS. DIANNE HARNAD: And, Your Honor, on the next
11 slide where you have the four quadrants, they're
12 screening and treating behavior. There's a little bit
13 of prevention here and there, suicide prevention,
14 prescription drug abuse. But again, it's missing
15 there, too, so maybe it's the questions, they were
16 asked.

17 MS. FRANCIS HARDING: First Kathy and then Pam
18 wants to weigh in.

19 MS. KATHLEEN REYNOLDS: Yeah. I think -- I'm not
20 surprised in your search that this came out as a
21 challenge in terms of finding prevention and

1 particularly in integration because if you look at the
2 evolution of integration, it started with mental
3 health and primary care integration, and even those of
4 us who were integrated with addictions forgot to bring
5 our addiction partners with us.

6 And so, I think when we through the Center for
7 Integrative Health Solutions did a survey of addiction
8 treatment programs about, I think, three years ago, we
9 only found about two dozen programs that were looking
10 at integration. And I think if you did it now, you'd
11 find that to be much expanded and much engaged. Not
12 saying it was an absolute complete review of every
13 one, but I think it just wasn't present, and I think
14 we're starting to have that discussion even much more
15 now.

16 We have learning communities now for addiction
17 sites to do integration type activities and to take
18 their services out there, but I'm not totally
19 surprised. I don't remember when you did the survey.
20 But I think that this is something that we've been
21 working on probably over the last four years is

1 bringing addiction into the integration in a different
2 way than maybe we had before.

3 ADMINISTRATOR PAM HYDE: Yes, I was just going to
4 comment. I think your point is well taken, and I
5 think that what you're saying, Kathy, is true. And
6 I'd just say a couple of things, and then
7 unfortunately the nature of the day is I've got to go.

8 But I want to underscore what Marla said. This
9 was our first foray into seeing what people would tell
10 us. So it was a set of stakeholders that we chose
11 fairly carefully about people we deal with all the
12 time, people we don't deal with all the time, people
13 who should know about us, but don't know about us, or
14 whatever. So it was an attempt to sort of get the
15 best cross-section.

16 And then I would look at -- and it's a baseline,
17 so if the baseline says to us the people we asked
18 don't give us very good feedback about prevention,
19 then that tells us something. So how we have to
20 change our words, how we have to change the messages,
21 how we have to change the way we ask the questions,

1 whatever, is exactly what it's telling us.

2 So on some levels I actually think the outcomes
3 about what's in prevention is actually pretty cool,
4 not that it's far enough. But the fact that people
5 who think about prevention would actually think about
6 the ACA and parity is actually a step forward.

7 I think if we would've asked those same
8 questions, you know, three or four years ago before
9 this, people wouldn't have even thought to connect
10 those things. And at least they're starting to, so in
11 some ways -- or workforce. People wouldn't have
12 thought about prevention and workforce. They just
13 didn't put those two things together in their heads,
14 and they now do. Prevention as part of the workforce
15 is something people are concerned about. So, I mean,
16 you can view it as both a negative and yet a good
17 baseline. So I think you're totally right to raise
18 that issue of what is this.

19 But the other thing is, I think, that just
20 thinking about where we go from here, so another
21 example is if you looked at some of this, people liked

1 a lot about our grant information. So they liked our
2 grant information and our data. Well, that's good,
3 but those are the two things we've been pushing in our
4 communications for the last 20 years, so no wonder
5 they would say they liked those two things.

6 So then the question we all have with you is do
7 we keep pushing our data and our grants or do we now
8 start pushing policy language, or do we now start
9 pushing prevention language, or do we now start
10 pushing workforce issues?

11 So I don't think you should see anything in what
12 Marla shared with you as something that we think is
13 telling us where we should go, but rather where at the
14 point we ask the question were we. And now there's a
15 lot of decisions that we've got to make, and I think
16 that's what Marla is trying to engage you about, but
17 it may be a level of detail that's hard to get your
18 head around.

19 So maybe there's a way to start first with
20 thinking about, okay, given the messages, or even
21 another great example is people talk about substance,

1 and they talk about mental health in terms of gun
2 violence, oh my god. Well, of course that's not where
3 we want to be. I mean, we need to think about
4 recovery, and we need to think about mental health in
5 a different way than just associated with gun
6 violence. So how do we get our communication
7 strategies to help that messaging?

8 So that's the way I would try to engage your
9 minds about this, and maybe as you go to lunch or
10 whatever you do next, then you can think more and
11 provide some more input to Marla and to us about that,
12 that would be terrific. More heads are going to be
13 better than one or two or three in this process. All
14 right, so that's -- thank you.

15 MS. FRANCIS HARDING: And thank you, Pam, for
16 stopping in. And we'll be hearing a lot more tomorrow
17 from Pam and her leadership around integration
18 particularly as well as the SI. So we thank you,
19 especially now that you've had to actually go from
20 building to building and not floor to floor.

21 Steve Keel had a question.

1 MR. STEVE KEEL: A thought as I listen to the
2 discussion. Number one, it's great that this
3 discussion, I think, is happening. Number two, it
4 continues to amaze me how the word "prevention" means
5 different things to different people. If I were to
6 mention the word "prevention" to police officers, it
7 would not be primary prevention in any way. We took
8 the alcohol from the kids on the playground, and then
9 it was an intervention. It was not necessarily
10 prevention.

11 A similar thing happens, I think, with healthcare
12 providers. In my experience, pediatricians do
13 prevention. Did you wear your bike helmet? Are you
14 using condoms? They ask a number of different
15 questions. Adult providers frequently don't do
16 prevention. It goes back into the intervention range,
17 which I think is also very interesting.

18 So I think the conversation has started, but the
19 word itself means so many things to different people,
20 and it's loaded. It has a lot of emotion that, I
21 think, also goes with it.

1 Tie into that the whole issue of payment. You
2 think of the healthcare system. They'll pay for
3 intervention, but they're not going to pay yet for the
4 primary piece at all, and they're not interested at
5 this point, in my experience, to pay for that piece at
6 all.

7 So SBIRT is a good example. We'll pay, you know,
8 for SBIRT. We're thinking about paying for SBIRT.
9 But in terms of real primary prevention where you're
10 really trying to do a more global approach, we don't
11 see the return on investment in that.

12 So we're making progress, but we're grappling, I
13 think, with the language itself. I think Pam touched
14 on that. And unfortunately, language is how we
15 communicate. We're stuck with these words. So I'd
16 just raise that as an issue to think about.

17 MS. MARLA HENDRICKSSON: Great points. I'm
18 hoping that this dialogue will continue, not just here
19 today, but this is something of a reflection that will
20 happen, you know, as you leave this room and as we
21 have other meetings, and I hope that this won't be the

1 only time I'm invited to talk with you.

2 But also, you know, feel free to contact me if
3 you have an idea, or if you had a reflection on
4 something, or you found an article that made sense or
5 captured it in a way that we should be having these
6 conversations.

7 And, in fact, during these conversations is when
8 -- and finding other conversations where we need to be
9 is probably where we can be more of the influencers to
10 not only drive the conversation, but help people
11 better understand what prevention is. So if it's okay
12 to move to another question, you know, we can always
13 come back to this. We can certainly share these
14 questions with you to reflect on afterwards.

15 As I mentioned, part of the strategic plan is to
16 improve the way we engage with others. And I know
17 that the word "engagement" is a heavily-used term, you
18 know, especially in social media. The fact that
19 you've reached someone means you engage with them,
20 which is not true. Engagement is an ongoing
21 relationship that you have with your stakeholders.

1 So in the course of not only creating, but having
2 real conversations with folks, we need to be reaching
3 the right folks in terms of creating a conversation
4 around prevention. To do that, apart from the folks
5 inside this room who we are engaging with, who isn't
6 in this room that we need to go and reach out to? Who
7 are the influencers or influencers of influencers?
8 Those kinds of folks that need to be in a conversation
9 definitely can put more legs to our work. It
10 increases the collective understanding.

11 So the next question was about how can we
12 identify and reach key prevention stakeholders beyond
13 those who are represented in the NAC?

14 MS. FRANCIS HARDING: I think the silence is
15 they're thinking about all the different people. We
16 have strived to make this an eclectic group, so we're
17 -- but again, I refer back to our conversation. As we
18 talked yesterday about integration into the medical
19 community among others, are there people that you
20 feel, professionals that would assist us with that
21 conversation going forward?

1 We used to have a pediatrician, and she served
2 her term. We haven't found a replacement for that.
3 So we're going down that path, Marla, in our thinking.
4 Yes, Michael?

5 DR. MICHAEL COMPTON: Yes. I was thinking
6 primary care.

7 MS. FRANCIS HARDING: Can you broaden that? I
8 mean, are there specific specialties within primary
9 care that maybe we should look to really go in rather
10 than just the academic kind of primary care person?

11 DR. MICHAEL COMPTON: I guess either pediatrics
12 or family medicine I view as sort of the true primary
13 care. If we're going to continue talking about
14 integration, which we should, I think, you know, to
15 have that level of engagement would be important.

16 MS. MARLA HENDRICKSSON: Great comment. That's
17 why I hired Dr. Metra. But also it's a conscious
18 effort at SAMHSA to begin reaching such an audience,
19 in fact. Not only do have Dr. Metra here with us as
20 our clinical communications specialist, but also we
21 have begun conversations with WebMD and Medscape, in

1 fact, to build on two key areas, one being the --
2 reaching the primary care physicians themselves
3 because they are for a large part, as you know, the
4 key and the first touch point for most people.

5 And to reach them, we have an effort now to
6 create a curriculum, and each year we're going to --
7 you know, we also have constrained resources. So each
8 year we're going to identify a key curriculum area,
9 and this year we chose SBIRT because it's home grown.
10 It's something that is very easy to package, and it's
11 something that is a good way to get folks involved in
12 the primary care field.

13 Through Medscape, we are able to reach one to two
14 million doctors through CMEs, and if this is an area
15 that they need to get credits for and we find a way to
16 get them in the door, it's a ready audience for us.
17 Along with that, we also have an effort to reach the
18 general public. Through Medscape and WebMD, we are
19 able to reach through our ads and general public
20 outreach practically every doctor's office through
21 magazines, through web applications. The subscription

1 rate for WebMD is about 100 million, so with even just
2 a Google -- I mean, a WebMD ad on your phone you can
3 certainly raise a general awareness and then point
4 them back to our site.

5 So it's simple things like that that we are,
6 again, testing -- starting to test ways to reach out
7 to other audiences. But primary care was one that we
8 were very anxious to start identify as a group to
9 reach out to more conscientiously.

10 MR. MICHAEL MONTGOMERY: I'm not sure I
11 completely understand the question, but what kind of
12 partnership do you have with the state mental health
13 and substance abuse programs, and how do you engage
14 them in getting your message out?

15 MS. FRANCIS HARDING: I think, Michael, you're
16 specifically talking about our communication
17 outreach --

18 MR. MICHAEL MONTGOMERY: Yes, exactly.

19 MS. FRANCIS HARDING: -- or our programming
20 because you know what we do.

21 MR. MICHAEL MONTGOMERY: Yes. Yes.

1 MS. FRANCIS HARDING: I think he's looking for
2 the different programs, like NSADAD and the
3 stakeholders, and then you worked with us for the
4 communities, that kind of thing.

5 MS. MARLA HENDRICKSSON: So through the State
6 partners, right now it's still very general in terms
7 of getting people to be more aware of the things we
8 have on our site and how we can use them. We're also
9 working with -- through the regions the folks that
10 they can reach in their areas.

11 But this is -- part of this conversation is,
12 therefore, trying to make that relationship deeper so
13 that it's more than just, hey, this is the stuff we
14 have. These are publications. These are the things
15 on our web. Here's the latest findings in ISDA. But
16 how do you -- that's still a one-way conversation.
17 How do you then turn that through your partners and
18 folks that we need to be reaching out to more to
19 actually have a conversation with them on what types
20 of information do you really need, and in what forms
21 do you need that information.

1 MS. FRANCIS HARDING: The only thing I would add
2 is, so here's the part of the struggle. As we began
3 three years to ago really look at the stakeholder
4 groups and what's out there, mental health is very
5 structured in several different layers of
6 organizations -- groups of people that come together
7 for like reasons. Substance abuse is not. Substance
8 abuse is more about the treatment centers, about the
9 -- and then when we went to outpatient services and
10 stated servicing through communities. So now we have
11 gone even further, and then the prevention realm was
12 community-based in States.

13 So when you go the states, there is a layering of
14 organizations and structure, but not national. So
15 when SAMHSA began to do this search, the national type
16 of organizations was tipped. So we have been working
17 very hard, and Marla has done an excellent job in
18 trying to figure out where are the pockets of people
19 that we need to go to, and that's really what this
20 conversation is about. How can we enrich our list and
21 our reach? And at the time, I think it's a golden

1 opportunity to get primary care more involved while
2 we're doing this. So we're skipping a step for
3 substance abuse, but I think that it's a useful step.
4 And who knows, we might end up being ahead of the game
5 when it's all over. So I think that we are looking to
6 be equal ground. So that's kind of a strange answer.

7 I would like to -- we're out of time, and that's
8 very usual. When you're in a conversation, it always
9 gets lively at the end. If we don't cut this
10 conversation off, you will not get lunch, and so, I
11 figure I'm in a safe environment here.

12 Seriously, though, Marla, what we could -- what I
13 could do for you and us is to at the end of the
14 meeting we're going to talk about where do we go and
15 what are we going to do between now and August. This
16 to me is feeling like it's one of those conversations
17 that we want to continue. You have put out a couple
18 of questions to us. We have two more that we haven't
19 even gotten to.

20 So we'll talk about this, and we'll let you know,
21 because what we have is in a couple of months we will

1 have a conference call meeting of the NAC, and we'll
2 invite you or one of the members of your staff. The
3 last time at our conference call Matt came.

4 So we'll take this on by the end of the day, and
5 everything else we talk about is still a priority,
6 which I'm just going to take a wild guess it is. But
7 we'll let you know. Is that okay?

8 MS. MARLA HENDRICKSSON: Yes, thank you. Can I
9 take just a minute to tee up the other two questions
10 for your reflection, then we can -- you know, I really
11 hope that we can continue the discussion toward the
12 next --

13 MS. FRANCIS HARDING: They will go home with
14 these questions.

15 MS. MARLA HENDRICKSSON: Okay, good.

16 MS. FRANCIS HARDING: Is that okay? I'm just
17 really conscious of the time that we have to devote
18 for the rest of the meeting. Is that okay with
19 everyone? We'll make sure before you leave you get a
20 copy of them and with Marla's contact information
21 because I did hear her say please contact me. And I

1 particularly liked if you see an article or something
2 that reflects your thinking in this discussion. I
3 liked that. I haven't heard anyone ask for that
4 before, and I think that's a great ask.

5 So thank you so much, Marla. We thank you for
6 your patience. We thank you for your flexibility. I
7 know it's hard to, A, come into all of these different
8 buildings and then to have sharing time with the
9 Administrator. I mean, it's not difficult to be doing
10 that, but not when you have an agenda in mind. So we
11 thank you very much. This has been very helpful, I
12 think, to the Council.

13 MS. MARLA HENDRICKSSON: Thank you. The two
14 questions are mobile apps and on the media. So just
15 to let you know that we are -- this came from a
16 discussion with what you thought you wanted to hear.
17 So hoping that you will engage with us on mobile apps.
18 And the fact that we have media guidelines coming out
19 soon, and we'd love to hear more information from you.

20 MS. FRANCIS HARDING: Okay. So good news, bad
21 news. Bad news is we're 20 minutes behind. Good news

1 is we've extended lunch until 1:30. So we need to be
2 back here at 1:30 so that -- and if you need to bring
3 your lunch back with you, totally okay with me, so
4 that we can fit in the rest of the meeting and the
5 conversations that we need to continue from yesterday.
6 So everybody good with that? So 1:30.

7 [Lunch break at 12:21 p.m.]

8 [Reconvened at 1:30 p.m.]

9 MS. FRANCIS HARDING: Okay. We're going to get
10 started. Thank you for coming back. I hope you all
11 got out and had a little bit of walking and
12 nourishment, and you're ready for the rest of the
13 afternoon. Hopefully no sugar so you can stay awake,
14 although these are our two favorite topic areas again.

15 So we're going to now go into the conversation
16 about the role -- prevention's role in integrating
17 healthcare. We discussed a little bit of this
18 yesterday. We actually spent quite a lot of time on
19 this yesterday. Today what we have, and that was set
20 you up for today, which are the five questions that
21 you heard on the conference call that we had a couple

1 of months with Pam. This was Pam's overall -- the
2 joint NAC conference call.

3 And tomorrow we will be -- we will have a
4 representative, which Rich will be talking about
5 again, that will give our -- represent the NAC during
6 another conversation on integration. You heard a
7 little from Administrator Hyde this morning about some
8 of her thinking and where was going, although with the
9 schedules being the way they are, unfortunately we
10 didn't get a lot of time with Pam. But we'll hear a
11 lot from her tomorrow, and she'll weigh in on this
12 subject in a big way.

13 It's very, very important to her that SAMHSA
14 hears from all of the NACs and many of our
15 stakeholders as we go forward with this because this
16 will be -- we're setting the footprint for the future.
17 So we want to make sure that we do it right. That's
18 why we spent the time on communications.

19 So we've changed the schedule a little bit so
20 that we could be caught up, and how we changed it is
21 this conversation is going to be about 75 minutes, not

1 90. And then we're taking away the break, and then
2 moving on right into the SIs. So please get up when
3 you need to, do whatever one has to do between now at
4 the end of day rather than us taking a break and all
5 going at the same time. Is that agreeable to
6 everybody? That way we think we can fit everything in
7 at a comfortable pace and still get you out of here at
8 the promised hour of 4:00-ish.

9 So Rich Lucey is going to moderate this
10 conversation of the five questions. And I am going to
11 turn it over to Rich, and hopefully we'll have a very
12 lively conversation. I remind you again that we are
13 being recorded so that these will become the minutes
14 for when we get together in August. Your comments
15 will be among those minutes. So this would be good so
16 you don't have a memory. We'll be feeding it back to
17 you, so I always find the minutes very useful for that
18 purpose of remembering of who says what and what we're
19 talking about, the contents. So, Rich?

20 AGENDA ITEM: PREVENTION'S ROLE IN AN INTEGRATED
21 HEALTHCARE ENVIRONMENT

1 MR. RICH LUCEY: Okay. So as Fran mentioned,
2 we're going to go until 2:45. We've got five multi-
3 part questions to get through. These were all
4 questions that each NAC was asked to address within
5 their individual Council meetings and discuss. And as
6 Fran mentioned, one of you lucky NAC members tomorrow
7 will get to report out during the joint NACs meeting
8 on what our conversation centered around. So I think
9 we'll save the selection of that person to the end of
10 this conversation.

11 So between all of your own individual notes, one
12 of my partners in crime in the Center, Nel Nadal, is
13 also going to be taking some high-level notes on some
14 key words, phrases, and concepts that she's hearing
15 throughout the conversation to turn over to the person
16 who is going to report out. That can help you in your
17 duty tomorrow.

18 We're going to do this sort of like a speed
19 dating type of situation to ensure we get through all
20 five questions. We're going to give each multi-part
21 question 12 minutes maximum. So at the end of 12

1 minutes I'm just going to just cut in and say "time,"
2 and we're going to stop right there. It will feel
3 awkward, but it's the only way we're going to get
4 through all five questions.

5 I'm just simply going to read the question and
6 all of its parts. And as you feel comfortable to join
7 in and offer your thoughts, don't feel you have to
8 address every part of the question. Pick whatever
9 part of the question you want to address, okay?

10 So we're going to -- basically setting the
11 context, as you saw with these questions if you got
12 them in advance, that the reason for the conversation
13 is SAMHSA is continuing to think about what does
14 integration look like in the future, what should it
15 look like, what should we do at SAMHSA to embrace
16 integration, promote it, help to influence the
17 evolution of it and its impact. So that's the context
18 for why we're having this discussion.

19 So we'll kick right in with question number one
20 and all three of its parts. "What do you think the
21 concept of integration means? In the future, what

1 should behavioral and physical health integration look
2 like, and how will we know it when we see?? The
3 question is also up on the screen for you on the
4 slide, and so there's your three-part question. And
5 our 12 minutes starts now.

6 Question two -- no, I'm kidding.

7 [Laughter.]

8 MR. RICH LUCEY: Michael?

9 DR. MICHAEL COMPTON: This is Michael Compton.
10 In my own field of psychiatry, integrated care is a
11 really hot topic right now, and it means something
12 very specific. It means embedding mental health
13 services into primary care, mainly to help primary
14 care clinicians detect and treat depression and
15 anxiety disorders.

16 It also means embedding primary care into
17 community mental health agencies primarily because
18 people with SMI are dying up to 25 years early, and
19 it's because of chronic health conditions that largely
20 go untreated. That's what integrated care means in
21 psychiatry.

1 But I think in the future, integrated care in my
2 field also needs to include prevention, not only
3 prevention of mental health problems in the primary
4 care setting, but prevention of chronic physical
5 conditions in both settings because I think that
6 mental health can have a role in the prevention of
7 physical health conditions because most chronic
8 physical health conditions are driven by, you know,
9 behavioral and lifestyle issues.

10 So at present, in my field it means something
11 largely about treatment, but eventually it's going to
12 need to include prevention on both sides, primary care
13 and mental health.

14 MR. RICH LUCEY: Kathy?

15 MS. KATHLEEN REYNOLDS: I would just add -- Kathy
16 Reynolds -- just adding to what Michael said, I think
17 it's on a continuum as well. I don't think it's any
18 one single thing, that healthcare and clinics tend to
19 be local and that there's a continuum of integration
20 all the way from what I call a referral model where
21 people are in their own places all the way up to an

1 onsite fully integrated system of care, very much like
2 Michael talked about.

3 MR. STEVE KEEL: When I think of integration, I
4 think of whole person health, the complete person,
5 human being. And when I think of integration, I also
6 think that prevention needs to be integrated basically
7 as a cost of doing business, almost like a policy
8 change requires that primary prevention be part of
9 this. And I think it's almost going to take a policy
10 change as a social cost in order for this to occur. I
11 don't think going to occur on its own.

12 MR. RICH LUCEY: John?

13 DR. JOHN CLAPP: John Clapp. Just to build on
14 what Steve just said, I kind of also view this in
15 terms of a system of care and prevention. So we have
16 to conceptualize it at a systems level, and what kind
17 of organizational variables would be important to look
18 at. And so, how do providers within the system
19 interact with other providers at other organizations
20 in a system, and what kind of a coherent plan is that.

21 Just to get the second half of the question, what

1 it might look like in the future, I think you can
2 almost talk about instead of behavioral health, health
3 behavior, flip it on its head, because now we're
4 talking about behavior that cuts across the whole
5 person in terms of health.

6 DR. MICHAEL COMPTON: Can I throw in one other
7 comment?

8 MR. RICH LUCEY: Yes, please.

9 DR. MICHAEL COMPTON: Michael Compton here. I
10 think we also can't, especially in the future, achieve
11 integration without sharing of medical records, so
12 electronic health records plays an important role in
13 all of this. And, of course, those need to include
14 prevention activities.

15 MS. FRANCIS HARDING: Which, by the way, Dr.
16 Clark leads up the strategic initiative that's looking
17 at technology, and spends a lot of time discussing
18 electronic health records for treatment. And we have
19 been trying to figure out how the prevention world
20 begins to join in on that. So I never thought of it
21 as part of an integration issue, but this might be

1 something for a future discussion for us to look at,
2 how do we utilize as preventionists the electronic
3 health record system to better link us together.
4 Thank you for bringing that up.

5 MR. RICH LUCEY: Kathy?

6 MS. KATHLEEN REYNOLDS: Kathy Reynolds. Just a
7 couple more comments. I think when we talk about the
8 continuum of integration prevention as part of that
9 continuum, when you talk about the folks with serious
10 and persistent mental illness who are dying earlier,
11 we have to do prevention to prevent that from
12 happening. They're still going to have serious and
13 persistent mental illness. They don't have to develop
14 the other chronic illnesses that go along with that.
15 So I think thinking about that.

16 And then how will we know when we see it? I like
17 the comment I heard in another meeting, which is we'll
18 know that we've gotten there when we no longer have to
19 use the word "integration," that when we talk about
20 healthcare, we will know that behavioral health and
21 prevention are a part of it and essential to health.

1 MR. RICH LUCEY: Dianne?

2 MS. DIANNE HARNAD: Hi. Dianne Harnad. For me,
3 the concept of integration would be an increased
4 emphasis on prevention versus dilution of it. And
5 what I mean by that is I looked at the coalition
6 strategy, that report, and there were roles for
7 prevention, such as engaging people in applying for
8 healthcare benefits and things like that. And that,
9 to me, is an example of dilution of prevention in the
10 way that we know actual prevention works.

11 So I mentioned this yesterday, and I want to add
12 onto what Dr. Clapp said. I think this is a system
13 organizational sort of change strategy where we need
14 to have language, and based on the foundations of
15 prevention, the Institute of Medicine's framework, so
16 that there's a goodness of fit for all different
17 levels. If it's substance abuse prevention, we have
18 primary selected. If it's a mental health promotion
19 or behavioral health, emotional development, it could
20 be where it's all defined.

21 So what it would look like is that people would

1 be practicing prevention at all levels, but there
2 would be codes where they could bill for it and say
3 this is clinical prevention, for example, substance
4 abuse, SBI, .5 prevention. This is mental health
5 promotion .7, tertiary prevention to prevent onset of
6 depression for someone who's already being treated.
7 That's sort of how I envision it, and also that would
8 be the workforce strategy.

9 So when we see all these people doing that, and
10 there's codes in place, and people are billing. And
11 it's happening in all different places, not just in
12 the community, but in medical offices and private
13 practice, things like that.

14 MR. RICH LUCEY: Okay. Any other comments on
15 this? Patricia?

16 MS. PATRICIA WHITEFOOT: Yes. When I think about
17 the integration of services, I think about holistic
18 health and well-being. And for me, because of the
19 work that I'm doing with the Coalition, we're looking
20 at, you know, healthy families, successful students,
21 but we've taken it a step further, safe environments

1 and, you know, stable communities. And then including
2 the research that is sensitive to diverse communities
3 as well.

4 And I also agree with the comment about policy
5 changes as well because throughout each one of those
6 components, there are policies that you have to be
7 examining and making recommendations on.

8 MR. RICH LUCEY: Thank you. Any other comments
9 with our two minutes to go on the question?

10 [No response.]

11 MR. RICH LUCEY: Okay. Hearing none, Matthew is
12 going to do a reminder on a housekeeping issue.

13 MR. MATTHEW AUMEN: Yes. Folks, I moved the mics
14 a little bit closer to the table so that helps for the
15 virtual participants on the phone. We'll continue to
16 monitor that, but if you can, try to speak up a little
17 bit into the mics. And also state your name whenever
18 you can for the transcription. Thanks.

19 MR. RICH LUCEY: And, Nel, you okay with what you
20 got? Okay. All right.

21 So we'll move onto our second question. Again,

1 you can see it up there on the screen. I'll do the
2 dramatic reading of it. "How will or should people
3 think differently about the role of behavioral health
4 with a broader public health perspective to support
5 the overall health of their communities?" The final
6 part of that question being, "How do we ensure that
7 the cultural needs, preferences, and resources of
8 communities are considered as part of integration?"

9 I'll give you a moment or two to mull that over.
10 Patricia?

11 MS. PATRICIA WHITEFOOT: Yes, I think my response
12 would've gone -- would've been more appropriate here
13 as I take a look at this. And just again, because in
14 some of our tribal rural -- those of that live in the
15 West, you know, the environment is important, and it
16 impacts our daily perspectives as well in our
17 communities. So I would just clarify my response to
18 this portion.

19 MR. RICH LUCEY: Thank you. Michael?

20 DR. MICHAEL COMPTON: Michael Compton. And
21 responding to the first question, I think it's

1 historically been easy for public health to sort of
2 carve out mental health or behavioral health. But
3 what we know is that you prevent mental illness, and
4 you prevent substance abuse using the exact same tools
5 that you prevent obesity, and diabetes, and
6 hypertension, et cetera.

7 As one example, adverse early life experiences
8 are very important and robust risk factors for all of
9 those conditions. And so, in terms of how we should
10 think differently about the role of behavioral health
11 in the broader public health perspective, behavioral
12 health is just part of it all. It's really not
13 something that can be separated.

14 So I think we need to get to the point where
15 we're talking about health rather than behavioral
16 health or physical health.

17 MR. RICH LUCEY: Fran?

18 MS. FRANCIS HARDING: I agree with that entirely.
19 And one of the pleasures of working with this question
20 per se or this whole area of bringing behavioral
21 health into a broader public health perspective and

1 bringing it together with health is helping people see
2 the connection of what you just said. We're using the
3 same tools to prevent all these other conditions, as
4 well as substance abuse and mental health disorders.

5 People's eyes sort of widen when you say that if
6 you're careful in how you're presenting it because it
7 becomes real to them. And if we can get more people
8 to understand that it becomes real and natural, we'll
9 get to the state that you're saying, I think, that
10 we're talking about health, and we won't have to
11 always tag on whether we call it behavioral health,
12 mental health, or what from the previous discussion
13 earlier.

14 The last thing I'd say is for -- while you're
15 working representing the NAC and all of the SAMHSA
16 people in the room, what has been an incredible tool
17 for us to help set the stage of this conversation is
18 the Secretary's National Strategy on Prevention,
19 because that has the seven priorities. Some of them
20 are physical, and some of them are behavioral, and it
21 helps start the conversation. So I throw that tool

1 out for people to start a difficult conversation with
2 some, or not difficult, just new. Thank you for
3 bringing that up.

4 MR. RICH LUCEY: Kathy?

5 MS. KATHLEEN REYNOLDS: Kathy Reynolds. I hope
6 that this also would lead to less stigmatization for
7 the illnesses, and that it'll just become part of, as
8 you said, health and who we are, and not this unique
9 idea that differentiates it from others.

10 MR. RICH LUCEY: Michael?

11 MR. MICHAEL MONTGOMERY: Michael Montgomery. Try
12 to speak a little bit to the second part of the
13 question. I was thinking in the context of my
14 experience in working with substance abuse 40 years
15 ago where we had to create separate agencies to serve
16 specific populations, and, in my case, the gay and
17 lesbian community, that was necessary because of the
18 lack of trust in the general population services that
19 were available.

20 And I think in terms of how you ensure that
21 cultural needs and preferences are considered part of

1 integration implies that there is an understanding in
2 the development of knowledge about those communities
3 that would allow members of those separate communities
4 -- disenfranchised communities -- to have a sense of
5 trust in the services and understanding the people who
6 would be involved.

7 There is, I think, still a pretty broad distrust
8 of those kinds of services. And the populations don't
9 have to both educate people that they are intending to
10 get therapeutic services from.

11 MR. RICH LUCEY: If we take a look at the
12 question that's in bold, and I don't know that it's
13 necessarily for emphasis. However, obviously one of
14 the things we do in prevention is around cultural
15 competence and ensuring that our message is tailored
16 to the people we're targeting. How do we ensure that
17 the cultural needs, and the preferences, and the
18 resources of our communities are considered as part of
19 this integration? John?

20 DR. JOHN CLAPP: Yes, John Clapp. I think you
21 can just look historically at what CSAP has done over

1 the years with the community coalitions and those
2 sorts of things. You have good models for getting
3 community-based input, participatory input that meets
4 local conditions and can be culturally and locally
5 appropriate. So I don't think you have to reinvent
6 the wheel on that and just adapt what you have to this
7 scenario.

8 MR. RICH LUCEY: Michael and then Dianne.

9 DR. MICHAEL COMPTON: Michael Compton. I would
10 just also add that one way to ensure this is by
11 ensuring a diverse workforce. If the workforce is
12 diverse, then the product is going to be diverse and
13 appropriate and culturally competent.

14 MS. DIANNE HARNAD: I just wanted to add that
15 within the National Prevention Strategy, it sort of
16 addresses both question one and two because it really
17 does align nicely with everything in health and
18 behavioral health and ensuring cultural needs,
19 preferences, et cetera. It also talks about at the
20 community level, doing education and empowering people
21 to own their own health and to learn how to take care

1 of themselves.

2 And so, one of the overall sort of mantras with
3 the National Prevention Strategy, we're all a part of
4 it, so I think we need to get that message out. So I
5 was thinking of Rob, because you were talking about it
6 in your awareness campaigns collaboration. And I
7 think maybe a greater collaboration would be helpful
8 with the National Prevention Strategy. It's just so
9 -- if they're promoting that, there's no reason why
10 this can't be embedded in what we're doing.

11 MR. RICH LUCEY: Patricia?

12 MS. PATRICIA WHITEFOOT: I would just like to
13 speak to evidence-based and scientific-based criteria.
14 I think we really need to be concerned about the
15 multi-faceted issues that diverse communities strive
16 toward in terms of community empowerment, community-
17 based voice, and community driven because we're having
18 to just grow or own rather than being, you know, so
19 dependent on the professional arena.

20 And it's really up to us as communities to define
21 what we mean by, you know, that research, but also

1 what we mean by the criteria that is established for
2 our work, particularly in indigenous populations
3 because in indigenous populations, we're sharing
4 internationally the work that we're doing with other
5 indigenous populations as well. And so, we're not,
6 you know, necessarily looking solely at higher
7 education institutions, criterias, et cetera. We're
8 doing ours with our own voice from our people.

9 MR. RICH LUCEY: Thank you. Steve?

10 MR. STEVE KEEL: I would just reiterate, I think,
11 what John said and I think a number of the comments
12 that have been made that the framework exists.
13 Something like the strategic prevention framework
14 actually would be one way to ensure that that
15 integration happened simply because if an in-depth
16 assessment is done in terms of the community, then the
17 strategies selected that are likely to be used are
18 going to be based on the assessment itself. And I
19 think the likelihood of success just goes up
20 dramatically if that's the case.

21 Having a framework that is in place or maybe

1 several frameworks that are very close or that are
2 very similar I think provides guidance to ensure that
3 something like that would happen.

4 MR. RICH LUCEY: Okay. Any last minute thoughts
5 in our two minutes left on this question?

6 [No response.]

7 MR. RICH LUCEY: Okay. Nel, you okay down there?
8 Great.

9 Okay. So we'll go onto question three, and as
10 you can see with all the "wills" and "shoulds," you
11 should've picked up your crystal ball on the way in
12 because that's what we're asking you to do is help
13 predict the future. "What will or should providers
14 and practitioners be doing differently than they do
15 today? How will or should funding be arranged, and
16 how will or should systems look?" So I guess if you
17 were to try to break this down into some categorical
18 topics, you're looking at programming, funding, and
19 systems. Dianne, jump right in.

20 MS. DIANNE HARNAD: I would like to add to what
21 Steve said. When we -- maybe it was 10, 15 years ago

1 when we started the strategic prevention framework,
2 that was so effective because we had to change the
3 system of prevention moving towards evidence-based,
4 but we had to do it at the systems level, the state
5 level, the community, the program level. So we had
6 the data to drive it.

7 So if all of this was integrated, it would be --
8 I could envision it being very much like the initial
9 SIG, which is an MOA among all the state partners,
10 probably including insurance and physicians and all of
11 the other stakeholders that we talk about. And we'll
12 be using the same process and coming up with common
13 language.

14 I remember as a state agency work group, we had
15 to come up with common language for what prevention
16 was, the programs that we funded, what was considered
17 evidence-based, what wasn't. And, I mean, it took a
18 couple of years to get through that initial process,
19 but then the funding, it was all set up to fund
20 programs after that.

21 So I think silos need to be broken down. We need

1 to take a more comprehensive look, more collaboration
2 and pooling of resources. And it probably has to come
3 from, like, the governor's level in each state.

4 MS. FRANCIS HARDING: Can I push back a little
5 bit on that and ask for a little bit more detail?
6 Going back and thinking about the individuals that
7 you've pulled together in your communities and in your
8 state level, who would you invite that would be
9 different than who are already at your tables now that
10 would help to get us to what we've been talking about,
11 integration into health?

12 MS. DIANNE HARNAD: The other people that did
13 this from the NPNs can jump in. But, I mean, first at
14 the state level, we had state agency partners, and
15 then at the community level they had to -- very
16 basically mirror what we did at the state level. But
17 now you would have healthcare providers, actual
18 providers or representatives of, let's say, healthcare
19 systems in the state, insurance companies, whoever
20 would do -- was it Medicaid?

21 UNIDENTIFIED SPEAKER: Insurance.

1 MS. DIANNE HARNAD: All of those -- I don't know
2 who all the stakeholders are, but it would be
3 different stakeholders and more like the health
4 integration stakeholders that we'd have to add.

5 MR. RICH LUCEY: Steve?

6 MR. STEVE KEEL: I would just add to that, Fran,
7 in response to your question, it might be more than an
8 invitation also. An invitation might be to include
9 members of the community, all parts of the community
10 -- business, faith groups, whatever. But there are
11 parts of the community that have been so historically
12 disenfranchised that an invitation is not going to be
13 enough. There's going to have to be active outreach
14 and going to the other -- to the houses or the homes
15 of others as opposed to expecting people -- the door
16 is open, you can come in now.

17 So it's going to have to be a much more active, I
18 think, proactive plan as opposed to one where it's
19 just inviting people, if that makes sense.

20 MS. FRANCIS HARDING: It makes a lot of sense.
21 This is a great conversation because as you're

1 speaking I'm trying to figure out could you maybe not
2 today, but in a future conversation what would --
3 because that's where I was going to go.

4 We tell people to knock on the door and invite
5 yourself in, right, for the conversation. What else
6 would we need to do to begin to help on both ways,
7 help the community or the state that is embedded in
8 behavioral health programs? What do they need -- what
9 tools they need? What kind of training might they
10 need to be able to go and knock on the door of health
11 insurance and the like, and then vice versa? What
12 would you need if you're the -- you know, this is a
13 rural area and you're the pediatrician that everybody
14 goes to. What would you need to be convinced that
15 your time is well spent in the community for
16 behavioral health programming?

17 So it's just bringing up a lot of questions of
18 what our group could start to think about and do as
19 far as recommending, yes, we're answering the
20 questions, but just going a little deeper into the
21 questions. John?

1 MR. RICH LUCEY: We'll do John and then Ruth.

2 Okay.

3 DR. JOHN CLAPP: All right. This is John, and
4 now I forgot what I was going to say.

5 [Laughter.]

6 DR. JOHN CLAPP: To get to Fran's point a little
7 bit, and I think we talked about this yesterday, and
8 Michael had some ideas on this. But I think one of
9 the places to start is a model that shows how this
10 hangs all together for all these parts of the overall
11 system. And once that's laid out, and it doesn't have
12 to be overly complex, but just conceptually how that
13 goes together, I think that's the basis to build.

14 And then you go into the task of translation, and
15 there's nomenclature and terms and ideas that are
16 common to all these organizations, but we use them
17 differently. And I think so coming up with some way
18 to cross-train or expose people to the different
19 systems, as Michael said yesterday, makes a lot of
20 sense. And then people are starting to talk a common
21 language. They have a framework to hang it on, and

1 they understand each other's part.

2 MR. RICH LUCEY: Ruth?

3 MS. RUTH SATTERFIELD: Okay. I need to tell you
4 my dendrites, they're just firing like crazy, so I
5 can't capture all the pieces throughout this part of
6 this conversation, but I'll try to capture a few.

7 This is Ruth Satterfield, and I'm fully in
8 agreement with what we were just saying. And when I'm
9 thinking about other people that we can try to engage,
10 I'm thinking about the nursing schools. I'm thinking
11 about your community colleges that have nursing
12 programs at different levels, that you have your tech
13 programs, that have obviously your physician training,
14 all of those, because sometimes we just head for one
15 school maybe to get all the different piece of the
16 medical field. I lost another piece, but that was
17 like the big piece, okay, when we keep thinking about
18 who we need to touch.

19 Oh, the other thing that I kind of was thinking
20 was from our experience when you try to go in and they
21 are -- you're trying to go into a physician or you're

1 trying to work with them, it's, again, that value
2 added piece we talked about yesterday. That I'm not
3 going to ask you to do something different or ask you
4 to do more. I will bring you a person, and that
5 person will do it for you because that will bring a
6 preventionist to your space, and I will have them
7 provide. So I'm not asking more of you, which allows
8 a little bit of an open reception.

9 MS. FRANCIS HARDING: Michael, would you be
10 willing to repeat a little bit of what you discussed
11 yesterday about your theory of you need to really have
12 exposure into another part of working by actually
13 taking someone and putting them in there for two weeks
14 or so, or whatever the timeframe is for the record so
15 we'd have that on here? I think it fits in this
16 conversation.

17 DR. MICHAEL COMPTON: Sure. I think it was in
18 the context of cross-training. And I mentioned above
19 and beyond sort of didactic training, we need cross-
20 exposure. As an example, when I was a medical student
21 or even a psychiatry resident, it would've been wildly

1 illuminating for me to go a community coalition
2 meeting because it wasn't until just a few years ago
3 that I learned that there is such a thing as community
4 coalitions and that they're out there practicing
5 prevention. And you can do prevention without a
6 patient sitting in front. In fact, you should do
7 prevention without a patient sitting in front of you.

8 And so, I think this is sort of cross-exposure
9 and cross-training not only for healthcare providers
10 learning more about public health oriented prevention,
11 but also vice versa.

12 MS. FRANCIS HARDING: Thank you.

13 DR. MICHAEL COMPTON: If I can also comment just
14 a bit about the -- probably the most difficult
15 question, and that is how will or should funding be
16 arranged. So in modern U.S. medicine, physicians and
17 hospitals and health systems benefit when they do more
18 procedures and they provide more medicine. So the
19 more prostates you take out, the better off you are
20 either as a surgeon, as a hospital, or health system.
21 The more you replace, the better you're going to do.

1 The more prescriptions you give out, the more frequent
2 the psychotherapy sessions, et cetera.

3 So somehow eventually although the ACA does begin
4 to tackle this problem in an important way, somehow
5 we're going to have to get to the point where we're
6 getting paid more and we're doing better by preventing
7 more rather than by trading more. And that's, I
8 think, the biggest hurdle for us to overcome.

9 MR. RICH LUCEY: Okay. We have about a minute
10 left on the question. Any last minute thoughts?

11 [No response.]

12 MR. RICH LUCEY: Nel, you're good? Okay.

13 All right. We'll go onto question four. And as
14 you can see, it's a multi, multi-part question.
15 "Given that SAMHSA funds programs," and I'll let you
16 read the parenthetical up there, "and in addition has
17 a role in influencing other payers, policy makers, the
18 public, behavioral health and healthcare
19 practitioners, and community prevention leaders, how
20 do you think SAMHSA can best address the issue of
21 integration in these four areas: community

1 prevention, healthcare delivery, supportive recovery
2 from health and/or behavioral health conditions, and
3 community living for those with disabling conditions?"

4 So the crux of the question is there at the end:
5 "How do you think SAMHSA can best address the issue of
6 integration in these four areas?"

7 MR. MICHAEL MONTGOMERY: "How does SAMHSA
8 address," what does that mean? Does it mean
9 encourage?

10 MR. RICH LUCEY: I guess if I were to answer
11 that, Michael, I don't want to waffle. I mean, I
12 think it can mean whatever we want it to mean in terms
13 of address. Is it requiring, is it strongly
14 encouraging, is it including it as part of RFAs? I
15 think it's, you know -- this is, again, the prediction
16 of the future. I think it can mean all those things.
17 It's the wish list, I guess.

18 MR. MICHAEL MONTGOMERY: This is Michael
19 Montgomery. In that case, I think that if you want to
20 encourage it, you require it, and that means that when
21 you put out RFAs you define that this RFA is going to

1 serve this purpose in this setting, and that you
2 require that the integration be part of the
3 organization you're going to fund. And that will
4 encourage organizations to move in that direction.

5 MR. RICH LUCEY: Kathy?

6 MS. KATHLEEN REYNOLDS: Kathy Reynolds. I think
7 SAMHSA could model it. So what you were saying both
8 in its releases and its documents and its grant, but
9 also in the way it functions day to day across the
10 different elements that are part of SAMHSA, and HRSA,
11 and different Federal agencies as you do now.

12 MR. RICH LUCEY: I'll just ask you to elaborate,
13 and not to necessarily put you on the spot, again,
14 knowing we're being recorded. Is there an example of
15 how we are not doing that so it gives an example of
16 how we could better do it?

17 MS. KATHLEEN REYNOLDS: I don't know if I can
18 come up with an example -- again, this is Kathy
19 Reynolds -- about that other than, I think, what maybe
20 Michael said in terms of requiring it or using it. We
21 talked yesterday about potential projects coming out

1 where prevention and treatment are together and
2 supported in the same application, those kinds of
3 elements.

4 You know, we talked yesterday a little bit about
5 peers and the challenges we have with recovery
6 supports and peer supports and community health
7 workers getting parced out in the same silos we've had
8 in the past. So I think thinking of ways to bring
9 those together.

10 MR. RICH LUCEY: Thank you. Other thoughts on
11 how you think SAMHSA can address the issue of
12 integration in these four areas? Also learning to
13 become very comfortable with pauses, which is okay.

14 I want to remind and/or encourage the senior
15 staff, those that are sitting at the table from
16 SAMHSA, to feel comfortable to offer comments as well.
17 I mean, we're trying to get the NACs members' thoughts
18 on this, too, but among the division directors who are
19 sitting around the table, too, who are kind of are
20 living this day to day within the Agency, feel free to
21 offer up your thoughts as well.

1 MS. DIANNE HARNAD: Hi. Dianne Harnad. I would
2 like to add onto what Michael said. And I think
3 through funding or RFPs we could just test out some
4 different models of whether it's coordinated care or
5 co-location or full integration. So for community
6 prevention you may be working through a coalition.
7 They would test one model which may be co-location.
8 Within the healthcare delivery system, I guess that
9 might be integrated where you literally have, like
10 what Michael said, a person that does prevention.

11 It could be a funded community program that we
12 have in place now, but they have a partnership with a
13 community health center, and their provision -- their
14 prevention staff person goes there a few days a week
15 and does different kinds of prevention work --
16 screening intervention. And then also supporting
17 recovery of health or mental health conditions, we
18 could do that same thing. We could do in-home or
19 medical, also test the medical home model out by doing
20 different pilots.

21 And the other thing I think we need is some kind

1 of clinical prevention benefit where you can bill
2 because I think that would be encouraging for
3 physicians and a lot of other people. Back in the
4 day, I remember with -- through ACM there was a
5 clinical prevention code, .5. And I don't know
6 whatever happened to that, but it was part of ACM
7 criteria. We were developing a clinical preventive
8 benefit when healthcare reform started. And so, it
9 may have only been Connecticut when we were looking at
10 that, but I think it has been in place in other
11 states. I'm not sure.

12 MR. RICH LUCEY: Richard?

13 MR. RICHARD MOORE: One of the things that I'll
14 bring up, and hopefully the Advisory Council members
15 will think about this. But there was an observation a
16 few minutes ago that we should look at model programs
17 as a way of addressing this. This gives an
18 opportunity for communities that are struggling with
19 these issues around integration. Give them an
20 opportunity to test it out, so to speak.

21 So one of the things that I'm thinking is, you

1 know, should we begin to look more at doing
2 demonstration programming? Should we use our funding
3 to do demonstrations? I know that Michael just
4 indicated a few minutes ago that we perhaps should
5 look at having requirements in our RFAs.

6 One that we've done in the past is we've
7 suggested. We've tried to influence. We've been
8 short of directing, you know, communities as far as a
9 requirement, but we've provided some incentives for
10 communities to do integration. We give them ideas.
11 And some of the ideas we spoke about, you're inviting
12 the various specialties to come to the table in the
13 form of, you know, being invited to the community
14 coalitions and other ways of doing that.

15 And so, I'm just curious if the Council would
16 actually do a recommendation or do you think it's a
17 good idea for us to perhaps do demonstration
18 programming?

19 MR. RICH LUCEY: Thank you, Richard. We have
20 four minutes left on this question if people have any
21 reaction to what Richard just said or their own

1 thoughts on these four areas up here.

2 DR. JOHN CLAPP: Yes, this is John again. I
3 agree with -- I think that's a great idea. A
4 demonstration kind of program would be a nice first
5 phase. And then perhaps a second phase would mirror
6 your original SIG concept where, you know, the states
7 were given a menu of different appropriate ways to
8 integrate -- or not integrate at the time, but
9 implement prevention programs. I could see the same
10 kind of scenario here. These are different models of
11 integration, and, you know, select from this menu and
12 use what fits best for your state.

13 MR. RICH LUCEY: Steven?

14 MR. STEVEN GREEN: Yes, this is Steven. I
15 certainly support your concept of demonstration,
16 particularly for Indian country, Richard. Indian
17 country has been set up in co-location for decades,
18 and it would really give a disenfranchised population
19 an opportunity to be fairly competitive for some of
20 these grants.

21 MR. RICH LUCEY: Thank you. Kathy?

1 MS. KATHLEEN REYNOLDS: Just as you're talking
2 about demonstrations, you do have the PBHSCI, the
3 primary and behavioral healthcare integration grants,
4 which are, you know, 100 sites across the country that
5 are piloting different models of integration, and do
6 include a specific recommendation that prevention be
7 included in those. So you have started some of that
8 already, and may want to look at that as a possible
9 replication opportunity.

10 MR. RICH LUCEY: Okay. Jorielle, and we're at
11 two minutes.

12 DR. JORIELLE BROWN: Jorielle Brown. So this is
13 just an idea that popped into my head as I was driving
14 down the street one day. But I know we have the
15 medical home model, which is the patient-centered
16 medical home model, which is being obviously
17 promulgated through ACA and is finding a lot of
18 success because it's basically taking the holistic
19 approach, which you've heard "holistic." We've heard
20 "culturally competent" in a number of the different
21 conversations we've had today.

1 So, but it's individual focused, it's patient
2 focused, which, of course, is a needed aspect of the
3 larger system. Perhaps we consider something like a
4 community home model, because basically what we
5 haven't done is said, yes, we're doing this at the
6 individual level, but then how do we take the
7 community into the context?

8 How do we maybe invite some of our existing
9 programs, like the DFC Program, the other community
10 coalition programs to approach a community home model
11 so it would do what some of the literature is saying
12 is bringing together the multiple entities to the
13 table to have a conversation, to do the planning, to
14 develop the metrics for what is the community trying
15 to achieve in addition to what the medical home or the
16 patient-centered model is trying to achieve?

17 MR. RICH LUCEY: Okay. Thank you. And that
18 brings us right up to our time limit. And our final
19 question, again, has to do with SAMHSA's role from two
20 different perspectives. I'm quickly summarizing it, I
21 think, before I ask the question, around being

1 generalists as well as specifists, if I can put it
2 that way. "How do you see SAMHSA's role in addressing
3 integration both as part of specialty care for persons
4 with serious conditions and as part of generalist care
5 for persons who may have needs that could be best met
6 outside of the specialty behavioral health system?
7 What prevention, treatment, recovery, financing, and
8 system issues need to be part of SAMHSA's approach to
9 integration that is part of specialty care and part of
10 generalist care?" That's a lot to digest, and I will
11 give you time to do that before you respond. And Dr.
12 Brown will start us off.

13 DR. JORIELLE BROWN: Jorielle Brown. I have a
14 one-word answer. Workforce. I mean, I know that it's
15 -- well, I don't want to go where Pam is probably
16 going to be going tomorrow with discussing the
17 overarching SI that is moving forward. But that's the
18 first thing that screamed to me when I read this was
19 how are we going to better prepare the workforce?

20 I know as a clinical psychologist, A, for me and
21 my training, substance abuse was maybe 10 percent or

1 less of the training that I received in my program.
2 And it wasn't until really doing a post-doc in public
3 health where substance abuse and/or the public health
4 approach was integrated more into the training that
5 was received. And I actually did a tally of different
6 colleagues that I had that all received training
7 around that same era, how many of them really, really
8 received training in that arena.

9 And so, if we are going to deal with the
10 specialty care, I think it was talked about yesterday
11 about how do we reach out to those entities. What
12 trainings are we going to do? And I think we need to
13 identify where is the greatest need, and then invest
14 the energy there first versus trying to do a
15 disparate, okay, we're just going to address all the
16 workforce needs. I think that's the challenge that we
17 keep facing about why do we -- why are we addressing
18 or not addressing workforce is because of the
19 magnitude of the issue.

20 I think if perhaps the NAC has some insights
21 about where do we want to focus our energies first and

1 then do a phased approach, it may not quite as
2 daunting a task.

3 MR. RICH LUCEY: Steven and then Michael I think.

4 MR. STEVEN GREEN: Yes, Steven Green here again.
5 I think the overarching issue for me is really the
6 cost of the infrastructure to do integrated care. We
7 at Gila River will probably never be fully integrated,
8 but we're probably always going to be very close to
9 that. My behavioral health program will be on a
10 common EHR probably within the next six months. We
11 just issued an RFP, and we're going over the bits
12 right now.

13 And to my delight, behavioral health will be the
14 trailblazer in going on the system first. And dental
15 health is following us second. They must've gotten
16 confused with mental health or something like that,
17 too.

18 But the time that my medical director and the
19 cost of him to be in meetings for integration -- you
20 and I had talked about this, Kathy -- is just
21 enormous, and it takes a lot to do it. So I just

1 wanted to share those comments with, again, the cost
2 of the infrastructure.

3 DR. MICHAEL COMPTON: Michael Compton here. To
4 follow along with Jorielle's point and speaking of my
5 own training, I did a residency in psychiatry and then
6 a residency in preventive medicine. And I know of
7 only two other psychiatrists in the country who are
8 double boarded in psychiatry and preventive medicine.
9 That's a problem if we're ever going to pursue true
10 integration.

11 There are lots of family doctors -- family
12 physicians who are double boarded in family medicine
13 and preventive medicine, but if you only have three
14 double boarded in psychiatry and preventive medicine,
15 to my knowledge, then that's a major workforce
16 problem. And so, I don't know what SAMHSA can do
17 about this, but if we can encourage sort of dual
18 training in some of these areas.

19 MR. RICH LUCEY: Fran?

20 MS. FRANCIS HARDING: I think that we don't have
21 enough time to wait for that. What you're saying is

1 absolutely true. SAMHSA through Now is the Time,
2 which you'll hear about tomorrow, which is the
3 President's initiative of responding to Sandy Hook and
4 where we are working with another Federal agency,
5 HRSA, to transfer dollars so that we can bring in or
6 can we pay for scholarships for more psychologists and
7 psychiatrists to come in to get their degrees and to
8 go into schools.

9 I get frustrated with these conversations because
10 we have an entire workforce out there of prevention
11 trained individuals that do not have degree in
12 psychiatry or psychologists or whatever other area we
13 need to have to be recognized for funding in
14 insurance. I mean, let's be serious. So we have an
15 identity crisis problem in one respect. We also have
16 a workforce that has been trained for over three
17 decades -- three decades of training.

18 So what I don't normally hear when we have these
19 conversations, especially when it goes to workforce or
20 especially when we look at these types of questions.
21 And the representative, there's only going to be one

1 representative at the table thinking about prevention,
2 by the way, tomorrow. So that's not going to help us
3 get a volunteer, but --

4 [Laughter.]

5 MS. FRANCIS HARDING: But I just realized --
6 okay, I take that statement back. We're really
7 looking for someone who wants a challenge. I only say
8 that so that you know the freedom you have to speak on
9 prevention.

10 But part of the big problem for us is how do we
11 get that well-trained workforce, the respected needs
12 with our health partners so that we can figure out --
13 that's why I was so intrigued yesterday and continue
14 to be today about this work experience thing. You
15 know, walk a mile in my shoe, and I'll walk a mile in
16 your shoes. I won't have the degree, but I'll still
17 walk the mile because I want to know what you're
18 doing, and then maybe we can sit down and discuss how
19 do you take the, you know, over hundreds and hundreds
20 and thousands of individuals who have been trained for
21 over three decades of science-based programming, and

1 how does that affect what we need to do?

2 So I just -- it's just something when you're
3 thinking about this question, and it does relate to
4 everything that's up there. It relates to services.
5 It relates to funding. It relates to care. And it's
6 just interesting to me that it might be something we
7 want to give some thought to because it's a real
8 problem. When we talk about workforce, and if anybody
9 feels challenged tonight, try to figure out how do we
10 put that into a sound bite, what our workforce really
11 needs right now.

12 It's not the training. They don't need the
13 training. What the need is how do they integrate?
14 They need access. They need respect. We need to
15 figure out -- that's why I liked the -- Marla's
16 presentation on messaging. All of this conversation
17 is just in my head thinking of there's another problem
18 we haven't addressed.

19 Is this a good time to ask for a volunteer?

20 UNIDENTIFIED SPEAKER: Maybe not.

21 MR. RICH LUCEY: Dianne?

1 MS. DIANNE HARNAD: As I was looking at this --
2 integration, specialty care, generalist care -- I
3 could see the continuum of care, the continuum of
4 health behavior -- I mean, the continuum of behavioral
5 health services. How do we develop a model, like a
6 diagram, that integrates health in that? We have the
7 continuum of care and they have wellness, but how does
8 that fit into the bigger model? Maybe something like
9 that? I don't know.

10 And in terms of prevention, specialty care, I see
11 prevention more generalist. The field is so talented.
12 You as a prevention professional, you need to do
13 research. You need to understand epidemiology. You
14 need to understand evidence-based programs,
15 collaboration, working with others, leadership.
16 There's so many skills, but me that's more generalist
17 versus specialty. I see more intensive services for
18 people with long-term chronic health issues.

19 MR. RICH LUCEY: Michael, and then Steven, and
20 we're coming up on about three minutes.

21 MR. MICHAEL MONTGOMERY: Just quickly, since we

1 began talking about integration, as a non-professional
2 on either sides of behavioral health or physical
3 health, I've been wondering, and you just expressed in
4 your frustration what I've been wondering the entire
5 time. And that is, if part of the basic problem isn't
6 the lack of respect for the workforce, particularly on
7 the drug prevention side. Of course, substance abuse
8 prevention side. Is that -- does that underline the
9 whole problem with encouraging --

10 And the other thing I would say in that regard is
11 that document that came out that we provided -- the
12 HRSA -- SAMHSA Center for -- whatever. That document
13 talks about that issue of understanding each other's
14 language and developing respect. So it may be that
15 what you're addressing is exactly what needs to be
16 done. How does SAMHSA develop respect in the
17 healthcare workplace for the work prevention --
18 substance abuse and mental health prevention can do?

19 MR. RICH LUCEY: Steven, we've got two minutes.

20 MR. STEVEN GREEN: Yes, Steven Green here. Well,
21 I guess I feel so blessed in Indian country because

1 the people I serve and many American Indians treat the
2 body, mind, and spirit. And I just want to validate
3 the Walking in My Shoes experience.

4 Although we don't have a formal program for that,
5 my behavioral health case managers can go into the
6 exam rooms of the primary care physicians. They know
7 what A1C hemoglobin is. They learn it. They pick it
8 up. And there is an exchange of knowledge, but I
9 can't get the physicians to go out in the field and
10 see patients in a crisis. But it does work for us,
11 and I suppose it's maybe an informal sort of Walking
12 in My Shoes. And we do get some mileage out of that.

13 MR. RICH LUCEY: Cynthia, one minute.

14 COMMANDER CYNTHIA RUBIO: I'll be fast. I
15 haven't had much experience with this yet.

16 I was a family advocacy nurse in the Air Force,
17 and they had their inpatient site rotation for their
18 family practice physicians. So I took them out in the
19 field, and we home visited their babies as I went and
20 saw newborns in a universal prevention program. A few
21 people were high risk. Nobody knew who was and who

1 wasn't. And I did play groups, and I took doctors to
2 play groups. We went hunting for trailers. We went
3 all over the place.

4 And that was voted one of the most popular
5 residency rotations because they got out of the
6 hospital so they got to see their wives. They got out
7 and got to see what community health workers actually
8 do. And it was very valuable for them, but it was
9 almost like they just had space to fill, and they
10 needed to do something valuable with the physicians.
11 But it was a very neat experience.

12 They like Burger King, too. I had to work on
13 that, get them on my food.

14 MR. STEVEN GREEN: If I may, just in fairness to
15 the nursing staff at Gila River Healthcare, they do
16 home visits and get out, and they do accompany the
17 case managers on occasion when indicated.

18 MR. RICH LUCEY: Okay. So we have now eight
19 minutes to bring us up to our 2:45 transition to the
20 next topic. First of all, let me thank all of you for
21 staying on task and on time both with these five very

1 difficult questions, very heady type questions.

2 I made three notes to myself of things to address
3 in this eight minutes. One would be to put Nel on the
4 spot, if she feels comfortable. Since you were
5 writing out what the discussions were, any key
6 concepts just threaded throughout the five questions,
7 not necessarily per question. But anything that pops
8 out at you and what you heard as you were taking
9 notes?

10 MS. NEL NADAL: I'm assuming this probably
11 mirrors what your pre-discussion was yesterday. But
12 some of the same words that were used in the
13 questions, people were talking about things that were
14 comprehensive, so whether that was comprehensive in
15 terms of holistic health, whether it was comprehensive
16 in terms of the approaches, in terms of using --
17 whether it's strategic prevention framework or any
18 other planning model, comprehensive in terms of who
19 you bring to the table, same ideas as far as
20 understanding one another and different things or
21 strategies as to how to get to that point.

1 I think one phrase that I liked was sort of the
2 goodness of fit, and I think also the larger piece
3 that folks had talked about was conceptual framework,
4 conceptual model, whatever the ecosystem is that's
5 going to exist when we say this is integration. This
6 is integration at the college level. This is
7 integration at the state level. This is integration
8 at the community level.

9 I think within our center as project officers and
10 other folks have been working through this issue on
11 their own and in groups in terms of being able to talk
12 to one another to figure out how we can provide
13 guidance, I think the one thing that we're all landing
14 on is besides trying to find the examples that
15 currently exist is drawing up what does the ideal look
16 like.

17 So I think having your final goal post, at least
18 for the initial part knowing what do we know and where
19 we think funding is, probably would help the
20 conversation get a little further because I think we
21 tend to get tangled in a lot of the challenges,

1 because I've heard a lot of that in terms of the
2 concepts and the definitions.

3 And since we know there's always going to be a
4 difference of languages regardless of the profession,
5 so now being able to put that on the table and then
6 kind of moving from there to get over that. Because
7 it's going to happen without us or it will happen
8 where we can help shape it.

9 MR. RICH LUCEY: Okay. Thank you. The second
10 thing that I wanted to mention -- you may have noticed
11 Matthew and I were passing notes during class here in
12 front of you. One of the things that we heard, part
13 of the discussion was, you know, perhaps SAMHSA might
14 want to think about doing some type of a demonstration
15 grant program or what have you.

16 And knowing that one of the functions of the
17 National Advisory Council would be to work on, like, a
18 specific task or such, and Matthew came up with the
19 thought, and I guess I'll punt to you if you want to
20 take a minute or two just on this question. Would you
21 like to work on as a group, you know, what a

1 demonstration grant might look like if SAMHSA were
2 going to do that?

3 And so, Matthew, I don't know if you want to
4 flush that out. Not putting you on the spot, but kind
5 of what's the role of the NAC if that were to happen?

6 MR. MATTHEW AUMEN: Well, it's self-explanatory,
7 I guess. But the NAC certainly has an opportunity to
8 create formal recommendations for SAMHSA to act, and
9 this could be one of those. If the Council would like
10 to get together and put together a -- whether it be a
11 research document or a paper or some sort of
12 conceptualization document of what a -- I'm at a loss
13 for words.

14 MR. RICH LUCEY: Like a position paper or
15 something, or demonstration.

16 MR. MATTHEW AUMEN: Yes. So what a demonstration
17 project or whatnot would look like. That's certainly
18 within the scope of your role as a Council. That
19 could be something that could be worked on over a set
20 period of time. It doesn't have to be something
21 that's worked on and decided on before our next

1 meeting. It could be something that's worked on over,
2 you know, whatever time the Council prescribes itself
3 to do that.

4 So is that something that everyone thinks is
5 something that's tangible that you can grab onto and
6 further investigate?

7 MR. RICH LUCEY: Seeing at least nodding heads in
8 the affirmative on this side of the table. So I
9 guess, Matthew, that's something we would further
10 flush out with them either electronically or through a
11 conference call or just soon.

12 MS. FRANCIS HARDING: Yes. I also -- this is
13 Fran. I think that it would also help if we go
14 through the conversation tomorrow on integration in
15 general and the bigger question because we'll be going
16 through these questions again. And Suzanne Fields
17 will be taking us through them, and she has a lot to
18 add. Yes, Dianne?

19 MS. DIANNE HARNAD: I just hope that the
20 demonstration project isn't just a little funded
21 demonstration, that it incorporates a lot of what many

1 of us said today has to be systems-wide organizational
2 issues need to be looked at like language integration,
3 different models. So it's not just come up with a
4 demonstration project. It's something bigger.

5 MS. FRANCIS HARDING: And I think, yes,
6 demonstration I think was used as an example. I think
7 that to me it's more of a work plan of different
8 pieces. But again, my recommendation is let's go
9 through the conversation tomorrow. Matthew will then
10 send out a note. We'll regroup through emails and see
11 if there's any traction. We're throwing out a lot of
12 decisions here for you to make.

13 So I think that it will just take a little bit of
14 time unless there's someone who's just, you know,
15 hearing this and saying this is really, really what I
16 want to take on. That was sort of a serious question
17 because, you know, sometimes things hit you. I don't
18 see that, so.

19 MR. MATTHEW AUMEN: So this is Matthew. The
20 decision is really are you interested, and it seems as
21 though there's interest. So moving forward, you know,

1 we can put together the ideas and figure it out. We
2 don't have to make that determination right now that
3 you're going to act on putting something like that
4 together. It does at least seem like there's
5 interest.

6 MR. RICH LUCEY: Okay. And to wrap up, the third
7 and final thing on my to do list in this eight minutes
8 was to -- which of the lucky NAC members is going to
9 be the reporter out for the CSAP NAC at tomorrow's
10 meeting on this topic? And short of putting all your
11 names in a bowl and having a *Hunger Games* type of
12 reaping --

13 [Laughter.]

14 MR. RICH LUCEY: We're looking for a volunteer
15 rather than a volun-told. And again, you'll have not
16 only your own notes, but I guess maybe a quick confab
17 with Nel and her notes to help formulate your
18 thoughts. And I don't know if it helps. Matthew, do
19 you -- or Fran, at last meetings when this has had to
20 happen, how much time -- I mean, I don't know that --
21 part of it may be the trepidation to volunteer. Are

1 they supposed to talk for 10 minutes, or it just a
2 five-minute, I mean, tomorrow? I don't know.

3 MS. FRANCIS HARDING: Yes, I was going to say
4 what has happened in the past is what -- Suzanne is
5 doing this one tomorrow, so it's not Pam. But when
6 Pam does it, she would set the stage, and then go
7 through these questions and ask from each of the --
8 no, it's not a you must have an answer to every
9 question either. It's does anybody have anything
10 additional to add, because you certainly don't want to
11 pare it back what we have that three other people just
12 said.

13 And again, you have a very -- there's a great
14 opportunity for us in prevention because there won't
15 -- you like the way I said that better, Steven --
16 there won't be a lot of competing voice on prevention.
17 So there's -- you'll have a lot more flexibility to
18 express yourself in my humble opinion.

19 So you can think about it. We want to move on.
20 And before we leave, we won't let you out until we get
21 a volunteer or --

1 [Cross talking.]

2 MS. FRANCIS HARDING: Well, you know --

3 MR. RICH LUCEY: It was either Patricia or
4 Michael.

5 MS. FRANCIS HARDING: No, no, in Michael's
6 defense, he said -- just so you know, he said I
7 would've loved to have done that. And he was sincere
8 because as you can tell, this is his thing. This is
9 his field. Unfortunately, he has to go an
10 international conference tomorrow morning.

11 UNIDENTIFIED SPEAKER: [Off mic.]

12 MS. FRANCIS HARDING: When we started off this
13 conversation, we were not going to pressure anybody.
14 You guys do the pressuring, we can't.

15 UNIDENTIFIED SPEAKER: [Off mic.]

16 [Laughter.]

17 MS. FRANCIS HARDING: She's a newbie. We're
18 throwing a newbie in? Okay. Kathy, up for the
19 challenge? We'll give you everything we have.

20 Oh, and by the way, you can chime in and help
21 her. So this is not -- this isn't a very strict

1 conversation. I mean, obviously they want
2 representatives so that we have a voice and there's
3 somebody I can -- if I were doing it. I'd say Kathy,
4 and then she starts to say something. But, you know,
5 there's something else that we talked about, and then
6 Steven jumps in and answers it. It's a very -- you've
7 been through these before.

8 UNIDENTIFIED SPEAKER: [Off mic.]

9 MS. FRANCIS HARDING: I would get that in
10 writing.

11 [Laughter.]

12 MS. FRANCIS HARDING: So at the end of the
13 meeting, you let us know if you're -- if the peer
14 pressure worked.

15 UNIDENTIFIED SPEAKER: The peer pressure worked?

16 MS. FRANCIS HARDING: Yes. Thank you. Okay.
17 And he's writing notes for Kathy.

18 [Laughter.]

19 MS. FRANCIS HARDING: So as a reminder, we took
20 away your break, so please do feel comfortable to get
21 up, and we won't talk about you when you're out of the

1 room, and we won't think you're leaving now that Kathy
2 has taken the pressure off.

3 We have also been joined with two guests that we
4 want them to for the record and for the NAC, first
5 invite our colleagues from Center for Mental Health
6 Services, and have them introduce themselves. So the
7 way we do it is who we are, what we're doing. And it
8 will become, I think, why you're here, not to mention
9 you just love prevention.

10 DR. RICH MCKEON: We do just love prevention. My
11 name is Richard McKeon. I'm the Chief of the Suicide
12 Prevention Branch within the Center for Mental Health
13 Services.

14 MS. INGRID DONATO: Hello. My name is Ingrid
15 Donato. I am Chief of the Mental Health Promotion
16 Branch within the Center for Mental Health Services.
17 And with Richard, we represent your prevention annex
18 in the Center for Mental Health Services where we are
19 tirelessly advancing the work of prevention while
20 being respective of congressional authorization. So
21 thanks so much for having us here.

1 AGENDA ITEM: STRATEGIC INITIATIVE #1: 2015-2018

2 MS. FRANCIS HARDING: Okay. So yesterday for you
3 and for the public to know, CSAP/NAC spent a half a
4 day discussing both integration and SI 2.0. And so,
5 what we wanted to do here in the short time that we
6 have, which I think is about -- I think we go until
7 3:30, 3:25 to giving us some transition time -- to
8 discuss -- to go over some of the areas that we
9 discussed yesterday so it's in the record.

10 I'm very happy you're here because some of the
11 questions that came up yesterday, particularly about
12 goal number three around suicide, I think you'll find
13 very interesting in the conversation. And I open this
14 up for individuals. You don't have to stand on
15 script. So what you said yesterday, if you need to
16 change your mind today, you go right ahead.

17 But we didn't want this to go off the record. We
18 wanted to be able to have an informed discussion going
19 forward. And at the end, the reason why I'm leaving
20 five minutes is we're going to talk about a task that
21 we think that you would want to help us with and

1 formally recommend to the National Advisory Council
2 certain changes to the SI. So that's -- so you can
3 think about that as we're going through the
4 conversation.

5 So what I have here is a -- some of the changes
6 that we discussed yesterday in the SIs or in the
7 goals, rather, and in some cases in the metrics. And
8 I'm going to say group number one or group number two.
9 We're just collectively going through them.

10 So goal 1.1, there have been some wording
11 changes, particularly around -- instead of behavioral
12 health issues, just talk about behavioral health in
13 general. Add community level wellness as well as
14 state and leadership, and then responding to emerging
15 issues rather than focus on emerging issues. Focus is
16 not an active measurable word. So those are the kinds
17 of things right off the top.

18 Some of the three areas that came up for
19 discussion is the need to build capacity within
20 prevention, moving forward with health and wellness in
21 this particular goal, the need for communication

1 engagement to build into the goal somehow, and the --
2 to add integration into the goal. Somehow we left
3 that out, and it was pointed out to us that if this is
4 all about integration, how could we have left that out
5 of the goal?

6 The objective 1.1, providing policy and
7 leadership, the -- well, that's wordsmithing. So not
8 a lot of change to that particular objective.

9 Objective 1.2, which relates to tobacco,
10 basically the -- the change is to add "prevent," not
11 only reduce, but prevent tobacco use from the
12 beginning. Interesting that that was left out. Also
13 some of the anecdotal issues were to allow communities
14 to identify these components of wellness. And it's
15 particularly tied, which we've been talking all day,
16 to physical health, exercise and smoking, other
17 diseases and smoking, and that kind of a thing.

18 1.3, "Provide leadership to prevent and address
19 emerging behavioral health issues in a comprehensive
20 and coordinated manner." I'm stumbling here a little
21 because there's like all -- everything is chopped up,

1 so I don't have the goal written out the way it was.
2 The only suggestion from yesterday's conversation was
3 to once again add community education within the body
4 of the objective.

5 And then objective 1.14, "Focus on prevention of
6 serious mental health issues to include
7 identification." Oh, I should say the goals were re-
8 worded -- re-numbered. I forgot to say that off the
9 bat. It wasn't on here, but it's all coming back to
10 me. We took the four objectives and we rearranged
11 them because the 1.1.4 used to be 1.1.1. That's what
12 reminded me. So focus on prevention of serious mental
13 illness to include identifications of persons at risk
14 for psychosis and identification of risk factors, such
15 as childhood trauma related to the development of
16 serious mental illness, and including psychosis.

17 The big question that came up was why psychosis.
18 And the background for risk, commonalities, prevention
19 science looks at risk factors. Psychologists observe
20 many other common factors earlier than psychosis.
21 Interesting question.

1 Discussion of childhood trauma versus
2 intergenerational and veteran trauma, point to include
3 overarching community education among stakeholders.
4 Again, the word "focus" is inserted in this. We can't
5 measure focus. We're going to change that to a
6 measurable action word. And it came up to why are we
7 not looking at reflecting mood and anxiety disorders
8 along with psychosis. If we need to bring in
9 psychosis, early identification, then why are we
10 skipping over mood and anxiety disorders?

11 Now, there are answers to the thought process
12 within SAMHSA, and we'll -- and let me finish with the
13 metric, and then we'll stop for a second, have a quick
14 conversation about any and all of this, and then we'll
15 go forward.

16 So the only change on the metric is to include --
17 do you all have it front of you so I don't have to
18 keep reading? No, you don't. Okay. "Increase the
19 number of positive changes and prevention outcome
20 measures reported by states in the substance abuse
21 block grant and mental health block grant." The

1 proposed change was to add "including enhanced
2 capacity of states, territories, tribes, and
3 communities across the Nation to respond to changing
4 needs."

5 Some of the questions for this particular metric
6 was is there a measurable -- in other words, is it
7 measurable? Do we have the ability to make this
8 measurable? Do we know where to go to find that
9 answer out?

10 Drug free communities don't receive feedback from
11 SAMHSA. I don't know what means. Grantees don't have
12 access. Okay. Block grants don't have the metrics
13 for capacity development, which is interesting.
14 Skipping on some of these, and OMB is setting the GPRA
15 measures you can't kind of move those too much.
16 That's one of the -- I know in our group we talked
17 about the political influences on some of these SIs.
18 And that very well could be one.

19 So any overarching comments? Does it sound like
20 some of the things you talked about in your group?
21 Are there some glaring issues that that maybe we

1 missed? Is there something that you're hearing for
2 the first time that you question? Are they valid?
3 Have they come up before? Have you heard this,
4 Richard and Ingrid, at all -- particularly about this
5 psychosis question?

6 DR. RICH MCKEON: Well, I can just mention a
7 couple of things. Clearly I think the -- when you
8 look at serious mental illness, you could
9 theoretically look at the development of mood
10 disorders, depression and bipolar illness, as well as
11 schizophrenia. And, of course, anxiety disorders are
12 one of the most prevalent, and are often very severe
13 in their own right. And all of them are associated
14 with increased risk for suicide and for suicide
15 attempts. So they all certainly are important.

16 I think there has been a particular focus on work
17 with early identification of psychosis, and prodromal
18 syndromes, and first episode psychosis. And I imagine
19 in part it's because there's been a lot of recent
20 work. NIMH has been involved heavily in that, so I
21 think that that is certainly -- that is certainly part

1 of it. Ingrid, you are more involved in that
2 particular area than I am.

3 MS. INGRID DONATO: Right. No, I think that's
4 really it. We have a lot of very exciting new and
5 emerging research science. There's a lot of evidence
6 that is backing an emphasis on addressing early
7 psychosis issues. We realize that if we are able to
8 effectively reduce the onset of psychosis, there is
9 also a reduction in the costs. You know, this is a
10 very devastating illness, and if we are able to make
11 significant reductions in this very serious mental
12 illness, the cost savings, the impact on our
13 behavioral health systems instructors will show some
14 meaningful impact.

15 MS. FRANCIS HARDING: Thank you. Any questions?

16 [No response.]

17 MS. FRANCIS HARDING: We're good? We're not
18 getting into tremendous detail because this is --
19 again, we're doing this for the public record, and we
20 just want people to know what's in the -- what's being
21 proposed and some of the reactions of the high-level

1 proposals.

2 So goal number -- thank you very much for that.

3 Goal number 2, "Reduce underage drinking and young
4 adult problem drinking," is the goal that's proposed.

5 If it sounds familiar and looks familiar, it's because

6 it is. We haven't -- SAMHSA has not proposed to do a

7 lot of change to that, although we have been -- we

8 have proposed to look into different ages and

9 populations. One is to look at the negative effects

10 in the college age area. Second is to look at the

11 young adults that are not in college and their

12 underage drinking issues. And the third is to look at

13 increase our cooperation with the Federal government

14 more around the issue of underage drinking.

15 So the conversations really have been more about

16 we are doing a good job in the country lowering the

17 underage drinking rates for 12 to 17, and we are now

18 looking at the other areas of concern, age groups,

19 particularly around binge drinking and heavy drinking

20 with higher education and such.

21 Any questions on goal number two?

1 [No response.]

2 MS. FRANCIS HARDING: Okay. Now, this is where
3 we'll hear a lot from Dr. McKeon possibly. Our third
4 goal is "To prevent or reduce suicides and non-fatal
5 attempted suicides among populations at risk,
6 especially working age adults." We're proposing to
7 look at ages 25 to 64. We are also proposing to look
8 at men in mid-life ages 35 through 64. And suicide
9 attempt survivors, military service members,
10 Reservists, veterans, and their families, American
11 Indians, Alaska natives, Pacific Islanders, and the
12 LGBTQ population.

13 It says youth, but after a conversation I'm
14 thinking maybe youth, maybe not youth, although that
15 was one of our discussions was focusing on the culture
16 of youth within the LGBT population in general. We do
17 not have currently something that pulls them out, and
18 that was something that we had in our work group,
19 conversation around that.

20 Our objectives range from -- there's been a lot
21 of work on this, Richard, that when we get the notes

1 finalized and written up, you will certainly get a
2 copy of that once we hear from the public and we hear
3 tomorrow during our discussion with the integrated
4 National Advisory Council. We were actually looking
5 at attaching some of this to the goal number eight of
6 the National Strategy for Suicide Prevention and
7 making more of a connection there. The NAC members
8 are also looking at regarding the use of the term
9 "promote" rather than actually having it a little bit
10 more of an intervention action tool.

11 A greater emphasis on referring to treatment
12 services for some of our youth and young adult
13 population that we're looking at. As a matter of
14 fact, then on the other side, there was some
15 conversation by one of the groups that perhaps this
16 goal is very treatment oriented, so you got it from
17 both sides. And that may be that we should be looking
18 at terminology at brief intervention or brief
19 treatment -- excuse me -- rather than just straight
20 out treatment. More concentration on maybe a
21 continuum of care that includes more prevention, and

1 integration of screening and treatment to reach out to
2 prevention and coordinate. There seems to be a theme
3 here, and that is under the second objective if you're
4 following along in yours.

5 Although there is a comment that this happens to
6 be one of the issues that SAMHSA's prevention
7 community seems to be both gravitating to and working
8 across, both substance abuse and mental health. So
9 people seem to have a good feeling about that, that
10 we've gotten the message across. So I found that to
11 be very positive.

12 The objective, 3.3, "To promote rapid follow-up
13 of individuals who have attempted suicide or
14 experienced a suicidal crisis." A lot of conversation
15 around the term "follow-up." What does that mean?
16 Should we be more descriptive?

17 In one of the groups -- this came up a lot with
18 all of the goals that they should be more descriptive
19 in what exactly we're trying to express, so that the
20 reader who is not as informed as we who sat down and
21 read it. But that's for all of them. I'm just

1 picking it up right in goal number three, but it was
2 in all four goals in general.

3 Something that I know that is one of those things
4 that may not need to be stated, but the comment came
5 up just the same that perhaps SAMHSA should take into
6 consideration to treat individuals who have already
7 attempted suicide once differently than someone who
8 when we're just preventing suicide in general. I'm
9 sure that you've got experience in that.

10 And then to increase the public awareness of
11 suicide more, really get that message out there. We
12 also had an interesting conversation -- actually
13 Jorielle sitting next to you was a great spokesperson
14 on this of what was the National Alliance, and how
15 does that interplay and what role does it have. And
16 then we were able to then also bring in the strategy
17 -- the national strategy. So the group was very
18 interested in that, and I kept telling them that you
19 were coming, so they were waiting for you, so they may
20 have a lot of questions.

21 The metric that we're looking at, the example

1 drew everyone's attention in a proposal that we're
2 actually looking possibly at zero suicides. That's
3 quite an ambitious goal. We gave them -- so we talked
4 about that. Some liked it. Some didn't. I suspect
5 we'll get those comments very similarly. I'm sure you
6 have already had that conversation. And then there's
7 no real emphasis on family, and they wanted to bring
8 that in the family, which sounds pretty on target as
9 well.

10 Any questions? Anything you'd like to say,
11 keeping in mind that we're not getting too much into
12 the weeds, but around some of what came up here,
13 because I just think we're in a unique situation that
14 you're here in this particular goal.

15 DR. RICH MCKEON: Sure. I'd be happy to make a
16 couple of comments, and I'll try to keep it brief
17 because I know that you have a packed agenda. And
18 certainly thank you for sharing the feedback from
19 yesterday, and, you know, I'll look forward to being
20 able to look at it in more detail.

21 But certainly, none of that feedback would be

1 anything that we would disagree with, you know, at
2 all, and can certainly be open to in terms of how we
3 craft the language.

4 Let me just mention a couple of key points that
5 inform the revision of the goal, the objectives, and
6 the metric. So one would be -- really the major
7 change, I think, in the goal itself really has to do
8 with the problems of the populations that are
9 referenced. Problems weren't dropped, but it really
10 reflects a recognition that in the United States, the
11 largest numbers of suicide are occurring in mid-life,
12 and among men in particular where there's a four to
13 one ratio of deaths by suicide.

14 And so, we feel that -- so in order to
15 meaningfully reduce suicide rates in the United States
16 will require getting to the population. And so, that
17 was the reason for adding language, you know,
18 especially working age adults. And it's not that we
19 think that people are unimportant or that youth are
20 unimportant -- in fact, our Garrett Lee Smith grant
21 programs, most of our funds by statute or age 10 to

1 24.

2 So this is a way of emphasizing that suicide
3 prevention can't stop at age 24 because many, many,
4 many of the deaths are occurring between age 25 and
5 64, and of course older Americans also have an
6 elevated rate.

7 And then in terms of the objectives themselves, I
8 think you correctly noted that there is a strong
9 healthcare component to this, an important piece of
10 the national strategy, which is a comprehensive public
11 health approach, is trying to get healthcare systems
12 to include suicide prevention as a core priority. And
13 you may think, well, aren't they already doing that?
14 And really, no, they're not, not in general.

15 There's kind of an assumption that if you're
16 doing mental healthcare, you're doing suicide
17 prevention. The evidence suggests that doing kind of,
18 you know, treatment as usual mental healthcare is an
19 important component, but there are many other things
20 that need to be done. Suicide prevention is very
21 challenging. And so, it really requires a

1 comprehensive approach, and it needs to be made a core
2 priority of who wants to do it successfully.

3 The issue around rapid follow-up of individuals
4 who have attempted suicide or experienced a suicidal
5 crisis is reflective of the fact that this is an area
6 where we know we have some of the strongest evidence
7 that we can save lives. But we also know that the
8 rates of people leaving emergency rooms, inpatient
9 units, that they have high rates of death by suicide
10 and non-fatal re-attempts, but poor rates of
11 connection to services. And so, despite the fact that
12 we -- that there is -- the only areas that have shown
13 reductions in actual deaths by suicide in randomized
14 control trials are focused on just that area.

15 The public knowledge of the warning signs is
16 really part of the broader public health approach, and
17 the idea that when we want to raise awareness of
18 suicide, it's not just saying the numbers are
19 terrible, even though the numbers are terrible, that
20 the message has to be telling people what they can do,
21 not just that it's a problem. And so recognizing the

1 warning signs and what to do in response, such as
2 calling the National Suicide Prevention Lifeline,
3 which last year answered over a million calls, would
4 be an example of that.

5 And let me just reference in terms of the metric
6 because we didn't go into any detail, and that zero
7 suicide is clearly a provocative notion in some ways.
8 But the reason that some of these efforts have been
9 called the zero suicide initiative started with some
10 work done in the Henry Ford Healthcare System. But
11 what it comes down to is that if you aim for zero, you
12 do things differently than if you say it's really hard
13 to prevent suicide, let's see if we can get a five
14 percent reduction. You approach it differently, and
15 it really backs up the idea that to really reduce the
16 rates, you have to make it a core priority. You have
17 to make sure that people are trained. You have to
18 make sure that care isn't fragmented. You have to
19 make sure you have data driven quality improvement
20 efforts, et cetera.

21 So there is a heavy healthcare system emphasis,

1 but it is within the context of a comprehensive public
2 health approach. So as you can probably tell I could
3 go on for a long time, so I won't. But I'll stop
4 there, and, you know, whatever will be most helpful,
5 just let me know.

6 MS. FRANCIS HARDING: I thought that was
7 excellent because it helps us with the frame of
8 reference to some of the questions that came up
9 yesterday that we didn't have that level of detail of
10 explanation. And that's exactly some of the questions
11 we were getting is that the -- for every single one,
12 and correct if I'm wrong. My memory may not be the
13 same from yesterday for the people that were in our
14 group, that we needed to have more explanation in most
15 of these, just like what you said, to be able to help
16 people understand why were these goals chosen, why
17 were the objectives given.

18 For instance, on a -- well, first of all, before
19 I go on, any questions for Richard on that? Yes,
20 Michael?

21 MR. MICHAEL MONTGOMERY: I was curious about the

1 inclusion, and now you're saying that the high rates
2 of suicide among middle-aged men -- that's younger
3 than me. Does that exclude the military, the epidemic
4 of suicides among military men?

5 DR. RICH MCKEON: No, it doesn't exclude them at
6 all. But when you look at the overall burden of
7 suicide in the United States, I mean, we, of course
8 are incredibly concerned about suicide among our
9 active duty military, which ranged -- it was about 300
10 to 400 suicides a year fall into that. By comparison,
11 suicide among veterans, about one in every five
12 suicides in the United States is by a veteran. So by
13 comparison, we're talking about perhaps about 8,000 --
14 between 7,500 and 8,000 suicides by veterans,
15 significantly more than among active duty military.

16 That being said, we work very closely both with
17 the Veterans Administration as well as with the
18 Department of Defense on our suicide prevention
19 efforts. And the National Suicide Prevention Lifeline
20 has a feature whereby if you press "one" connects to
21 the crisis center in Canandaigua, New York. It's run

1 by the VA, but it functions as both the veterans'
2 crisis line and the military crisis line.

3 And over time it's basically become the focus of
4 immediate intervention and in getting the word out
5 about how to access care at any time of the day or
6 night. So by no means does it exclude military
7 service members or veterans, and they are referenced
8 in goal 1.3.

9 And I should mention as well for our Garrett Lee
10 Smith grants, which are by statute age 10 to 24, we've
11 also been focused -- we know we lose some of our
12 active duty military as well as some of our veterans
13 who, you know, are in the 18- to 24-year-old category.
14 And we're trying to figure out how to best work and
15 engage them.

16 Later this Fiscal Year, there is going to be a
17 policy academy or implementation academy that's going
18 to be focusing specifically on suicide prevention with
19 these groups.

20 MS. FRANCIS HARDING: Okay. So I'm moving on to
21 the last goal, which is reduced prescription drug

1 misuse and abuse. The biggest change to this goal are
2 some of the objectives are more focused on actual
3 opiate abuse -- the prevention of opiate abuse, and
4 what tools we have to look at how those balance out
5 with overall prescription drug misuse.

6 So one of the comments here was to -- we were
7 going from prescription proper, everything from
8 education drop offs and that kind of thing, and then
9 we jumped to opiate abuse, and then we jumped back to
10 third goal -- the third objective was focusing back on
11 more of a general prescription use misuse, and then
12 around education. And then the last one focuses back
13 on opiate abuse and drug testing.

14 So the conversation was more, not that they have
15 a problem with what is being proposed, but the wording
16 is a little bit off. So we're re-numbering those
17 metrics. And again, as with all of these, tighten up
18 the metrics to become more of a percentage that we're
19 going to reduce a percentage or reduce a number, and
20 not just use the word "reduce." We use the word
21 "reduce" a lot.

1 And one of the -- and the last thing, which I
2 skipped over, which I can't believe I did that, and I
3 can't believe John didn't jump in and say, Fran, you
4 forgot something. In goal number two on underage
5 drinking, there is a proposal on the table that we
6 include back in the focus on the younger children --
7 younger kids, 12 to 17. Even though we are doing well
8 with that age group, they're part of our metric. So
9 if you're going to have them part of your metric, then
10 we should have an objective to do that. Do you have
11 any comment on that, Mr. Lucey?

12 MR. RICH LUCEY: Oh. Other than, well, we had
13 thought about that and we put it aside. So quickly,
14 what Fran has structured for the strategic initiative
15 is there are certain staff who are designated as leads
16 or co-leads on these certain goals. Ingrid, for
17 example, is one of the co-leads on goal one, Rob
18 around goal two. And when we were looking at the
19 revision of strategic initiative number one for Fiscal
20 Year '15 and beyond, Fran and Rob and I tackled goal
21 two around underage drinking.

1 And so, I put the proposed objectives together,
2 shot them out by email. We looked at them,
3 wordsmithed them a little bit, and then we all came to
4 agreement and said, yeah, these look good. And then
5 in hindsight, a little bit later that day, I wrote to
6 Rob and Fran and I said, all right, so I'm the one
7 that wrote these, and I realize we left out 12- to 17-
8 year-olds. Should we put them back in?

9 And we intentionally left them out only because
10 we felt that they were indirectly, but that's part of
11 the issue, addressed in the third objective, which is
12 around coordination and collaboration among the
13 Federal partners, which is the ITPUT, the Interagency
14 Coordinating Committee for the Prevention of Underage
15 Drinking. I think it's an easy fix, so to speak, to
16 easily put them back in. I also saw another comment
17 about possibly collapsing two of them. I think that's
18 an easy fix that we can do if we decide to do that.

19 And third, just quick comment I'll make, I wasn't
20 at yesterday's discussion. I see that there was
21 possibly some conversation around including the phrase

1 "high risk drinking" in there. I personally would not
2 have an issue with that, but I think it would need to
3 be defined. And from my work, and John knows it, from
4 the Department of Ed, we had a more or less
5 operational definition of what high risk drinking is,
6 and we have flushed that out. We may just want to
7 adopt that definition. Since it went through a
8 *Federal Register* public comment period and everything,
9 I don't think there's any reason why we couldn't.

10 But it includes things like underage drinking,
11 drinking while impaired, drinking while taking meds,
12 drinking while affected with mood disorders and
13 depression, those types of things. So it encapsulates
14 a lot. So I appreciate the discussion you had on this
15 particular goal yesterday.

16 MS. FRANCIS HARDING: So the last thing I have to
17 say, which should've probably been the first thing I
18 had to say, was to remind everybody of the process.
19 And I want to restate, and I can't remember if we
20 talked about this in our small group or our last
21 group, so bear with me. But the time spent on the

1 strategic initiatives for the last four years has
2 really been probably some of the most productive time
3 because it has really turned out to be quite the
4 guiding document for SAMHSA to keep focused.

5 And when you're getting hit with all crises, and
6 people's favorite projects, and emerging issues, and
7 all that we get hit with over the last 4 years, it was
8 very, I won't say "comforting," but it was very
9 helpful to have the initiatives that we knew while
10 we're doing everything else, there were four areas in
11 prevention that we had to focus on and make sure that
12 we followed, performed, and met our objectives and
13 metrics.

14 We are all -- and these are all part of our
15 performance reviews. This becomes a real, living,
16 breathing document for us. And to add to that, so the
17 only thing we really changed was the wording of goal
18 number one. And we -- that's the one that I'm not
19 surprised got the most attention, and not necessarily
20 confusion, but a lot of questions on the why and the
21 how and, you know, what did you do. And actually we

1 talked about moving a couple of other things up there,
2 and if it were up to the small group I was in, there
3 would be eight objectives, which, of course, Pam said
4 absolutely not.

5 But the reason is because we have learned over
6 this last four years a lot more about integration and
7 primary care. We also have learned that there are
8 emerging issues, both on the addiction side as well as
9 in mental health and the prevention of mental health
10 disorders and such.

11 So we really struggled with how were we going to
12 word a particular goal to fit just about any need that
13 may come up between now -- a huge need that comes up
14 between now and 2018. In the addiction world, we know
15 we fight so desperately not to chase today's drug
16 problem. And so, that's where the emerging issues
17 came up because we also knew that there are a lot of
18 issues out there that we're going to take a look at,
19 not just the serious mental illness, but also the
20 psychosis, the mood disorders or anxiety. I was
21 quoting from one of the people in the group, but

1 anxiety disorders.

2 I have found personally over the last four years
3 goal number one was almost the easiest goal to work
4 within because it was that emotional wellness piece
5 that seemed to bring both fields together pretty
6 quickly. They started to get it, and they understood
7 how programming and risk factors, you know, were
8 sometimes the same, sometimes overlapping in the
9 community.

10 So we've taken a stab at this. We thank you, the
11 NAC, for having your review, and we spent a lot of
12 time in discussion. Tomorrow there will be another
13 discussion on the SIs moving forward, but obviously
14 all of them.

15 And if you remember from yesterday, we kind of
16 bled over to several of them, workforce being one of
17 the biggest ones that we were talking about, and
18 trauma, and justice, looking at some of what was
19 happening in prevention at the moment and what some of
20 these goals and objectives, particularly no surprise,
21 goal number one and goal number three.

1 And then, of course, the ever, you know, hanging
2 around problem in our country about our love-hate
3 relationship with alcohol and where that fits into
4 overall health. And then the emerging issues that are
5 coming up consistently around prescription drugs.

6 So we will be sending this out, all of our
7 thoughts. We'll add that -- you'll have that in
8 addition to what comes out of the conversations
9 tomorrow with the joint NAC, which will be, of course,
10 across the board for all of them.

11 My role tomorrow is to just talk about the goals,
12 what we've proposed, none of this detail, and why we
13 proposed it if we get a question of that nature, and
14 all of the other five strategic leads for 2015-2018.

15 So we thank you for all of this. And I'm just
16 here to tell you this is the first time you're seeing
17 it, but it won't be the last. It does take -- it
18 takes a while because the general public comment is
19 taken very seriously. And I remember last time
20 because we didn't include workforce, we got, you know
21 "thousands" is an exaggeration, but hundreds and

1 hundreds, close to a thousand comments on why did you
2 do that, why did you drop it. So it will be
3 interesting to see now that we've added in workforce
4 what comes out and what do they focus on next. So
5 thank you.

6 Any lasting comments before I turn it over to
7 Matthew?

8 [No response.]

9 MS. FRANCIS HARDING: And we thank our partners
10 from CMHS, who are embedded. This is their SI as much
11 as it is CSAP's, and it's the one area that we
12 collaborate pretty well together. We almost are to
13 the point where we finish each other's sentences, and
14 that's a little scary. But the depth of knowledge
15 that they bring to the table outweighs basically
16 anyone else around the table, unless you're in that
17 business. So it's so valuable to do this.

18 And we are the one few SIs that actually have
19 this integration from the very beginning, so it's like
20 what we talked about yesterday a little bit, that
21 integration for substance abuse and mental health.

1 We're over it. I mean, we're there, and Kathy and I
2 were talking about that, too. It's time now to talk
3 about the behavioral health integration with primary
4 care, which we have spent the bulk of our time today
5 discussing, and we'll spend a big chunk of the time
6 tomorrow discussing. So thank you, and I turn it over
7 to Matthew.

8 AGENDA ITEM: PUBLIC COMMENT PERIOD

9 MR. MATTHEW AUMEN: All right, folks. So each
10 meeting we want to give the public an opportunity to
11 make comments. So at this time, anyone from the
12 public who wants to make a comment is invited to do so
13 and address the Council, folks either here in the room
14 or on the phone. And hopefully the phone didn't
15 just --

16 MS. FRANCIS HARDING: No, no, no, public comment
17 period.

18 MR. MATTHEW AUMEN: Oh. I thought I heard a
19 beep, so I hope we didn't get hung up on. But for the
20 -- I have a script, and it's amazing, and I can read
21 from it. Oh, I probably have Fran's, but the same

1 thing. And the operator will coordinate opening lines
2 for folks who are on the phone for each person to
3 speak. Those on the phone and here, please make sure
4 you introduce yourself, provide your name, and speak
5 clearly into the microphones we have around the room.
6 I think we do have a floor mic, but it's not picking
7 up on the transcription, so we'll try to use table
8 mics.

9 And it depends on the number of comments, we
10 might limit you to a few minutes so that we don't drag
11 on and go past 4:00, so if that's possible.

12 OPERATOR: If you would like to ask a question
13 from the phone line, please --

14 [No response.]

15 MS. MARIA BOBROVNYK: This is Maria Bobrovnyk,
16 American Public Human Services Association. I note
17 Dr. Compton talked a lot about prevention and the role
18 of the primary care physician. And I was just
19 wondering if any of you could elaborate on specific
20 examples of this prevention. When you talk about
21 prevention, do you mean generally just educating and

1 counseling the patient and just more awareness of
2 certain conditions? Is that what prevention, so to
3 speak, means, just more education of the patient?

4 And then also if you could just give some
5 specific examples of how a physician would do this.
6 Would it be something where they go back and show a
7 medical history and see -- family medical history and
8 see maybe what mental health conditions they could be
9 predisposed to, and then educate them on the role of
10 stress and those conditions coming about, or something
11 along those lines? What would be prevention
12 specifically be?

13 MS. FRANCIS HARDING: All very good questions,
14 very long, in-depth answers. So what we will do is,
15 particularly seeing that Michael Compton is not here
16 right at the moment, is we will -- your questions have
17 been recorded, and we will get back to you with the
18 answers to the questions that you've asked. Thank
19 you.

20 Were there any questions or testimonies or
21 comments from the phone?

1 OPERATOR: Actually, no questions from the phone
2 line.

3 MS. FRANCIS HARDING: Thank you. We have one
4 testimony that was sent in that Matthew will read for
5 the record.

6 MR. MATTHEW AUMEN: All right. I misplaced my
7 paper copy, so I have this Blackberry here. This
8 comment comes from Deacon Donald M. Clark, Vice Chair,
9 District Advisory Committee in the Twin Rivers Unified
10 School District. And that's McClellan, Sacramento
11 County, California.

12 And so he states, "It's very important that the
13 National Advisory Council, or CSAP, consider the
14 concerns of consumer peers who are parents and
15 grandparents raising children in the 5,000
16 chronically-troubled school districts, urban and
17 rural, in the United States.

18 First of all, is there anyone who can identify as
19 a parent or grandparent of K through 12 children in a
20 rural/urban areas and who identifies as very low and
21 low income in their family economic status? Likewise,

1 the Consumer Subcommittee should screen and select
2 members based on the fair and equitable criteria of
3 above.

4 Deliberation is being sought on this matter by
5 the NAC, and it's suggested that Director Harding make
6 contact or have staff seek out Deacon Clark regarding
7 consultation about the development interagency
8 relationship between CSAP and the appropriate agency
9 inside the U.S. Department of Education.

10 Major Federal laws, like the ACA and NCLB," which
11 is Affordable Care Act and the National --

12 UNIDENTIFIED SPEAKER: CLB?

13 MR. MATTHEW AUMEN: Yes. I thought I had it, and
14 I forgot. Okay. "The ACA and NCLB need to
15 collaborate by first establishing a national
16 demonstration project. Let's bite the bullet and take
17 everything to a higher level for consumers' peers
18 under national healthcare reform as it impacts on
19 prevention for mental health and substance abuse and
20 families who rear school children in the midst of
21 poverty."

1 So the NCLB is No Child Left Behind. And ACA is,
2 of course, the Affordable Care Act. So that comment
3 will be recorded for the record in the minutes, and we
4 will certainly put a response together as well.

5 MS. FRANCIS HARDING: Okay. Any other comments,
6 entries for -- from the public either on the phone for
7 the last time or in the room?

8 [No response.]

9 MS. FRANCIS HARDING: Thank you. Hearing none,
10 any other business issues that the NAC members have
11 that you really thought we were going to address and
12 did not since we have a minute?

13 [No response.]

14 AGENDA ITEM: CLOSING REMARKS

15 MS. FRANCIS HARDING: Seeing and hearing none, I
16 thank you officially for the work that you have done
17 for the National Advisory Council for the Center for
18 Substance Abuse Prevention. I thank all of our guests
19 and staff who attended the Council meeting. I thought
20 that we had some very good enriching conversation. It
21 seems to me we started up a lot of issues, so we have

1 set ourselves for a lot of work for the future.

2 To remind you that the next National Advisory
3 Council meeting is tentatively scheduled to be a
4 virtual meeting. We discussed that. You can express
5 your opinion about that tomorrow in the joint NAC.
6 And the date will obviously be chosen at a later time,
7 but the month we're targeting is August, just like we
8 did last year.

9 So I am going to turn this -- oh, and thank you,
10 thank you, thank you for your flexibility. Thank you
11 for anybody who is still on the phone. We know that
12 you had difficulty hearing us. We tried our best to
13 use the microphones where possible, but we got enough
14 word from you that that wasn't working out so well.
15 We apologize, and all I can say is thank you for
16 bearing with us. It's been a very difficult NAC
17 experience having to be shifted from outside of SAMHSA
18 was everything was all set up and ready to go. You
19 would not have had these problems.

20 Transcripts will be shared if you request them,
21 so you hopefully will not have missed any of this

1 particular experience. It was -- we talked about, I
2 think, two of the most vital issues that we are
3 looking at for now and the future moving forward.
4 One, structuring our strategic plan for SAMHSA to
5 follow and getting some of your input, and, of course,
6 the integration issue specifically focusing on
7 workforce for substance abuse prevention, and what
8 does that mean when we're talking about a behavioral
9 health field, and looking at substance abuse and
10 mental health disorder prevention, and how are we
11 going to engage the medical community, and how will we
12 get the medical community to accept and engage the
13 prevention community and all of our strengths.

14 We really covered a lot of material, and I
15 thought it was very enriching, and hopefully you did
16 as well. I will see you all tomorrow at the -- I'm
17 going to let the logistics be done on the left side
18 and the right side of me behind there. So we will be
19 transporting you to another location tomorrow. Do you
20 have the logistics? Sometimes has the time and the
21 place. We'll get all that to you. So I'm going to

1 pass this onto Matthew so he can officially adjourn
2 the meeting.

3 AGENDA ITEM: ADJOURN

4 MR. MATTHEW AUMEN: Okay, folks. Tomorrow from
5 what I recall, we are meeting in the HRQ building. I
6 don't have the address offhand, but if you go to the
7 SAMHSA website, there's an update on the meeting times
8 and locations.

9 So the joint Council will be meeting tomorrow
10 starting at 8:30 a.m., and looking at the agenda it
11 will run until 5:00 p.m. So registration is online,
12 and that can be done from the SAMHSA website.

13 Barring any other further questions or comments
14 from the Council.

15 [No response.]

16 MR. MATTHEW AUMEN: None? The meeting is
17 officially adjourned. Thanks.

18 [Whereupon, the meeting was adjourned.]

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