Table of Contents

PROCEEDINGS........................................................................................................... 4
Agenda Item: Call to Order.......................................................................................... 4
Agenda Item: Welcome, Introductions, Opening Remarks........................................... 7
Agenda Item: Consideration and Approval of the August 30, 2021,
Minutes....................................................................................................................... 13
Agenda Item: Update on SAMHSA Budget and Funding Opportunities................. 14
Agenda Item: Recent Reports to Congress -- Interdepartmental Serious
Mental Illness Coordinating Committee (ISMICC) .................................................. 23
Agenda Item: Council Discussion............................................................................ 28
Agenda Item: Recent Reports to Congress -- 988 Crisis Services........................... 32
Agenda Item: Council Discussion............................................................................ 38
Agenda Item: Language Matters: Cultural Humility and Unconscious Bias,
Including Material from the Office of Minority Health and
ONDCP....................................................................................................................... 50
Agenda Item: Council Discussion............................................................................ 54
Agenda Item: Center for Behavioral Health Quality and Statistics......................... 56
Agenda Item: Council Discussion............................................................................ 59
Agenda Item: Harm Reduction Grant and Stakeholders' Feedback......................... 64
Agenda Item: Council Discussion............................................................................ 70
Agenda Item: Office of Recovery.............................................................................. 76
Agenda Item: Council Discussion............................................................................ 80
Agenda Item: Public Comments.............................................................................. 87
Agenda Item: Closing Remarks/Adjourn.................................................................... 89
Council Members Present:

Miriam E. Delphin-Rittmon, Chair
Valerie Kolick, DFO
Rahn Kennedy Bailey
Laura Howard
Cristina Rabadan-Diehl
Francisco Rodriguez-Fraticelli
Sally Satel
Allan Tasman
Tracy Neal-Walden
Barbara E. Warren

Ex Officio Members:

Joshua A. Gordon
Jennifer A. Hobin
George F. Koob
Marsden H. McGuire
Aaron White

Other Participants:

Captain Jeffrey Coady
Tom Coderre
Dona M. Dmitrovic
Anita Everett
Anne M. Herron
Kurt John
Captain Michael King
Yngvild K. Olsen
Charissa Pallas
Mary Roary
Josh Shapiro
Phil Skolnick
James Wright
PROCEEDINGS

Agenda Item: Call to Order

MS. VALERIE KOLICK: So good afternoon, and welcome, everyone, to SAMHSA's 71st National Advisory Committee meeting. This is a virtual meeting, and I am Valerie Kolick. I am acting on behalf of Carlos Castillo today for the Designated Federal Official for the SAMHSA NAC.

I officially call this meeting to order.

Before we begin, I want to hand it over to Josh Shapiro, who's going to quickly go over an overview of the Zoom system, which I'm sure everyone has been inundated and probably doesn't need this, but we'll just check in and make sure real quick.

MR. JOSH SHAPIRO: Yep. So, really, for those on the phone, if you are on the phone and on Zoom, *6 is how you mute and unmute yourself, which is an important feature for you guys. But for everybody else, please do use the chat liberally, and we will be having discussions at the end of each session for everybody to be able to chime in.

So, if you have any questions, please feel free to chat me. Send me a private chat or shoot me an email. I'll put my email in the chat right now.

Thank you.

MS. VALERIE KOLICK: Thank you, Josh.

And I'm going to go ahead and do a roll call of our current members. If you can just unmute yourself and let me know that you're here, that would be great.

Tracy Neal -- Dr. Tracy Neal-Walden?

DR. TRACY NEAL-WALDEN: I'm here.

MS. VALERIE KOLICK: Welcome. Laura Howard?

MS. LAURA HOWARD: I'm here.

MS. VALERIE KOLICK: Hi, Laura. Francisco Rodriguez-Fraticelli?


MS. VALERIE KOLICK: Good afternoon. Dr. Barbara Warren?

Page 4 of 90
[No response.]

MS. VALERIE KOLICK: I know Dr. Sally Satel will be joining us around 1:30 p.m. Doctor --

MR. JOSH SHAPIRO: So, Dr. Warren -- Dr. Warren is here, by the way.

MS. VALERIE KOLICK: Okay.

MR. JOSH SHAPIRO: I just think she hasn't come off mute yet.

MS. VALERIE KOLICK: Okay. All right. Dr. Allan Tasman?

DR. ALLAN TASMAN: I'm here.

MS. VALERIE KOLICK: Welcome. Dr. Cristina Rabadan-Diehl?

DR. CRISTINA RABADAN-DIEHL: I'm here.

MS. VALERIE KOLICK: Thank you. Dr. Rahn Kennedy Bailey?

DR. RAHN KENNEDY BAILEY: Yes, I'm here. Good morning.

MS. VALERIE KOLICK: Good morning. All right. We officially have a quorum for the National Advisory Council meeting.

Now I'm going to move through the ex officio members and representatives. Again, if you can just take yourself off mute if you're here to let me know.

All right. Marsden McGuire, or a member from the Veterans Affairs?

DR. MARSDEN H. MCGUIRE: Present.

MS. VALERIE KOLICK: Great. Welcome. Thank you. George Koob?

DR. GEORGE F. KOOB: I'm here. Hi, everybody.

MS. VALERIE KOLICK: Hi, welcome. Joshua Gordon, or a member from NIMH?


MS. VALERIE KOLICK: Great, thank you. Nora Volkow? Do we have representation from NIDA?
DR. JENNIFER A. HOBIN: Hi, this is Jennifer Hobin, on behalf of NIDA. I'm sorry. My technology wasn’t working there.

MS. VALERIE KOLICK: That's all right. Thank you.

All right. Rick Mooney? Do we have representation from DOD?

[No response.]

MS. VALERIE KOLICK: Dr. Neeraj Gandotra?

[No response.]

MS. VALERIE KOLICK: Okay. Wilson Compton?

DR. JENNIFER A. HOBIN: Jennifer is here on behalf of Wilson.

MS. VALERIE KOLICK: Okay. As well as Ernestine?

DR. JENNIFER A. HOBIN: Correct.

MS. VALERIE KOLICK: Okay, great. Thank you. Aaron White?

DR. AARON WHITE: Present.

MS. VALERIE KOLICK: Thank you, Aaron. Patricia Powell?

[No response.]

MS. VALERIE KOLICK: Lindsay Drennan?

[No response.]

MS. VALERIE KOLICK: Aurelia Higginbotham?

[No response.]

MS. VALERIE KOLICK: And Secretary Becerra?

[No response.]

MS. VALERIE KOLICK: Just making sure I didn't miss anyone here. Did I get everyone?

[No response.]

Page 6 of 90
MS. VALERIE KOLICK: Okay, great. All right. Assistant Secretary of Mental Health and Substance Use Dr. Miriam Delphin-Rittmon will be joining us around 2:00 p.m. On her behalf, I would like to go ahead and introduce you to our Acting Deputy Assistant Secretary of Mental Health and Substance Use, Tom Coderre, to provide the official opening remarks.

**Agenda Item: Welcome, Introductions, Opening Remarks**

MR. TOM CODERRE: Thank you so much, Valerie, and welcome to everybody. It's great to be back with all of you at the NAC here.

We're going to recognize Dr. Satel when she joins, but this will be Dr. Satel's last SAMHSA NAC meeting, as her term is going to be ending in June of this year. And she joined back in 2018, and we really appreciate her commitment to the council and all her valued advice over the years. So, we'll take a moment to pause after one of the presentations after Dr. Satel is onboard.

Now I'd like to just go around online so that members and attendees can introduce themselves. I know Val did the roll call, but we'll start with the council members first, and we will then follow with any of the SAMHSA staff who are joining us today.

So, Val, could you call out the council members again?

MS. VALERIE KOLICK: Recall? Yes.

MR. TOM CODERRE: Just so they could briefly introduce themselves.

MS. VALERIE KOLICK: Yes. Dr. Neal-Walden?

MR. TOM CODERRE: Tell us who you are and what you do just briefly so that folks who are following can know who is here.

MS. VALERIE KOLICK: Thank you, Tom. Dr. Neal-Walden?

DR. TRACY NEAL-WALDEN: Hi, I'm Tracy Neal-Walden. I'm a clinical health psychologist. I served in the Air Force for 24 years as a psychologist, and now I'm the chief clinical officer for Cohen Veterans Network.

MR. TOM CODERRE: Thank you.

MS. VALERIE KOLICK: Laura Howard?

MS. LAURA HOWARD: Thank you. Laura Howard. I am an attorney by
training, but I am the Secretary for the Kansas Department for Aging and Disability Services and serve in the governor's cabinet. Have a long history of service at the State level in human services and also had the pleasure to serve for 3 years as a SAMHSA Regional Administrator.

MR. TOM CODERRE: Good to see you again, Laura.

MS. LAURA HOWARD: You, too.

MS. VALERIE KOLICK: Good to see you, Laura. Francisco Rodriguez-Fraticelli?

MR. FRANCISCO RODRIGUEZ-FRATICELLI: Thank you. Good afternoon again. My name is Francisco Rodriguez. I'm the executive president of Coalicion de Coaliciones. That is the largest continuous care homeless coalition in Puerto Rico. Been working with different vulnerabilities in Puerto Rico especially homelessness, mental health, substance use, and HIV, since the '90s.

So, it's a pleasure to be here and share my thoughts and my experience with this group. Thank you so much.

MR. TOM CODERRE: Thanks, Francisco.

MS. VALERIE KOLICK: Thank you. Dr. Barbara Warren?

MR. TOM CODERRE: Dr. Warren, if you can unmute yourself? We are not able to hear you.

[No response.]

MR. TOM CODERRE: We can circle back around to Dr. Warren.

MS. VALERIE KOLICK: Sure. Dr. Allan Tasman?

DR. ALLAN TASMAN: Hi. I'm Emeritus Endowed Chair in Social and Community Psychiatry at the University of Louisville. Most recently, I'm also a member of the American Psychiatric Association Presidential Task Force on Social Determinants of Mental Health, and I'm in charge of the Policy Workgroup there.

MR. TOM CODERRE: Thanks, Allan.

MS. VALERIE KOLICK: Dr. Cristina Rabadan-Diehl?

DR. CRISTINA RABADAN-DIEHL: Hi, everyone. Good afternoon. So, I am Cristina Rabadan-Diehl. I am a pharmacist, scientist, and public health
professional who works also in policy, with 25 years of Federal service, half of them at the NIH and a few years at the HHS level.

I am currently an Assistant Director for Clinical Trials at Westat, a research organization. But I'm also representing a collective of families who, like myself, have lost our loved ones to an opioid overdose. In my case, I lost my son Jonathan at age 28, 2 1/2 years ago.

Thank you.

MR. TOM CODERRE: Thanks, Cristina, for being here and for continuing to share Jonathan's story.

MS. VALERIE KOLICK: Thank you. And Dr. Rahn Kennedy Bailey?

DR. RAHN KENNEDY BAILEY: Yes, it's kind of an odd day for me. Thank you guys for including me today.

Rahn Bailey. I'm currently chairman of the Department of Psychiatry at LSU School of Medicine in New Orleans. I'm also in the role of Assistant Dean for Diversity. Been very involved with SAMHSA for a decade or more of my career. I actually had six SAMHSA grants when I was the chairman at Meharry Med College in Nashville and the Executive Director of Elam Mental Health Center, one of the larger inner-city mental health centers doing residential treatment mainly on substance abuse in Nashville during my time there.

Now we are very involved in inner-city New Orleans in what I call urban healthcare, run the university medical center, doing a lot of work on opioids. We are part of the -- we have the largest SOR grant in Louisiana. We have the Louisiana SOR. We've almost tripled our number of individuals treated since we started. So we're very proud of our work there.

We're going to probably move from 40 to 49 OBOTs this year. More cities are coming online, and more practitioners are interested in really learning about MAT and providing it, I think, with our overall support. So very happy, very excited about all this work. I was very excited about joining SAMHSA.

Personally, I'll be on today. A little personal note -- but I'll be on, although you can't see me. We had a tornado in New Orleans a day or two ago. And although it did not affect me -- I'm very fortunate, very thankful, very blessed, no acute damage -- it just threw our whole system in arrears. So I'm going to be actually in the car driving today, a trip that I should have done a day before. So I'm going to have to do that today, but I'll be listening and looking forward to it.

I really enjoyed my first meeting 6 months ago, learned a lot, and I really enjoyed the discussion by many of the members. I'm looking forward to a good session
today. So thank you guys very much for your help and your support.

MR. TOM CODERRE: Thanks, Rahn.

DR. RAHN KENNEDY BAILEY: You, too.

MR. TOM CODERRE: Thanks, Rahn. Our thoughts are with you and everybody else who's been impacted.

DR. RAHN KENNEDY BAILEY: Appreciate it. These increasing global [inaudible], I'll call them, are scary for all of us, and New Orleans sits right at a very vulnerable spot. So I will admit the one man that died was actually known by the daughter of my secretary. So it gets close to home. Gets real close to home.

But I thank you guys very much.

MS. VALERIE KOLICK: Thank you. Barbara Warren, I'm going to circle back to you, see if your audio is working yet?

[No response.]

MR. TOM CODERRE: How about our ex officios, Valerie?

MS. VALERIE KOLICK: All right. We have Marsden McGuire?

DR. MARSDEN H. MCGUIRE: Hi, everybody. Marsden McGuire. I'm a geriatric psychiatrist by training. I work in the VA, where I've been for a little over 10 years, as the Director for Continuum of Care and General Mental Health in the Office of Mental Health and Suicide Prevention.

The topics on today's agenda are all front and center for us. We have a Veterans Crisis Line, shifting to 988, healthcare disparities among veterans, and recovery in general and care for SMI population in particular.

So, looking forward to the meeting. Thank you.

MR. TOM CODERRE: Thanks, Marsden.

MS. VALERIE KOLICK: Thank you. George Koob?

MR. TOM CODERRE: Dr. Koob, are you still with us?

DR. GEORGE F. KOOB: Yeah, I am. I'm sorry.

MR. TOM CODERRE: That's okay.
DR. GEORGE F. KOOB: I'm the Director of the National Institute on Alcohol Abuse and Alcoholism. Thank you very much.

MR. TOM CODERRE: Thank you for being with us, taking time out of your busy schedule to participate. We really appreciate it.

MS. VALERIE KOLICK: Joshua Gordon?

DR. JOSHUA A. GORDON: Hi. Joshua Gordon, Director, NIMH. It's great to be here. Thank you.

MR. TOM CODERRE: Thanks, Dr. Gordon.

MS. VALERIE KOLICK: Thank you. Jennifer Hobin?

DR. JENNIFER A. HOBIN: Hi, I'm Jennifer Hobin. I'm the Director of the Office of Science Policy and Communications at the National Institute on Drug Abuse and filling in for our Deputy Director, Dr. Wilson Compton. It's nice to see you all.

MS. VALERIE KOLICK: Thank you.

MR. TOM CODERRE: Thanks, Jennifer.

MS. VALERIE KOLICK: Did Rick Mooney join us?

[No response.]

MS. VALERIE KOLICK: Yeah, okay. Dr. Gandotra?

[No response.]

MS. VALERIE KOLICK: I'm going to move to Aaron White?

DR. AARON WHITE: Hey, everyone. I'm very glad to be here with you today. I'm Aaron White. I'm at the National Institute on Alcohol Abuse and Alcoholism. I serve as Dr. Koob's senior scientific adviser, and I am interested in all things substance misuse, particularly domains of prevention and epidemiology and neuroscience.

So, thank you for having me.

MR. TOM CODERRE: Thanks, Aaron. Looks like Dr. Warren is back on, Val.

MS. VALERIE KOLICK: Yep. Dr. Warren, if we can hear you, please introduce yourself.
DR. BARBARA E. WARREN: Okay, hi. I'm sorry about that. I got a very important phone call right at 1:00 p.m., and I just muted my phone again.

MR. TOM CODERRE: No worries.

DR. BARBARA E. WARREN: So, hi. I'm Barbara Warren. I'm the Senior Director for Lesbian, Gay, Bisexual, Transgender, and Gender Diverse Programs and Policies in the Mount Sinai Health System's Office for Diversity and Inclusion, and I'm also an assistant professor of medical education, also a psychotherapist, a psychologist with a small private practice on the side in New York. And I've been doing substance abuse and mental health work and working with SAMHSA for most of my career, for over 40 years.

So very happy to be part of the advisory council, and happy to see you, Tom. And looking forward to our meeting and our discussions today.

I just saw the announcement of the funding for the mental health services, community mental health services. I'm very excited about that and hope you continue it.

MR. TOM CODERRE: Thanks, Barbara. Anyone else on the members or ex officio, Val?

MS. VALERIE KOLICK: Not that I can see.

MR. TOM CODERRE: Great. And I know we have several SAMHSA staff here, my colleagues. Just in the interest of time, since we're running just a minute or two behind, I'd just like you guys to wave. I see Anne Herron, who's going to be on the agenda later, our Director of Intergovernmental and External Affairs. Anita Everett, our Director of the Center for Mental Health Services. Mary Roary, our Director of the Office of Behavioral Health Equity.

I also see Dona Dmitrovic, a senior adviser for recovery; Kurt John, our Director of the Office of Financial Resources; Yngvild Olsen, our Acting Director of the Center for Substance Abuse Treatment; Jeff Coady, our Acting Director of the Center for Substance Abuse Prevention; and I see Michael King, our Acting Director of the Center for Behavioral Health Statistics and Quality. And last, but not least, I see Charissa Pallas, our Director of the Office of Communications.

I apologize if I missed any of the SAMHSA staff who I can't see, but those are the ones I can see on video.

With that --

MS. VALERIE KOLICK: Dr. Mary --
MR. TOM CODERRE: Oh, did I miss somebody else?

MS. VALERIE KOLICK: Dr. Mary Roary, did you get her?

MR. TOM CODERRE: Nope, I mentioned Mary.

MS. VALERIE KOLICK: Okay. I missed it then.

MR. TOM CODERRE: No, wouldn't want to -- wouldn't want to forget Mary. So thanks for mentioning that.

And as Val mentioned earlier, Dr. Delphin-Rittmon will be joining us just shortly after 2:00 p.m., and she'll take the reins. Unfortunately, something got double booked. We have our big 988 convening today, which is taking place at the exact same time as the NAC. So she is there doing opening remarks and the first couple of panels, and then we'll switch places.

I'll go over to the 988 convening, and she'll come here. So we'll be doing a little musical chairs today. So we appreciate you guys bearing with us as we do that.

I think the next order of business is the approval of the minutes for August 30 of 2021. Val?

**Agenda Item: Consideration and Approval of the August 30, 2021, Minutes**

MS. VALERIE KOLICK: So you've all had the opportunity to see and review the meeting minutes of the August 2022 -- or, I'm sorry, the August 2021 SAMHSA NAC. I'm assuming you haven't seen minutes from a meeting that hasn't happened.

So if we could have a motion to approve the meeting minutes?

MS. LAURA HOWARD: I'll move approval. This is Laura Howard.

MR. TOM CODERRE: There's been a motion to approve. Is there a second? Is there a second?

DR. CRISTINA RABADAN-DIEHL: I second.

MR. TOM CODERRE: Thank you for the second. Any discussion?

[No response.]
MR. TOM CODERRE: All those in favor?

[Response.]

MR. TOM CODERRE: Any opposed?

[No response.]

MR. TOM CODERRE: The ayes have it, and the minutes are approved.

Agenda Item: Update on SAMHSA Budget and Funding Opportunities

MR. TOM CODERRE: We'll now move on to updates on the SAMHSA budget and funding opportunities, which is going to be presented today by Kurt John, the Acting Director of the Office of Financial Resources.

Kurt, take it away.

DR. KURT JOHN: Thank you, Tom. And also I sincerely appreciate just the introduction of the council members. As most would know, this is my first time here at SAMHSA. But I also feel right at home just hearing that coming from the NIH and hearing so many council members affiliated with the NIH, and so the connection is extremely appreciated.

I'll do -- if you can kind of advance to the next slide?

Just as a quick overview, the intent is to provide a quick update in regards to what we accomplished with our FY ’21 funding, highlighting two key areas that were noted by Tom and others in the introduction largely around our harm reduction NOFO and then, secondly, around 988. And just from the funding perspective -- you’d hear more about the program perspective of those program announcements later in the agenda today.

I'll spend a little time talking about FY ’22 in terms of the funding that we received and just some of the funding opportunities that we have published so far and some that we have forthcoming. The Government Publishing Office has announced that the President's budget will be released on Monday, but we'll follow up with more insight in regards of the FY ’23 funding levels as soon as the budget is released.

The next slide.

It's a little bigger than anticipated, but this funding picture essentially shows overall distribution of funds across our major funding areas in FY ’21. As you can
see here, our substance misuse treatment center had accounted for around 65 percent of our funds. The mental health programs accounted for roughly around 29 percent of our funds. Our prevention programs accounted for approximately 3 percent of our funding. In addition, we received ARP funding in FY ’21 and provided $3.3 billion in awards to roughly 142 grantees.

And on the next slide, just highlighting one of the important programs for us here at SAMHSA, our harm reduction announcement, which was published in December of last year. As you can see here, we provided an interesting graphic showing the distribution of the 441 applications that we received across the regions, and you can spend some time looking at the number of applications we received across the various States. And our intent is to award close to $30 million in awards once these awards are actually made to States. And on the next slide -- or grantees, correction.

Our next slide is just a highlight in regards to our funding for 988 announcement, which was published in the fall of last year. We issued two awards, two announcements. One largely to build the backend capacity to a system administrator, and a second announcement for $105 million, which is going to go to the States and territories soon to further expand the workforce capacity.

We received -- we announced the announcement with an eligibility of 56 applicants. We received 54 applications. In our current timeline, we're working to make these awards and release funding to the States in April.

MS. VALERIE KOLICK: Kurt?

DR. KURT JOHN: Sure.

MS. VALERIE KOLICK: Sorry to interrupt. This is Valerie. We're hearing a lot of background noise. I don't know if your microphone may be rubbing on something?

DR. KURT JOHN: I'm not sure. My --

MR. TOM CODERRE: We were in a meeting earlier, and the same thing was happening. So I don't think Kurt can do anything about it, unfortunately.

MS. VALERIE KOLICK: Okay.

DR. KURT JOHN: It's a function of the computer, unfortunately.

MS. VALERIE KOLICK: No worries. Move on.

DR. KURT JOHN: Okay. Thank you.
Just one note about our 988-funding announcement, it is supported with a combination of funds, part ARP funding and part our base appropriation funding.

You can move to the next slide.

Transitioning to FY '22, as most of you know, we received our full-year omnibus bill on March 15th in response to the President's budget request for FY '22. Our SAMHSA funding level in the FY '22 President's budget request was $9.7 billion. Our enacted funding level for FY '22 is $6.5 billion. It's roughly about $530 million above what we had in FY '21.

We received increases across all our centers, and it includes support for some new programs that I'll highlight.

On the next slide, I'm not going to go through all of these. This is a breakout, a quick, high-level presentation of the $9.7 billion that we submitted in our FY '22 requests and what we received in the $6.5 billion that were received by some of our key programs for FY '22.

You can advance to the next slide.

Just a high-level summary again of the FY '21 funding level versus the FY '22 funding level that were received by our major Centers for Mental Health, Substance Abuse Treatment, and Substance Abuse Prevention, and our program support funds. The bottom line here being again an increase of $530 million above the FY '21 level.

On the next slide, just some quick highlights for some of the programs. As you can see here, our mental health block grants in FY '22 received a $100 million increase. Our Suicide Lifeline received roughly around a $77 million increase. We also had a $25 million increase to SOR, or State Opioid Response Grant Program.

We received a $5 million funding amount for our Behavioral Health Crisis Communication Office, which is directly tied to our 988 program, and $10 million for a new Mental Health Crisis Response Grant Program.

On the next slide, we have -- from the CR to now have been working to publish a lot of our funding announcements for FY '22. Our plan is to publish roughly 35 Funding Opportunity Announcements. To date, we have released 22 of those Funding Opportunity Announcements. The table shows the funding amounts in the ones that have been released so far, for the Center of Mental Health Services.

Similarly, on the following table -- next slide -- we have the Funding Opportunity Announcements that have been published for our prevention, plus our treatment
centers.

In terms of on the following slide, this is a list of our forecasted NOFOs. So these are the Funding Opportunity Announcements that we do intend to release between now and the end of the fiscal year. All of these funding announcements are available on our website in regards to what has been published and what's forecasted for the remainder of the year.

And I believe that's it. On the following slide, it's just more of a thank you and look ahead. So in terms of look ahead, we do anticipate that the FY '23 funding President's budget level will be released on Monday and look forward to coming and providing more information about our FY '23 PB as soon as it's released.

I'll stop here and take questions. I've been through that really fast, but happy to go back to any of the material.

MR. TOM CODERRE: Anne, are you going to facilitate this discussion?

MS. ANNE M. HERRON: I sure will.

MR. TOM CODERRE: Thank you.

MS. ANNE M. HERRON: Let's open it for any discussion or questions or comments. Dr. Tasman?

DR. ALLAN TASMAN: Thank you. I have a question about the public -- publicity, I guess, campaign for 988, and this was stimulated by my conversation with our very experienced School of Public Health chief here in Louisville, who was unaware there were any funding opportunities as recently as 6 weeks ago, when I got the announcement for the grant funding for the 988 support and sent it to him. And I don't -- again, he's a very experienced person. So I'm wondering how we're publicizing the availability of these funds?

DR. KURT JOHN: I can start, and probably Tom can add. Funding to date has been to two entities, largely the system administrator, the existing system administrator who manages the infrastructure for 988 and backup facility. And then, secondly, we provided funding to States. It is the States that will ultimately distribute that funding to the local workforce to kind of support the implementation of 988.

We recognize this largely as the initial major investment and look forward to coming back before you to provide additional insights about plans for additional funding for 988, but our funding initial to date has largely been to the system administrator and to the States.

We've held multiple, as Tom pointed out, engagements with the public to
communicate about what 988 entails, what it requires to get prepared. And you'll hear a lot more about the 988 later in the program from our program manager, James.

DR. ALLAN TASMAN: Okay. I know you can't do everything, but he's been working closely with our mayor's office, and our mayor is Democrat, our governor is Democrat. So it's not a political SNAFU, I don't think. But the mayor's office didn't seem to be aware either that there was going to be some funding available. So that was my stimulus for asking.

DR. KURT JOHN: I appreciate that, and we'll ask that question for a follow-up from our program manager on 988, once he provides more of an in-depth overview. That hasn't happened so far.

DR. ALLAN TASMAN: Thank you.

MS. ANNE M. HERRON: Thank you. Dr. Rabadan-Diehl?

DR. CRISTINA RABADAN-DIEHL: Yes. So, thank you, Kurt. This was really very interesting. I really liked the disbursement of funds on the different communities.

I don't know whether the question really is directed to you, to Tom, or maybe some programmatic folks. So we touched on this the last council meeting, which was the issue of tracking and accountability.

So a big percentage of your budget goes to States. And we were curious -- and I actually made a comment when we were asked for topics for discussion for this meeting -- I really would like to hear, and I think that some of my colleagues as well, how are you tracking accountability on the part of the States that are really going to the right place, to the communities? We discussed at the last meeting that there was a cry out by the community or base organizations that in many cases they were not seeing a lot of that money.

And the second part of my question is, it is wonderful that we are having this discussion of the funds, that the Biden and Harris administration has made substance use as well as mental health a priority. However, we all know that this probably will come to an end one day, but the problems are not going to go away. How are you ensuring sustainability of your efforts and continuation of a lot of the investments that you are making?

DR. KURT JOHN: I'll provide two examples and then probably allow for some of the Center Directors to comment in regards to accountability.

Just sticking with the scope of programs included in the funding in my update, one, in regards to 988 -- and you'll hear more about this later in our brief today --
we have developed key performance indicators that are required for the system administrator plus the local -- plus the local crisis center that we'll be closely monitoring. These are programs that we award through our cooperative agreement mechanism, which requires close collaborative work between the Government and the awardee. That's one example that we are kind of focusing in terms of like accountability.

The second one in regards to sustainability, I would just call attention to our like CCBHC program, for example -- our Certified Community Behavioral Health Center. And one of the key requirements around that program is to ensure that the awardees build a sustainability plan so that they can continue to provide that service into the future.

I would stop there and probably ask our Mental Health Center Director to comment on the CCBHCs or probably the program manager for 988 to provide some additional insight. We are going to hear a lot more about 988 later today. It's just such of a key priority for us. I do understand all the questions about 988.

Anita, did you --

DR. ANITA EVERETT: Yes. Well, I mean, I can just add that that's right in -- keep in mind that we have two basic types of grants. One is a block grant-style grant that's administered, in the case of mental health services, for instance, through the behavioral health authority of the State. And then the others are a series of what we call discretionary grants, and they are evaluated and scored competitively and given to -- in rank order of the score, and the scoring goes against the application process.

So those are sort of our basic processes. And we have a number of things that are in place, the details of which are far too granular to get into at this level of conversation, but I'd be happy to provide -- our grants are very -- overseeing processes for those two types of grants are somewhat different. But we have -- that's one of our main functions is management of grants, and that's the majority of our staff go to oversight of grants and assuring that the grants are doing what they were intended to do, per the instructions that are included in the NOFOs that Kurt mentioned earlier, the Notice of Funding Opportunities.

And so alignment with that is very important and is largely the basis of our checks and balances.

DR. KURT JOHN: I just have one --

MR. TOM CODERRE: I'll jump in and --

DR. KURT JOHN: Go ahead, Tom.
MR. TOM CODERRE: Yeah, just jump in quickly to follow up on what Anita pointed out, which is the majority of our grants are formula-based. They're block grants and formula-based grants that go to the States. States do needs assessments and make determinations about how to spend those resources. And that's because Congress has decided that's the best way for that to happen.

So they have directed us to provide that money to States. Of course, there are financial controls that they place, and we make sure that the money gets where it's supposed to go and is spent in accordance with the statutory provisions that are attached to it. But at the end of the day, States get to make those funding decisions about how that money gets distributed to counties and local community behavioral health service providers.

MS. ANNE M. HERRON: If I could also add in -- this is Anne. We may -- it's been a while since we've had a conversation with the advisory council about our performance and outcome data, and that might be something we want to set up for perhaps a future meeting is to have CBHSQ talk about some of the information we're getting, really about the impact that our grants are having on various populations in different parts of the country and some of our evaluation data. That may be something you want to offer.

DR. CRISTINA RABADAN-DIEHL: Thank you so much for your comments. I really would love to see something like that, Anne. Thanks for the suggestion.

MS. ANNE M. HERRON: Thank you. Dr. Warren?

DR. BARBARA E. WARREN: Thank you, Cristina, for raising that because that was going to be my question, too, and you already answered it.

And thank you, Anne. That's exactly what we need to see. I'm less worried about my State, New York. I know the Commissioner in the Office of Mental Health in our State and the current new Commissioner in the Office of Alcoholism and Substance Abuse Services will make sure the money is used effectively and according to, you know, what it's intended for, but I'm not so sure about that in other States, where I know that sometimes that block grant money has been diverted or put into administrative overhead and not really gotten to the communities that they serve.

So being able to see that data would be really helpful. I would also really ask that we look at the good, the bad, and the ugly in that data and be able to talk about it honestly here.

My question really is different. I don't know if it's appropriate to raise it at this time, but you all are probably very well aware of some of the anti-LGBT initiatives in particular legislation now that's either passed or pending across the country. And particularly, the recent directives in Texas and some of the legislation that's
pending that would criminalize both mental health as well as medical treatment of young transgender people, and I want to know what SAMHSA’s stand on that is.

I want to know what SAMHSA is doing about it, and I want to know how SAMHSA is spreading accountability for dealing with particularly with trans and gender diverse young people into the grant application processes, including the block grants that go to the States.

DR. KURT JOHN: I'll turn to either Anita or any of our Center Directors could probably comment on that question.

MR. TOM CODERRE: Dr. Roary may want to jump in here as well because some of the work that we do at SAMHSA sits -- especially on LGBTQ+ issues is done through our Office of Behavioral Health Equity. But, Dr. Roary, would you like to jump in?

DR. MARY ROARY: I'll jump in, but I'm going to present it soon. But --

[Laughter.]

DR. MARY ROARY: But I'll speak to you. This is a great opportunity.

We are gearing up to update everything LGBTQIA+ on our website. We're working closely across SAMHSA. All the centers and offices are involved. We are working very closely with our counterparts at the other HHS center agencies, such as the Office of Minority Health as we're working with FDA, CDC.

You'll see it in the slides in a few seconds, but we have rolled up our sleeves. We are so there, and we hear exactly what you're saying. We're also working closely with OFR to make sure our funds and stuff are allocated where they need to be. So you'll be proud. SAMHSA is headed in the right direction.

Thank you.

DR. KURT JOHN: I would just add one additional comment, just kind of continuing to focus on like our harm reduction NOFO, for example. One of the things that you had noticed in that funding announcement is the -- what we kind of categorize as bonus points for underserved communities, which includes the LGBT community, where we are providing really five bonus points to each application that comes in, go through the review process, and ultimately like really trying to get funding to these targeted communities for recognizing the importance and the need to continue to support funding in mental health and substance misuse services to these important underserved subgroups.

MR. TOM CODERRE: I'm sure folks are aware, but in case you're not, President Biden has been very clear in his support for these populations and actions that
have been taken at the State level, as has Secretary Becerra. And you know, the administration is in lock step in terms of our support for LGBTQ+ people in our country. So we'll continue to do that.

MS. ANNE M. HERRON: Thank you, Tom. Any other comments or questions or thoughts from the members?

[No response.]

MS. ANNE M. HERRON: I've got a couple just for you, Dr. John. You mentioned the number of the Notice of Funding Opportunities that we have already released. Do you have a sense of when the rest of the -- I love the acronym NOFO -- when the rest of the NOFOs will be released?

DR. KURT JOHN: It's an interesting acronym. You know, across the way at NIH, it's referred to FOAs, F-O-A. And within SAMHSA, it's NOFOs. Same family, same concept. So we do have all our Funding Opportunities Announcements kind of published on our website, where it's a NOSI, yep, Notice of Special Interest, within the NIH community.

They're all published. Where we are right now, we do anticipate that most of our Funding Opportunity Announcements will probably be released within the next month or two. That's a timeline that we're aggressively working towards to ensure that all the awards are made before the end of the fiscal year. But these funding opportunities that's yet to be published are all posted on our websites just to ensure that the community is aware that they are coming soon.

MS. ANNE M. HERRON: All right. Another question for you. 988, as you've heard already, has been getting lots of attention, will continue to get lots of attention, and you mentioned that there were two funding opportunities that were made available under 988. Has the funding for the States supporting 988 implementation been awarded yet?

DR. KURT JOHN: Great question. No, it has not. The funding to the system administrator has been awarded. The funding to the States for workforce capacity to scale, scope, build the workforce in support of the projected demand, our target and anticipated release for that is April 15th. So we are aggressively working to get fundings to the State for the 988 list.

MS. ANNE M. HERRON: Thank you. And one final question from the chat, does the NOFO list reflect the recently enacted '22 spending bill?

DR. KURT JOHN: To get ahead of the -- to help manage the idea that we are -- we didn't receive our funding until March, what we did, we went ahead and released a lot of our NOFOs with the understanding that what would change is potentially the number of awards. So we are combing through our NOFOs now
that we do have our kind of baseline funding for the year to ensure that we update the number of awards to reflect what we anticipate making awards to, given the new funding bill.

MS. ANNE M. HERRON: Very good.

DR. KURT JOHN: Thank you.

MS. ANNE M. HERRON: All right. Last chance for members. Any comments, questions, concerns?

All right. Tom Coderre, I turn this back over to you.

MR. TOM CODERRE: Thanks so much, Director Herron. We appreciate your facilitation of that discussion.

I don't know if Dr. Satel has joined us yet. Dr. Satel, are you on the line yet? Because we are running a little bit ahead of schedule, and we could go back and do the recognition if she is.

MR. JOSH SHAPIRO: I do not see her online, Tom.

MR. TOM CODERRE: She's not online yet. Okay. What would the pleasure of the council be? We are approximately 15 minutes ahead of schedule here. We could go into our next section around reports to Congress if folks are ready to do so?

Fantastic. So now we'll have Dr. Anita Everett, the Director for our Center for Mental Health Services, discuss the Interdepartmental Serious Mental Illness Coordinating Committee.

So I think you're starting us off, Dr. Everett, and then there may be some other presentations as well following yours.

**Agenda Item: Recent Reports to Congress -- Interdepartmental Serious Mental Illness Coordinating Committee**

DR. ANITA EVERETT: Great. Thank you very much, and I appreciate the opportunity to come and sort of brag a little bit, so to speak, about what we've been doing with the ISMICC, the Interdepartmental Serious Mental Illness Coordinating Committee, where it's been, where it is right now, currently rejuvenated -- I'll just go ahead and say that -- and where we hope to have the council move forward.
So, by way of reminder and context, ISMICC is a coordinating council that includes coordination dead-centered on SMI, serious mental illness, individuals and the circumstances that have to do with individuals that have serious mental illness, and also includes SED, or serious emotional disturbance, so the children's component or counterpart to serious mental illness. It's comprised of eight different departments. So HHS is just one of those departments.

Those departments include all of the departments that you would really want to see that have a stake, so to speak, in the enterprises, the Federal enterprises that manage or address or have programming that address individuals with serious mental illness. So I'm going to just say the names. Because I've got just a little bit of time, I'm going to take advantage of that, just to have you get your head around how inclusive this opportunity is that was created by Congress.

Social Security Administration; Department of Justice; the Veterans Affairs; Housing and Urban Development, HUD; Department of Education; Department of Defense; Department of Labor, which, of course, they are involved in many different aspects that have to do with employment but also are involved in enforcing parity, which we've seen a lot of recent traction on; and then, within HHS, there is ourselves and CMS that have been prominent partners of that. And we've been joined all along the way by our partners at NIMH that of the Institutes have the most overlap, I'd say, or contribution to the SMI space.

Let's go on to the next slide.

This was created -- the 21st Century Cures reference is there because this was created in December of 2016. So in the very waning -- just to give a context -- the very waning components of the Obama administration. It was one of a number of major initiatives that authorized -- reauthorized SAMHSA and helped to shape some of the ways that our offices and activities are created in the era that we're in right now for SAMHSA.

This was, to sort of provide an example, a little bit of the kind of accountability that we work with in the Federal domain. I describe our work as being all components of a very large, elegant bureaucracy with many checks and balances, and one of the processes that influences us, as well as Congress, is the GAO reports. Those, together with a series of reports that are created by the Office of the Inspector General, provide oversight and input to us.

And the GAO in 2014 -- so 2 years before this was incorporated, the ISMICC stand-up was incorporated as a component of the 21st Century Cures Act, GAO was sort of on the case of the Federal Government for lack of coordination across these important Federal programs, which impact the lives of individuals with serious mental illness. So it started with that framework. That's just another sort of example of the kind of checkpoints, checks and balances we have in our Government.
Let's go on to the next slide.

Let's go on to the next slide. I really want to land on slide 7. These were some of the -- we'll talk about this in just a quick second. These were some of the things that were set aside in the specific features of the act that were prescribed for ISMICC to conduct over time.

Let's go on to the next slide.

This is a map, so to speak, of the many activities that ISMICC engaged with, starting at the beginning. And one of the cornerstones of the entire ISMICC process has been a report, which is one of the requirements of ISMICC, the initial report, and then we're actually working right now on the follow-up report to Congress.

Let's go on to the next slide, and I want to get a little bit into the details of some of the components of that report, which under our current administration, current leader, we have activated considerably.

So there were recommendations that were made. One of the other unique aspects of ISMICC, or one of the other things that's very compelling about ISMICC is that it's combined -- it's a combined grouping of these Federal offices that I just reviewed earlier and also nationally prominent individuals who represent groups of people, conditions of people, details of which were spelled out by Congress in that act. But there are a number of private citizens, so to speak, that are there that provide input into the ISMICC process, into the full council, the coordinating committee that is ISMICC.

Those groups all got together, and that was how the first report was created. They came up with -- well, originally, it was 150 recommendations. But we knew -- you know, we bureaucrats in the Federal Government knew that was too many to sort of focus on at any given time. So we winnowed those down to 45 different recommendations and grouped them together in 5 focus areas. And this is an important element because it's what we plan to use carrying forward the work of ISMICC.

So those five focal areas were strengthening Federal coordination with regards to data and evaluation; making it easier to get good care access; close the gap between what works and what is offered; increase opportunities for diversion, criminal justice-related set of activities that we work on, both in adult and juvenile space; and then developing financial strategies that support the increased capacity that we need -- we all know we need in the mental health system at large and in particular the publicly funded mental health systems.

Threads of this, I will submit to you, you're seeing in the President Biden's recent
announcement, and we’re going to be talking about that a little bit later.

Let’s go on. So these five cornerstones are very important to us. Since we’ve had the privilege of working -- yes, let's go on to the next slide. That's right. Thank you.

Since we've had the privilege of working with Dr. Delphin-Rittmon, she has really invigorated the work that ISMICC has been doing, which was laid out and carried forward, again, over the 4 years prior to that but also has been sort of reshaped and energized. We've met several times under her leadership, the first of those being August of 2021, not too long after she assumed her role. We've met again in October of 2021 for a listening session. We solicited broad input from a number of stakeholders, including input through our public members, as well as - - as well as the departments that were represented there.

We will have the final report to Congress that we're actively working on now, and then we -- a debate or in deliberation is the idea of ISMICC being reauthorized.

Let's go on to the next slide.

So the working plan that we have right now -- let's actually go on to the next slide. I think that demonstrates that a little bit better.

Yeah, there we go. So the active plan that we have right now is to reconvene subgroups. There are, again, sort of the theme of elegant bureaucracy is that we work with many checks and balances to assure that the correct amount or assure that there is a balance between what the Federal Government does and the input that it receives from Federal Government.

And so ISMICC, as is the case with the NAC that we're part of right now, the National Advisory Council, falls under a Federal law, the Federal Advisory Committee Act, which creates rules of engagement for that. And so we had some rules that we had to work through with regards to how do we have the public members, which are part of ISMICC, engage in these subcommittees, and we have landed on that. That did take a bit of working through to achieve that, but at really the push and insistence of Dr. Delphin-Rittmon, we have been able to achieve that. So we can create these subdivided groups.

I know that our NAC members are very senior leaders and largely recognize that the capacity to address any complex problem really depends on the ability to deconstruct the problem enough so that you can make active working groups out of it that feed into the entire process. And so we have resurrected these five focus groups and have subcommittees now that are in the process of meeting prior to the next meeting that we have scheduled, which will be in April of 2022.

These are groups that are around -- again, these five focal areas -- data,
improving data, data coordination, access. Much of the -- much of the 988 work, for instance, was originally called out in ISMICC and has served as a kind of an organizing focus for us. We hit the ground running, so to speak, with the development of 988 largely because a lot of that had been set aside and recommended by some of the ISMICC members, who have carried forward in their support for the work of the 988 -- or the cornerstone for what we're now more increasingly calling 988.

Access also is -- there are a number of different ways that we're working on access, and that also includes the CCBHC program that Kurt referenced earlier, which CMHS, my center, the Center for Mental Health Services, is very proud to sort of hold the -- hold the process for. One of the important elements of the CCBHC -- and CCBHC stands for Certified Community Behavioral Health Clinics. One of the important elements of a CCBHC is that they're required to provide crisis services, and so that provides a local focus in the communities, the 400-and-some-odd communities where CCBHCs now are built and exist.

It requires crisis services as a component of that. It also requires access within a 10-day, 10 working day timeframe from the point of first engagement, which is usually a call to request for an appointment, to the time of actually -- an actual face-to-face virtual or a real face-to-face visit. Again, within that 10-day timeframe. And so access to quality treatment is a very important part.

Justice is also a very important component. Many of us know that justice is an ongoing problem. Upwards of 50 percent of individuals with SMI have had encounters with justice. Not necessarily been arrested, but we all know that a good number of individuals with serious mental illness have actually experienced arrest and/or adverse experiences when they have criminal justice interface. And so the justice component of ISMICC, reinvigorating that will -- we are really looking forward to having some good ideas and input for developing our justice portfolio.

That is an example of one of the activities that carried forward and the right set of words there. Focus area four is the justice area, and one of the recommendations that was made in the original ISMICC report is to include increased opportunities for diversion and improve care for people with serious mental illness and SED, children with SED, that are involved in the criminal justice and juvenile justice systems.

And as you may have noticed when Kurt went through his slides from the OFR perspective, we have some new funding that will enable us to expand our longstanding programs that are aligned with and really initially influenced by the recommendations that were in the justice component of the original ISMICC report.

We're asking each of these subcommittees as they meet to pull out those
recommendations and to make recommendations to the full ISMICC body regarding each of those recommendations, whether we are -- we're calling for three Rs, whether they think the recommendation should be retained in ISMICC's work moving forward, whether it should be retired because it's largely been addressed, or it's not -- no longer as relevant as it was at the time 3 or 4 years ago when the ISMICC report was originally conceived. And so retire, retain, or revise.

Some of the recommendations, the way they were initially written and conceived, need to be revised. Many of them were aspirational, and we really want to focus at this point in time in having the recommendations be measurable, not -- maybe not the full-on smart style of what recommendations or goals are, but at least things that we can measure and track performance against.

All these recommendations from the subcommittee will go up to the full ISMICC body and will just by way of checks and balances, they don't dictate to the Federal Government, but they provide recommendations for our SAMHSA leadership and the Secretary, HHS, our Secretary Becerra's leadership to make determinations about which of those recommendations they want to move forward with.

Next. Let's go on to the next slide, and I'm happy to answer questions as they come up, but we'll have some things up there.

ISMICC down the road. So, as I've said, we're in the process right now of having the subcommittees reconvene. Some of you may actually be on some of the subcommittees, and if you're not, we're happy to have you engaged in those. We have a combination of Federal employees and the public members that are specifically appointed to ISMICC to be part of those subcommittees, and we're very much looking forward to building a platform that we can work forward from over the next several years.

That's really what I brought to talk about with regards to ISMICC. The report that is currently pending has been largely completed but is -- we've run into a bit of a snag with regards to having the final report completed at this time. And so it's near completion, but not completed yet. It had very extensive public and private ISMICC member review, and we've had to incorporate the recommendations for the report itself. And so that is currently pending at this time.

So, so thank you very much, and I believe we do have a little bit of time if there are any questions about the ISMICC process, what we have planned for the future.

**Agenda Item: Council Discussion**

MR. TOM CODERRE: Yeah, we were going to save the questions -- we were
going to save the questions, Anita, until the end. But I don't see James Wright on yet. So I don't have any objection, if the council members don't, to taking questions now. We have 10 minutes for questions if folks want to jump in with them.

There's one in the chat from Barbara Warren. Two questions -- is therapeutic dockets the same as drug court, and what about treatment while incarcerated?

DR. ANITA EVERETT: So I don't know about -- honestly, I don't know, maybe someone on the call knows -- what a therapeutic docket is. There are some differences between, you know, mental health court. And if there are parallels in the addiction world, I don't know, Yngvild, if you have an answer for that.

But I don't -- I don't know what that is. We are very interested and recognize that work with judges is very important. Federal judges, of course, but also at the State and local level, and Tom himself has been very involved in promoting opportunities for us to work together more closely with judges so that they understand what mental illnesses are and can help with the important roles that we know they play in the lives of individuals who come before them.

MR. TOM CODERRE: Thank you, Anita. And we'll get back to you on the therapeutic docket, Barbara Warren.

Dr. Gordon?

DR. JOSHUA A. GORDON: Yeah, hi, thanks. Thanks, Tom and Anita, for that overview. It's really helpful.

I wonder if you might clarify the differential roles between the ISMICC and Behavioral Health Coordinating Committees?

DR. ANITA EVERETT: They are related, but separate. And Tom, I'll defer to you in a second. But the ISMICC itself is a body that functions as a NAC, which has cross-department membership and also has outside membership. And that's one of the reasons, my understanding, for why Dr. Delphin-Rittmon is interested in it.

It also focuses very explicitly on SMI and SED, not the other components that are broader of the whole mental health of our Nation, basically. But it's very focused on SMI. So it's narrower in scope, but broader in the kind of membership it has.

Tom, I don't know if you have any --

MR. TOM CODERRE: I missed the second part of the question. What's the difference between the ISMICC and the?

DR. JOSHUA A. GORDON: Behavioral Health -- go ahead, Anita.
DR. ANITA EVERETT: The BHCC, yeah.

MR. TOM CODERRE: The BHCC? BHCC. Yeah, one is external, and one is internal. So the BHCC is an internal Government coordinating council. Whereas the ISMICC has both public and Government members. And of course, as Anita mentioned, we do try to make sure that the work is coordinated and that we're talking to each other, so to speak, and not just operating in silos.

Laura?

MS. LAURA HOWARD: Yeah, thank you. I was really struck by the substantive focus of the topic areas, but I had a question perhaps maybe more about the implications of having a group like this that touches so many entities across Federal Government as well as others. To what extent is there discussion happening that would connect to, as maybe recommendations come forth, obviously, within HHS -- I assume in other agencies -- has there been discussion about the implication that might have for grants across different agencies or data sharing or those kinds of things in terms of sort of that whole of Federal Government response as we think about SMI and SED?

Does that question make sense?

DR. ANITA EVERETT: Yes, can you clarify just a little bit? Are you asking if there's advantages to say, for instance, to data sharing across? Is that --

MS. LAURA HOWARD: No.

DR. ANITA EVERETT: Maybe frame it just a little bit differently.

MS. LAURA HOWARD: Yeah, I'm sorry. I probably wasn't very clear, Anita. I apologize for that. I was wondering to what extent the group itself is talking about how entities could work together in addressing issues around SMI and if we would expect to see recommendations that touch on things such as how, you know, common grant applications share data, you know, things like that?

DR. ANITA EVERETT: Yes. All of that in the large sense is what the aim of ISMICC is, and many of those -- many of those -- many of those elements that you described involve a lot of details and time to get into the weeds to actually sort out the differences there.

One example of that is some of the rules around housing and for SMI individuals and the extent to which you can focus housing opportunities on the individuals with serious mental illness versus -- we can't violate the rights of anybody who's in need of housing, for instance, depending on the conditions of that. And so we've worked really well with HUD to look at some of the problems.
First, you have to understand sort of what the problems are across these different agencies, and then how to sort of build out solutions that work so that a problem like that can be addressed across the different rules, which involve combining these programs or putting them together so they best meet the needs of individuals with serious mental illness.

Yes, and these kinds of committees like this really help to build those relationships that lay out opportunities and identification of problems that need to be solved.

MS. LAURA HOWARD: Thank you.

MR. TOM CODERRE: Okay. Thank you so much, Anita, for that presentation on the ISMICC report to Congress. We appreciate it.

I don't see any other questions on that. So I understand that Dr. Satel has joined us, and Dr. Satel, can you hear us all right?

DR. SALLY SATEL: I'm sorry. Yes, I can hear you. Thanks.

MR. TOM CODERRE: Fantastic. We knew you were going to be joining a little late.

DR. SALLY SATEL: The first time anyone ever recognized my name.

MR. TOM CODERRE: Yeah, we knew you were going to be joining a little late today. So thanks for jumping on. We wanted to recognize you as we understand that this is going to be your last NAC meeting, as your term will be ending in June of 2022.

DR. SALLY SATEL: But I'm trying to -- can you see me now?

MR. TOM CODERRE: We can see you.

DR. SALLY SATEL: Okay.

MR. TOM CODERRE: Oh, well -- yeah, there you are.

DR. SALLY SATEL: Do I get a gold watch or something?

MR. TOM CODERRE: Yes, we can see you now.

DR. SALLY SATEL: Do I get a watch? Do I get any -- what do I get?

MR. TOM CODERRE: You get an opportunity right now to share a little bit about
what this experience has meant to you and a lot of gratitude from SAMHSA, from the council members, and the American people for your service over the last several years.

DR. SALLY SATEL: Oh, well, that's extremely kind of you. The reason I was late and feel, I have to admit, a little punchy is because we just did a virtual Hill briefing on the CDC's pain guidelines. So that's where I was. But anyway, no, thank you. I really feel -- I thank Ellie -- Dr. McCance-Katz -- for appointing me to this. And I, you know, don't want to sound like I'm living in the past, but I was always so grateful to her for putting the emphasis that she did on the severely mentally ill and for Dr. Delphin for carrying that on -- carrying on with that I can't say priority because I realize you can't put any one group above another, you know, in this setting, and we shouldn't. But for giving it the attention it really deserves. It's the most vulnerable population, and just we know they're more visible now than ever on the streets of San Francisco and other places.

So, so thank you again for having me.

MR. TOM CODERRE: Thank so, so much. Your service has been an example of true public service. So we really appreciate everything you've brought to the council.

DR. SALLY SATEL: You're really kind, but thank you.

MR. TOM CODERRE: You're welcome.

At this point in time, I'm going to turn it over to James Wright, who is going to give us a presentation on 988 crisis services report to Congress.

**Agenda Item: Recent Reports to Congress: 988 Crisis Services**

MR. JAMES WRIGHT: All right.

MR. TOM CODERRE: And Dr. Delphin-Rittmon is joining, James. So I do -- we are going to do a warm handoff, myself and her. Welcome, Assistant Secretary Delphin-Rittmon.

DR. MIRIAM E. DELPHIN-RITTMON: Hi, everyone. And thank you so much, Tom, for starting us off for the meeting. And Tom and I are now switching meetings. We're tag-teaming a little bit today.

MR. TOM CODERRE: No problem. James is just about to start his report. That's where we are in the agenda.

MR. TOM CODERRE: And we just said thank you to Dr. Satel, too, for her years of service on the council, and she mentioned what a pleasure it was to work with you as well.

DR. MIRIAM E. DELPHIN-RITTMON: Fantastic. And thank you so much, Doctor. We so appreciate just your service and work on the council. So glad that you've been with us.

MR. JAMES WRIGHT: Perfect. Thank you all, and Dr. Delphin-Rittmon can tell you, this is timely that we're getting to be able to present on this. We're hopping from a national convening around 988 in which Secretary Becerra kicked us off, along with a video that Dr. Delphin-Rittmon, you may notice her voice in the background of it.

So we're very excited to be able to talk a little bit about this today. And so I wanted to go over not only the reports, but more about the fundamental nature of 988, for those that might not be aware, and why we really see this as a pivotal moment in both mental health and substance use care across the Nation.

So, hopefully, people are aware of the critical nature of suicide and the need for suicide prevention in the United States. A lot of individuals each and every year struggle with suicidal behavior. Sixty-one-point-two million has had a mental illness or substance use disorder last year. About 1 death every 11 minutes in the United States. This is telling. The suicide rate increased from 1999 to 2018 35 percent and also the second-leading cause of death for 10 to 34.

But we've been proud to help support the National Suicide Prevention Lifeline since 2005, really helping millions of people a year. If you look at the growth since 2005, it's telling. Our first year active, we took 46,000 calls. And last year, we took 3.6 million calls, chats, and texts and are definitely looking at that rate continuing to increase in this upcoming fiscal year.

Next slide.

So I really wanted to highlight a couple components of not only what the 988 team is doing through calls, but also what is the hope for a better comprehensive crisis system under 988 and the services Lifeline and communities and States have been able to provide? So when you look at this graph, it shows kind of where individuals can meet behavioral health crisis services, and the goal is to have a person-centered approach that matches an individual where they are needed.

Someone to call, someone to talk to, and someone who supports, somewhere to
go. So someone to respond and somewhere to go. What we really wanted to do with the Lifeline is look at the very beginning, just having a number that an individual could contact. And I'll get into the transition of 988.

But how do we also build up, as we do this, services such as mobile crisis teams, crisis facilities, and wraparound services so there is a decrease of use of jail and emergency department and inpatient services where it is -- where it's appropriate. So matching that level of care to the exact need.

Next slide.

So, again, we do envision 988 as being transformative to crisis care in the country, creating an ease of access under one universal entry point, in line with other emergency medical services such as 911, working right now to strengthen and expand our national, State, and territory infrastructure response through some funding that I'll go through in a second, but also looking to shore up capacity on all of our services. That's calls, chats, and texts.

So, at the end, we are transitioning the National Suicide Prevention Lifeline number, the 1-800-273-8255 number, to a much easier number to remember, which is 988. But one thing to note, we can't do this alone. We really are focusing on State and territory partnerships, tribal partnerships, communities, other organizations, and that's really at the heart of the convening. And I'll talk a little bit about that here in a bit as well.

But one thing that's not put on here, the 800 number is not going away. We have promoted this number for 17 years. Actually, the FCC ruling mandated that the 988 go through the 800 number. So I do not envision in my lifetime there will be a time where someone will stop calling the 800 number. So regardless of the number out there, people will be able to utilize it. However, we truly believe that, come July and activation of 988, it is a much easier number to remember and to transition to.

Next slide.

So there are two overarching goals for 988, and we're really focused right now on the first one, looking at activation of 988 in July 16, 2022. First is strengthening and enhancing the National Suicide Prevention Lifeline. 988 builds on the existing National Suicide Prevention Lifeline. So there is not a new service, per se, occurring. It is an ease of access and an improvement of the current service that has been expanding and supporting the Lifeline response since 2005.

Now a couple pillars that we've identified and one specifically that I oversee is the readiness of the Lifeline Network, ensuring the Lifeline Network is equipped to respond to the projected demands of fiscal year '22 and beyond. Also looking at how do we strengthen and unite our messaging and our public communications
around 988. Federal planning, ensuring that we have adequate support, financial support, policy direction to strengthen the Lifeline Network in that broader crisis continuum. And then building that foundation again for that comprehensive service, which moves more into that second point of transforming and strengthening broader crisis care continuum.

Next slide.

So we did at the end of calendar year '21, or right at the beginning of calendar year '22, submitted our reports to Congress, our congressional reports. Three of them were submitted -- our Report to Congress on 988 Resources, a Report to Congress on Training and Access to 988 for High-Risk Populations, and then our 988 Appropriations Report. These two reports were put into the National Hotline Designation Act of 2020, and we did so with the report to Congress on 988 resources in collaboration with the Department of Veterans Affairs, which was embedded within the original legislation.

Part of SAMHSA's response to these were to announce $282 million to help transition the Lifeline to 988. $177 million of that is going specifically to strengthen our network operations and ensure that we have a strong backup center workforce, a chat and text service center, and also ensure that we can focus on training and development needs for the Nation's crisis centers.

The second builds off of the State partnerships. $105 million going out to States and territories for crisis call centers directly, though that $105 million is from ARP funds, and I think, actually, I have it on the next slide. So let me go ahead and hop to there. I hope I do.

Oh, not yet. "Effectiveness of Lifeline." I will get there in one second. So, apologies.

I did want to say that as we do expand and continue to build off of the existing Suicide Prevention Lifeline, many of you may not have seen some of the effectiveness studies that we've been engaged in over the past around the Lifeline services as a whole. But we do know through our studies that serious suicidal people do call the -- call, chat, and text the Lifeline.

And what you'll know there is there is a significant increase in suicidal behavior for those that contact through our chat services. We do know that a caller's intent to die is significantly reduced during the call, and counselors are able to collaborate on the vast majority of our imminent risk calls. That's important because most of our imminent risk calls we are able to de-escalate so we don't use emergent crisis services such as contacting 988.

We know that Lifeline counselors are more likely to inquire about current suicidal behavior and were more likely to -- callers were more likely to experience
reduced distress, which I believe is in line with the collaboration over those with imminent risk.

One of the biggest initiatives that we focused on over the few years with the Lifeline is embedding follow-up care in our centers. SAMHSA has funded follow-up services directly through crisis centers, and we know that for individuals that receive follow-up calls to suicidal callers, that 90 percent of those callers report back that having that follow-up call helped keep them safe, to include not killing themselves, in future contacts.

And we also know that suicide is reduced 50 percent amongst those that are accessing chat. And then, finally, third-party callers. Those are individuals that are calling on behalf of someone really do receive a wide range of interventions that can supplement and replace at times calling 911.

Next slide.

Very quick. Foundation about the Lifeline. I already shared about the contacts. You can -- we do serve chats through the Suicide Prevention Lifeline website right now. But I put this graph up here so you can see there's really two interactive voice recording prompts. One is to press 1 if you're a veteran. Two is to route to the Spanish subnetwork currently today.

But 988 will essentially be right in front of this 800-273-TALK. So 988, again, flows through by order of the FCC to the 800 number. So that is not going away.

Next slide.

For the State and territory grants that I talked about, $105 million is going out through the Notice of Funding Announcement we released back in December. We are very excited that here in less than a month we'll be able to award those out, and then their anticipating start date is at the end of April. Those will be seen under the Office of the Assistant Secretary, and in that, they are American Rescue Plan Act funds for this program.

I think that's noteworthy because that specifically points to the support of the workforce. Over 85 percent of the funds themselves have to go directly to the crisis centers to support workforce-related activities, which filters down to us actually helping support services for the individual callers, chatters, and texters.

Next slide.

What are the goals of this program specifically? It's to build a partnership and collaboration between States, territories, and crisis centers. Have 100 percent nationwide coverage and response through all the States and territories, meaning that if you're in a State, the first place you reach is, hopefully, a crisis
center, that there's not a gap in coverage where you would route automatically to our backup centers.

And really what we want to do is we want to get all of this funding out to all States and territories that apply and to align our key performance indicators or our metrics across to standardize the level of care that we're able to provide across the network.

Next slide.

What are some of those outcomes that we're looking at? For each and every State, we hope that they can achieve at least a 90 percent in-State answer rate. They can prepare for local chat and text. Right now, we do have chat and text that is centralized, meaning it's like the backup center. But we know that we have many States and crisis centers that are ready to activate come after -- come after April and the funding itself.

So we are looking to move that towards more State and territory response. And again, as I highlighted, several critical areas, follow-up services. Working with 911 and 988 integration and then specifically providing training and additional resources for populations at higher risk of suicide.

Next slide.

And so me and Dr. Delphin-Rittmon just left the convening that I discussed earlier. Really, this has been a partnership between the National Association of State Mental Health Program Directors and SAMHSA on really a roadmap forward with significant key partners. And I wish we could -- I had the slide of the partners that, Miriam, you shared earlier because it just showed kind of the breadth of how many organizations that we have engaged, and this is just a couple of them on here. But really well more than 100 organizations that we've identified.

It's really highlighting a roadmap, but in all honesty, it's just unity. Unity around communication and where we're going with 988, harnessed around the perspective of those that we're servicing. So we call that end use, but really those with lived experience or those that are needing care.

And we're working right now on finalizing playbooks for certain areas, such as the crisis centers and State and territory and tribal organizations in just a number of different areas that we're hoping that individuals can assess their own readiness for 988 and identify a few resources that can help them improve in certain areas.

Next slide.

And I think I only have a couple more, and then we'll answer for questions. I
wanted to share some of the resources that HHS is utilizing currently to support 988 and crisis services. Again, we just sent out the 988 State and territory cooperative agreement. We also have the 5 percent crisis set-aside from the block grant services.

But there’s a host of other ways that Lifeline over the years have been supported, through things like the Garrett Lee Smith Suicide Prevention Grants, Zero Suicide. We know that there is the Medicaid Waiver Program that certain States are utilizing to support crisis services and Lifeline services. And then a host of technical assistance that States, territories, and individuals have been able to utilize to get to -- to get us to where we are today.

Next slide.

Last few here. I did want to share the 988-fact sheet. Now what we did was we just took this 988-fact sheet, and we turned it into a website or more of a live review through our website. But wanted to show you what it looked like prior to us transitioning this, but we just did it over the last few days.

So if you go to the next slide, it shows a list of resources. If you go to samhsa.gov/988, we really took that and other things and embedded it and have just updated it with the most up-to-date 988 resources. Communications, we’re working on a communication toolkit for all partnering organizations and States and communities. But I do encourage everyone, if you haven't had an opportunity to do so, go to samhsa.gov/988, review it, and see what's there, what's helpful, what's missing. And you can provide any amount of feedback to our 988-team resource box. It's 988team@samhsa.hhs.gov.

Next slide.

And I believe that is the end of my presentation. So happy to answer any questions.

DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you so much, James and Anita. And I believe we're doing questions together, right? Questions for both. Or, Anita, did you take questions after your presentation?

DR. ANITA EVERETT: Yes, we had some questions after. Yes.

DR. MIRIAM E. DELPHIN-RITTMON: Okay, I see. Okay.

**Agenda Item: Council Discussion**

DR. MIRIAM E. DELPHIN-RITTMON: So I'll just go by the order that I see. So, Cristina and then --
DR. CRISTINA RABADAN-DIEHL: Yeah, so thank you. Wow. I am so excited about this initiative. Congratulations to everyone who has been involved. But I think that this was long overdue. Clearly, we have a crisis of suicide and mental health, and I think that this initiative is going to save so many lives.

James, one of the things that you have mentioned is that 988 can also -- so one of the things that I really liked is how you depicted some of the benefits at the beginning of your presentation. And one of the things that you were talking about was the issue of law enforcement.

And as you will know -- and I am now wearing the hat of substance use, right? So you were saying that 988 also can be used for substance use emergencies. As we know, right now we've been relying on 911, and immediately, you know, if there is someone in crisis or someone who is overdosing, immediately law enforcement comes, together with a lot of the emergency response.

How would this work for 988 for individuals with substance use disorders that are either in the middle of a crisis or someone who is in the company of someone who is going into an overdose and delivering Narcan, et cetera, et cetera? How do you deviate the presence of law enforcement in a situation like that?

MR. JAMES WRIGHT: It's a great question, and I think it goes back to the foundational question that we're going to be working here really to clarify is when do you call 988 versus when do you call 911? Everyone knows 911, and you know that you're expecting a response. We know when to call 911. Even when you don't know, you know when to call 911. We teach it at a young age. It's really embedded, and we hope to get 988 there.

The thing that we need to be mindful of is that 988 goes through our network of 200 crisis centers across the Nation. Now these are not federally owned and operated crisis centers. These are individual community centers that have agreed to not only the Lifeline standards, but also are accredited by organizations such as National Association of Suicidology and others. So there's a broad range of center experience and ability to respond.

However, we also know that not everyone that's in suicidal crisis should call 988 and not everyone that's in suicidal crisis should call 911. It's really dependent upon what the situation is. Same thing in substance use itself. So clarifying that, for example, if an individual just took a critical overdose and called, I would hope that they call 911. 988 will assess and have to link to 911 for emergency medical care. That's very different than an individual that is contemplating suicide.

So we are working with the National Emergency Number Association, we're working with the Office of Emergency Medical Services directly on clarifying what is that definition and what is that communication for individuals that call 911 versus 988? But 988 is for individuals in all types of mental and substance use
crisis, but those services that they might get to might be very dependent upon where in the Nation they link up with, with their crisis centers.

So I hope I answered that, but I think the biggest thing we're trying to work on right now, we're actually going to be hosting a policy academy around 911 and 988 integration here shortly, with the support of Dr. Everett and her team at CMHS. We're very excited to start trying to answer some of those more clearly because if we aren't clear, the public won't be clear as to when to call which service, and that's really the stance that we're moving towards.

DR. CRISTINA RABADAN-DIEHL: Yeah. No, I appreciate that response. As you are engaging with different stakeholders, I'd like to encourage you to also look for some stakeholders that are providing alternative responses to 911. I mean, there are other NGOs or private institutions that have mobile units that will respond to substance use disorder crisis.

I mean, the problem that we have, as you well know, is that if we deviate calls to 911, law enforcement shows up. And while rescue is doing their thing, they are looking around the household for drugs, and even though many States have the Good Samaritan law, you know, still the individual is at risk of being in front of a judge or whatever.

MR. JAMES WRIGHT: Yes.

DR. CRISTINA RABADAN-DIEHL: So I once again thank you very much for your response and your awareness of this.

DR. KURT JOHN: This is Kurt. If I can just add, one of the -- in our FY '22 funding that we received from Congress, we did receive $10 million for just that, to create a pilot program around mobile help response in regards to crisis care. So it's not on the list that I provided. It's a brand-new program that Congress provided $10 million to us in the FY '22 budget to kind of pilot an approach similar to what you were referring to in regards to mobile crisis response.

DR. CRISTINA RABADAN-DIEHL: Oh, thanks so much, Kurt. I think this is very much needed. I appreciate it.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah. And thank you for that question. It is really such a critical area, and through the resources that Kurt described, we can begin to look at a range of areas. But we can look at that as well.

Marsden?

DR. MARSDEN H. MCGUIRE: Yeah, hi. James, Marsden McGuire from VA. Work closely with Dr. Lisa Kearney and Matt Miller. Thanks so much for all of these efforts.
You know, you delivered so much. I may have missed a couple of things, but did you mention anything about the expected rate of increase in volume of calls as a result of 988 and how you project that? That's actually the first of and less important of my two questions.

The second is you had a bullet up there which said one of the key items was increased response rates above 90 percent within States. And I didn't know exactly what that meant. Could you clarify, please?

Thank you.

MR. JAMES WRIGHT: Absolutely. And thanks for being here, Marsden. I just actually left. I was the Deputy Director of the Veterans Crisis Line for the last 3 years. So I worked with Lisa very closely and carried over many of that. And they are a critical partner here with us, as we move forward with building 988. So very excited to have them onboard as well.

And so, to answer your first question, yes. In the appropriations report and several of the other reports, we did include a projection of potential volume for 988. It was upwards of 7.6 million contacts in the first full year of 988 implementation. But I think what we're getting at here is the more important question is how are we going to ensure response for all of these contacts, regardless of what the number is?

And so what we had to do is say, okay, what can we do from a backup center perspective versus -- i.e., a supportive perspective versus a live answer in State perspective, in State and territory? So, for example, every State -- we hope that every State in the Nation at least gets to 90 percent coverage answered within their State so individual callers, chatters, and texters do not roll out of State to a backup system.

So what we're doing is we're tracking monthly all of the percentages of contacts that are able to be answered within State, and then we are funding the backup center chat/text services. But we hope to really move that ownership over in that partnership with the States and territories. So they can get theirs. We can hold the backup center approach to 10 percent or less and also be mindful if you do that, you also minimize the amount of time someone has to wait to get to care.

Because if they answer 90 percent, that person didn't have to wait so long that they transferred out into a backup service. So that's that rate that we're looking at.

DR. MARSDEN H. MCGUIRE: Thank you.

MR. JAMES WRIGHT: Please don't -- please, nobody take away that that
means we're targeting answering 90 percent. We're absolutely trying to target to answer 100 percent of demand as much as possible while knowing there's obviously a band in that certain period. But it's about putting a level on our States so we can ensure that we have the appropriate response for the backup capacity.

DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you. Thank you, James. Laura?

MS. LAURA HOWARD: Thank you. I have a couple comments. I feel like I'm living and breathing this every day. I mean, including legislative action in our State, you know, yet this week related to funding of 988.

I appreciate the comprehensive approach. I mean in a sense where you're really looking at somewhere to call, someone to come, and somewhere to go. I mean, those whole pieces. And we're, of course, focused very much right now on that first piece, I mean, and building up our infrastructure there.

I think we already know in the State, as we get to the other pieces because we've been investing in some siloed ways in those other pieces over the last few years with individual, say, community mental health centers, maybe some doing mobile response, now being a State that's moved -- that's phasing in CCBHCs over 3 years. So that's sort of becoming a requirement. Having a statewide youth mobile crisis system in place. It kind of becomes overwhelming even to think about how all those pieces come together.

So I just guess I would just encourage you to continue, I think it was maybe (d) on your first slide. I mean, that piece, I do think folks are going to need help and assistance in really thinking about the coordination of those resources because we want to leverage what we have. We don't want people to walk away and say, well, it's not necessary anymore, what might be happening at the community level, because it is from a response perspective.

So, and I mean, just maybe a comment, just knowing some of the conversations our stakeholders are having in Kansas. And then a question. One of the things that's come up quite a bit in Kansas, frankly, in our legislative discussion about this, has been where -- has been concern about response to the IDD community and as that intersects with behavioral health issues. That's kind of taken on a life of its own in conversation, including then getting very designated target language within our legislation.

So has there been much conversation about that at the Federal level in terms of on the -- not so much on the call side, but on the response side, on the someone to come side?
MR. JAMES WRIGHT: Yeah, and first off, Laura, thank you. I know we've engaged from time to time in the past, and I'm very excited about some of the things that Kansas is really working towards there in their 988 response.

And you know, it's interesting. On your first comment, there are so many differences as to the way States have set up their crisis response. So when we look at the difference between child and adolescent, even mobile crisis outreach versus adult mobile crisis outreach, some have it split out. Some do not. Some don't respond to individuals under the age of 18, or they have parameters around parent and legal guardian response. So it's just -- I think it's one that we'll have to continue to closely track on a State-by-State perspective.

But the good news is almost every State and territory that was eligible for this program applied for this program. So I was extremely excited with the level of response that we got from the 988 Notice of Funding Announcement, and I will say that every State and territory in the Nation is going to be participating with and sharing information parallel to the grant process.

So, with that, actually, even yesterday we had a call with some key stakeholders around IDD population and response. Near and dear to my heart, I did my practicum at the Austin State School here in Texas, and one of the things that we were talking about is the need for respite care with IDD populations so many times, especially with adolescents. That without having that built in, that transforms into services that otherwise aren't necessary. It's really a break from a current environment and situation that, quite honestly, if built in properly when we talk about someone to respond and somewhere to go, can be an immediate level of support.

So we are looking at that as what it means for 988. We don't have data from -- yet from the Lifeline centers about the amount of contacts that come in from one -- like a diagnosis of one individual versus another. We don't assess on that level of detail, but I'm sure we have examples. So that's one of the things we're going to be working with the Lifeline administrator on is how can we gather information about the impact of our services and then the impact of services that we -- that we transfer them to or refer them to?

Anita has her hand up, and as a team member here, I didn't know if it was one of these two things. So I wanted to make sure I could just give you a chance in case it was.

DR. ANITA EVERETT: Thank you. No, I just wanted to emphasize that this is a job, an important job for all of us across SAMHSA, our working to support this whenever we can. And there's the block grant itself also has a set-aside amount of money that is going with it. And the good news about that is we are -- we think that is poised to be part of an enduring contribution that SAMHSA will make to every State and territory because it will give a set amount of money that the
States can use to plan.

911 was built over a 60-year period. We want 988 to be built much faster than that, but it may take -- we know that it will take a while. First and foremost, we're really focused on the call, and as James has really well referenced.

But we know communities are working really well together with law enforcement in the behavioral health space alone to develop the mobile responses. I mean, that's happening everywhere, and we want to do whatever we can to help sort of line that up so there's a common expectation. Just as there is for 911 now, so there will be for 988 in the future moving over time.

We're very excited about this. I can't emphasize that enough.

Thank you. Thanks, James.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, thank you. Thanks for that comment.

It really is exciting because it does, it highlights such a pivotal moment in terms of how we think about crisis responsiveness and crisis care. And even to Anita's point, I mean, we're seeing tremendous innovation already right now with law enforcement and behavioral health providers. And so that's something where there's a lot of activity and sort of work happening. So definitely an important time I think right now for crisis care.

Aaron and then Barbara. I know I have us a little bit off time, but this is an important discussion. So I want to get some of these questions in.

DR. AARON WHITE: Thank you. And thank you for your presentation, James. I learned a lot.

I have a question. I was really intrigued when the reports came out about decreases in suicide during the pandemic at the same time I was reading reports about increases in depression and anxiety, and we knew that before the pandemic all these things were escalating. And so I've read some explanations for why that might happen, but what I'm curious about is whether there was a concomitant decrease in calls at the same time, or did we see an increase in calls for help and a decrease in suicide, or how did that track?

MR. JAMES WRIGHT: No, it's a good question. But we did not see a decrease in contacts from fiscal year '22 to fiscal year '23. Or I'm sorry -- fiscal year '20 to fiscal year '21. I'm thinking of different fiscal years here. No, we actually saw an increase in contacts as a whole.

But during this time, we started responding to texts as well, although we are
really holding towards the activation of 988 for texts. So I considerably expect a jump in our texting services once we promote that. But those were included within those figures.

Now they were not enough to show that that was the significant reason. So contacts were actually increased from 2020 to 2021.

DR. AARON WHITE: Interesting. Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you, Aaron and James. Barbara?

DR. BARBARA E. WARREN: Hi, thank you. Very good, excellent presentation. I'm really excited about 988. I'm also kind of a little bit nervous about it.

You know, I'm in New York, and in New York City, we've had a local initiative that's kind of similar to that that you might be aware of that was a mental health help line that was instituted by our former mayor and his spouse who was sort of leading the mental health response initiative in New York. And I had a couple of experiences with that where the crisis line itself was really, really helpful, but the subsequent ability to move the person who was now no longer in crisis but really open to getting some subsequent access to care was not as effective.

And I'm a little bit concerned about that. And there's a number of issues, and I think at the last meeting we had, some of us raised this, too, around -- and maybe this new initiative around the Certified Community Behavioral Health Centers will mediate some of this, but there's a huge need for people who are experiencing anxiety and depression before they get to the stage where they have to call the crisis line or a suicide help line. There's a huge need for access to affordable ongoing care.

And part of the problem is, is that a lot of that care still resides in the domains of private practice. And let's be real about it. I love community health centers. We should have more of them, but they really are sort of oversubscribed and overwhelmed in a lot of places and under -- and do not have the capacity to meet that kind of need.

And one of the problems, I think, is that for many of us who are licensed on a State-by-State basis, having a national reciprocity around where we can serve people and how we can serve people, even online, coming out of this crisis I think would help augment the capacity of this effort to address crisis and then to prevent future crisis. And we actually need -- you know, I know some of these associations are trying to deal with this. But we actually need some more I think weighing in from a national standpoint, from the Government agency, about increasing capacity to access ongoing care, even in a preventive way.

Page 45 of 90
And so I'm wondering what -- and I really get the idea of the Feds interfering with
the State's right to license, but the State's right to license people is much more
about controlling the financial aspects of that or the revenue aspects of it than it
is about making access to care. So that's a problem.

And then the other question that I had was there is a number of national hotlines
already, any crisis lines are in existence. If you go online and you plug it into
your browser, a lot of them will come up. And some of them, like the Trevor
Project, for example, and the LGBT crisis line that's out there that specializes for
LGBTQ people, or the NAMI crisis hotline that is also not 24-hour, but it's like a
15-hour hotline that specializes. And there's a number of hotlines like that. Is
there a way that you're going to sort of try and coordinate with some of those,
too, in terms of increasing access through the 988 system?

So I know that was a lot to ask. I think it's great. I think you're going to have a
real challenge making this work. I heard about the 60 years with 911. I get it.
But, and I think this is really cool, but I think there's still some -- there's going to
be some capacity issues, and I'm particularly concerned about moving from the
crisis to the prevention of future crisis by access to affordable, accessible,
ongoing care.

MR. JAMES WRIGHT: Barbara, I'll do my best to target some of this, and then,
Anita, from a CMHS perspective, if you have anything to add, please do.

But I want to start by saying you're talking about licensure, but you're also talking
about workforce and capacity. That is something that we are -- it was brought up
in our convening as the number-one thing amongst crisis centers was what are
we going to do to ensure we have people to actually answer the phone?

Again, I mentioned I just left the Veterans Crisis Line, and we just completed a
transitioning to national-based service and care, which is one of the outcomes of
really COVID. It forced a lot of individuals to rethink their hiring and service
provision practices. And so for the 988 team, we're looking right now at, well,
how can we make known behavioral health providers that otherwise may not
have ever found one of these crisis centers, to identify that there are positions
available and services that they can help provide to enhance response?

Can we go beyond what the typical county or hiring lines have been for these
organizations, and can we really expand that in a unified way? Can you just
imagine 200 centers all independently owned and operated, how do you find out
whether or not there's a position in one week, that closes in a week or something
like that? Very challenging.

So what we're doing is we're looking at how can we improve identification and
communication of positions that otherwise can really boost up the services of the
system, and I think it carries over well with those additional based services you're
discussing. Anything on that, Anita, and then I'll target the second one?

DR. ANITA EVERETT: Yeah, just really quickly, one of the other opportunities that we have to influence the world to the good, so to speak, is through a longstanding transformation initiative that we have that's managed by SAMHSA. And we have this year 37 different grants that have gone to States that have enabled them to plan focuses on special areas.

One of those -- one of the three areas this year, one of those three areas was specifically on and also were related to crisis, one of them was related on crisis workforce and the development of crisis workforce entities. We also widely recognize that peers and people with lived experience can be an important component, and it expands the standards of what it is to have a terminal professional degree, so to speak. So that's a very important thing.

The other major area of interest among the States is LGBTQ special populations with regards to crisis services. So States have resources. Not all of them on that, but there's a lot of resources out there, and that does speak to what your original question was about is their interest in that. And these, to be honest, these are some States that you might not expect to have this interest that in our Western States. I don't have that with me right now, but it's what you'd want to see.

MR. JAMES WRIGHT: No, and Dr. Everett, I'm so grateful you highlighted really peers and warmline functions as well, as critical components of this. They're embedded within our crisis center playbooks. Because I don't want individuals to take away, well, crisis services just means someone to respond and somewhere to go. In providing those referrals, you really instill not only a safety net for the individual, but you're matching the level of service to need.

And so many need that additional based care that might not be 988 or suicide assessment, per se, but really lived experience and discussion from a peer directly and support from a peer. So those are getting built in and evaluated the same, exact way as we do in our other crisis services.

And going back to really just high-risk --

MS. VALERIE KOLICK: Excuse me, James?

MR. JAMES WRIGHT: Oh, go ahead.

MS. VALERIE KOLICK: I apologize. We are a couple minutes over our break time. I know this has been a really rich discussion, but I'm going to have to break you off. But we can come back at the end of the meeting. We do have about a half an hour that we can continue discussion. So if everyone can hold their questions, write them down, and be ready for that.
MR. JAMES WRIGHT: I'm going to have to go back to the convening. All I'll say is we did put in the report, appropriations report and others, responses on high-risk populations. So if you have other questions, please don't hesitate to ask. I'm happy to answer.

MS. VALERIE KOLICK: All right. Thank you.

MR. JAMES WRIGHT: All right, Valerie, thank you. And thank you, really appreciate it.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, thank you so much, James, and thank you for the questions.

So we are -- we are certainly over for our break. Why don't we take like a -- why don't we take a 5-minute break, and then we'll come back for the next -- well, you know what, we can break until 3:00 p.m. What are we doing in terms of time? Yeah, let's break until 3:00 p.m., and then we'll come back to this discussion.

Allan, I do see that you have your hand up.

DR. ALLAN TASMAN: I'll wait until we come back.

DR. MIRIAM E. DELPHIN-RITTMON: Okay, yes. Yep, that sounds good. All right. So we'll break until 3:00 p.m., everyone. Thank you. And thanks, James.

[Recessed at 2:53 p.m.]
[Reconvened at 3:00 p.m.]

MS. VALERIE KOLICK: Do we have everyone back on? Dr. Delphin-Rittmon, you want to get us moving to the next area?

DR. MIRIAM E. DELPHIN-RITTMON: Sure. Yes, thank you, Valerie.

MS. VALERIE KOLICK: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: So welcome back, everyone. And I do have to say it is so good to see everyone. I didn't get to say that when I popped in, but really good to see everyone again and glad that we're able to meet.

So why don't we -- we're going to go to the next presentation. Allan, I do see that you have a question. We'll take that. Is it a quick question? Or we can take it at the end when we might have a little --

DR. ALLAN TASMAN: It's a reasonably brief comment, but it's very pertinent to what Barbara was just saying and the whole issue of crisis intervention. So if you
DR. MIRIAM E. DELPHIN-RITTMON: Yes.

DR. ALLAN TASMAN: -- I'll try to be brief now or do it later.

DR. MIRIAM E. DELPHIN-RITTMON: Okay, why don't we try to be brief now, and then we'll continue on.

DR. ALLAN TASMAN: Okay. Part of the issue -- yeah, part of the issue that Barbara was talking about is inadequate workforce.

DR. MIRIAM E. DELPHIN-RITTMON: Yes.

DR. ALLAN TASMAN: And I think, you know, this is something I think should be considered more robustly. Back in the late 1960s, early 1970s, when the Community Mental Health Center Act had just been implemented, it became very clear there weren't enough psychiatrists to staff those community mental health centers, and there was a Federal -- large Federal funding to increase the psychiatrist workforce. And this went from about 4,000 trainees a year to 6,000, and that was sustained, even though the funding phased out by the early 1970s. That was just for psychiatrists.

But the other problem is no matter how much funding -- and I think there should be workforce development funding -- we have a big diversity problem. We don't have diversity in our psychiatric workforce anywhere near what we need, and that requires developing pathways for previously underrepresented groups in the mental health professions to have increased access to those pathways, however that could be done. It's not my goal here to fix that in this minute.

But I think the other thing is we not only don't have enough crisis intervention support, which is that first step after somebody calls 988, but helping someone navigate through the system. We don't have what I'm going to call navigators. Some institutions have healthcare navigators to help people deal with complex medical problems. We don't have navigators to help people through what we know is a fragmented mental health system, and that relates also to the possibility of new initiatives to train more cadre not only of peer support people who have lived experienced, but community support people who can also not only provide help to those individuals but help build community support, which addresses one of the major issues of the social determinants of despair and was partly, I think, an attributing factor to the increased suicide rate over the last 2 years. We don't need any more data than that.

So all these things sort of intersect, and I don't know what role SAMHSA can specifically play in any of these components. But it seems to me very timely to start thinking about that more robust -- in a more robust way because 988 I think
is going to work, and we're going to have an influx of need even beyond what we've got now, and we can hardly handle what we've got now.

That's it.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. Thank you for comments. I mean, it's right on.

In many ways, in fact, you've hit many of our priority areas and work that's under way. So appreciate those comments. You know, in terms of workforce, we are -- as you know, have the Minority Fellowship Program and also working very closely with HRSA in terms of their workforce strategy. And so that's absolutely a priority. The work there is focused on not only increasing the workforce, but also increasing the diversity of the workforce, as you mentioned.

Also work under way in terms of increasing the recovery, peer recovery workforce as well as like navigators and community health workers as well. So that's work under way as well.

But I appreciate those comments. The workforce is definitely a challenge area and a need that is critical that we continue to look at and address.

So, okay. So we're going to move on now to the next section of our agenda, and so pleased that we have Dr. Mary Roary with us, who is the Director of the Office of Behavioral Health Equity with SAMHSA. Dr. Roary is going to present on "Language Matters: Cultural Humility and Unconscious Bias" and will also share materials from the Office of Minority Health and also ONDCP.

So, Dr. Roary, happy to turn it over to you now.

Agenda Item: Language Matters: Cultural Humility and Unconscious Bias, Including Material from the Office of Minority Health and ONDCP

DR. MARY ROARY: Thank you. So you all know the first thing I like to do is to thank you all for all that you do for the communities, serving SAMHSA, especially your undying support for the Office of Behavioral Health Equity. You all know who you are, and we are all eternally grateful.

So I'm going to go through this. There were some questions, but maybe they were on the next slide. But if not, you all should be able to have some answers.

So what is cultural humility? I don't see it, but that's okay. What is CLAS? C-L-A-S.
Don't worry about it. We're going to go through all the slides. There we go. Someone put them at the end. Thank you.

What is one word to describe cultural humility? And what is unconscious bias?

So, right now, we're going to pause, and we're going to do something different. I want everybody to go to the chat box and give us one word that describes cultural humility. Thank you so much.

And while you are all doing that, we'll flip back to the beginning of the PowerPoint. Thank you.

Keep going. You've given them the answers, by the way. Keep going. Can you go all the way to the top? Thank you. There we go. That's perfect.

So why equity? Why now? Well, it's just the right thing to do.

Next slide, please. Thank you.

Also it's because that we continue with COVID-19. Folks would like to think that we're beyond it, but we're not. We're still in the fight. It's still uncovering a lot of things that we are seeing that is very unsettling. There's ongoing civil unrest, not to mention potential wars, and then just a rollercoaster of public health emergencies.

Also it's important because the President has said so. It's important, and he's sharing this through his executive orders, mainly advancing racial equity, support for underserved communities through Federal Government, which is Executive Order 13995.

Also it's about ensuring that everyone gets what they need in real time and that they are doing successfully well and whatever that looks like to each individual. Equity is also acknowledging and understanding, working to dismantle the systemic, intentional institutional discrimination, often based on race, gender, and that's what we're going to grapple with today.

Next slide, please. Next slide, please. Thank you.

So SAMHSA has been committed to this movement for a long time. So no surprise here.

Next slide, please. No, the slide before. Thank you. I'm so sorry. We need to stay on that slide for a second. Can you go one up, please? Two up now. One more.

Okay, thank you so much. This is perfect.
So while I share about this, you all will be able to note that I put the resources in the chat box. One more slide, please. Thank you. It's the one with A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. And what I'd like to say about that -- there you go. That's perfect. Thank you. We're going to stay there for a second. Thank you.

SAMHSA has been committed to this movement for a long time. Here is an exemplar. It was published in August 2012, but it's still relevant.

Next slide, please. Perfect. Thank you so much.

There is also information on Improving Cultural Competence. Well, this is TIP 59. I also put that in the chat box so you can click on that link. What you'd like to note here, that it's over 341 pages of information that is highly relevant right now.

Next slide, please.

Moreover, we're capturing through our key reports that highlight data disparities, such as the Behavioral Health Equity Report of 2021; Racial and Ethnic Difference in Mental Health and in Substance Use. I'll also put the links in the box for your expedited reading.

Next slide, please.

We are capturing this through our virtual roundtable. This is the NNED, which is the National Network to Eliminate Behavioral Health Disparities. And here you can see that back in just maybe a month ago, remember -- a reminder to reflect, understand, and continually pursue equity. We had a series of events there.

We also launched a wonderful celebration of Black History Month right here at SAMHSA. Dr. Delphin-Rittmon kicked us off. We had some distinguished guests. It was a wonderful event. It is also recorded. I would ask someone on the team to actually put the recording in the box so that you can click on that at your leisure.

Next slide, please.

Also back in November of last year, Dr. Delphin-Rittmon again -- shines once again -- helped kick off, with the OMH Director, the Behavioral Health Implementation Guide for National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare. It is designed to increase awareness, reengage our existing stakeholders, increase commitment widespread. It's also the right thing to do. It also has a host of trainings linked to it.

Page 52 of 90
Next slide, please.

The trainings you can find, and these will be clickable links. You all will get a copy of the PowerPoint. So no need to take notes. Also this is dedicated to each one. The Office of Minority Health Web page that tells you more about why we need to do this and how we can do it successfully.

Next slide, please.

There's no surprise that SAMHSA is also working with the Office of National Drug Control Policy at the White House. They, too, are eagerly working on this cultural bias issue, and they're also taking steps that are impactful throughout HHS.

Next slide, please.

Here, I am working very closely with the other Offices of Minority Health that have been mandated by the Affordable Care Act, and we are working on a ton of issues. Mainly, to highlight social determinants of health, the Disparity Impact Statement, the CLAS, and again, the Behavioral Health Implementation Guide for CLAS. For the Disparity Impact Statement, SAMHSA was the first agency to put out a Disparity Impact Statement. We're currently in the process of updating it to make sure that we're looking at things like social determinants of health as well as the CLAS standards. So we'll be able to track that information.

Next slide, please.

As you all so know, we work very closely with everyone. That includes the Regional Administrators, the Assistant Regional Administrators, all of the Technology Transfer Centers and other key stakeholders. Here, you can see that this is the Mental Health Technology Transfer Center, MHTTC, and they are intimately involved with culturally relevant activities as well. We work very closely with them as well, and we just did a presentation. Myself and Taylor Bryan from Region 1 just did a presentation with them in January.

Next slide, please.

Now if we talk about diversity and equity inclusion, it's important for us to understand that everyone sees and experiences the world very differently, and what is right in your experience may not be so right in someone else's. But here's the point where we have all got to grasp the concept by committing a lifelong commitment to self-evaluation and self-critique.

Cultural humility is not a prospect. It's not -- not a process, I'm sorry. Not an endpoint. We never arrive at a point where we're doing all the learning. We have so much more learning to do, all of us. We must be humble and flexible.
and bold enough to look at ourselves critically and desire to learn more.

I think we all get caught up in the day-to-day. But I think we need to take a critical look within ourselves and be willing to point out what those deficiencies are and understand that they're only as powerful as the actions that follow. So once we have identified those things that have held us back and made us less humble, we need to be able to work on it. So I think that that is very important.

Also we need to look at addressing microagression. And this is just a part of establishing inclusive and affirming environments and developing a keen sense of racial dynamics among the Nation and how it can be difficult to take steps toward racial and health equity. It's hard work. We've got to be willing to have those tough conversations that we all shy away from.

So now let's see if you all got the answers right. I didn't check the chat box, but I see that it's still empty. You all did not follow up, but that's okay. I'm here with the answer. So you better believe it. Language matters in overcoming bias, and overcoming can save lives. That's why we need to do it.

CLAS is the Culturally and Linguistically Appropriate Services, the 15 standards that we all should use. And so wherever you are within your organizations, not only require your grantees and your stakeholders, but you, too, should adopt these standards.

Cultural humility is about respect and empathy. And flip the script. Every day ask yourself how would you like to be treated if the roles were reversed?

Implicit bias, again, is unconscious bias or our attitudes and stereotypes that our decision-making can produce negative healthcare delivery and outcomes. And for SAMHSA, this impacts our continuum of care, prevention, treatment, and recovery. We are all guilty at some point in our lives, but it's important to acknowledge, address, and adjust.

Equality pertains to all people, no exceptions. And admit that there are some "isms." There's racism. There's sexism. There's ageism. There's ableism. They exist. Don't let them hold you back.

Our call to action today is to get comfortable with the uncomfortable and not to be afraid to ask the tough questions, apologize when you know that you're correct, and move forward with your new knowledge.

With that, I'd like to thank you all, and I'm definitely here to answer any questions.

Thank you.

**Agenda Item: Council Discussion**

Page 54 of 90
DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you so much, Mary.

And it seems like we're doing questions right after each presentation. So why
don't we go into -- see if anyone has any questions. I think I just saw a hand. Let
me move my -- Cristina?

DR. CRISTINA RABADAN-DIEHL: Yeah, thank you, Mary. As always,
inspirational.

This, of course, is very close to my heart, and I really appreciate you putting
things in the chat and making reference to SAMHSA's commitment to diversity
and all of the topics that you've touched. So I'm going to be a little bit devil's
advocate here because I know you respond well to that.

So how many of your pages, for example, are in Spanish? Like I notice -- I
mean, clearly, you can't really translate your entire website. But for example, you
know, colleagues at NIDA and NIMH, your landing page it says "informacion en
espanol." So, after all, we are about 14 percent of the U.S. population who we
speak Spanish, and although I do know that you pay a lot of attention on some
projects, manuals, information in Spanish, sometimes it is hard to navigate and to
land there.

Would it be something to consider to put on your landing page "informacion en
espanol"?

DR. MARY ROARY: Yes.

DR. CRISTINA RABADAN-DIEHL: Thank you.

DR. MARY ROARY: And I'm glad that you raised that, and thank you so much
for all your help. Because we're working closely together on various projects, I
want to give you a shout-out and thank you for everything that you continue to
do.

I want to say, moreover, that you'll be proud of SAMHSA. So we're headed
towards -- and we're working very closely with the Office of Communications to
revamp all of our Web pages and links to make sure that they are more culturally
relevant. We also now have a values statement within our NOFOs. Like we're
going all out. You're going to be so proud of SAMHSA.

So here, not only is the Office of Behavioral Health Equity is working very closely
with all the centers and offices, we have made a commitment. And Dr. Delphin-
Rittmon is putting her money where her mouth is, and so we're working closely
with the resources that we have to revamp so that things can be in multiple
languages.
We're also -- just to give you a preview kind of, sort of -- working on the Office of Behavioral Health Equity’s strategic plan. And in it, we plan to make sure that things are offered. We're going to pilot test it first to make sure it works and get all the appropriate approvals, but we're looking to have it in the most populous languages. So it would be English, Spanish, Chinese, and French. So we're working on all of that.

So, stay tuned.

DR. CRISTINA RABADAN-DIEHL: Thank you, Mary. I appreciate that. And just for the record, I'm always proud of SAMHSA.

DR. MARY ROARY: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. We'll take any bit of love we can get. So, thank you for your question.

Any other questions?

[No response.]

DR. MIRIAM E. DELPHIN-RITTMON: Okay. So now we are going to -- thank you so much, Mary. Always -- I always love your just energy and just thank you for your passion and all the work that you're leading with the OBHE team.

And so now we're happy to introduce Dr. Michael King from CBHSQ, so our Center for Behavioral Health Statistics and Quality. And Dr. King is going to give an overview of our Behavioral Health Statistics and Quality reports on equity.

So, Michael?

**Agenda Item: Center for Behavioral Health Statistics and Quality**

CAPTAIN MICHAEL KING: Thank you so much. And hi, everybody. As our Assistant Secretary said, I am Captain Michael King, and I'm the Acting Director for CBHSQ. I am also the Region 4 Administrator. So all of you based out of Region 4, please feel free to reach out to me. I'm your Federal BFF for everything behavioral health in our region. So please remember my name.

Next slide, please.

So this is verbatim verbiage from our website, and it describes, essentially, the mission of our Center for Behavioral Health Statistics and Quality. I think of it as
your one-stop shop for behavioral health data in the U.S., and I like to think of it as the best place to come for that. So I may be a little biased. Hope you'll forgive me. But I expect everybody to come and visit our website after this talk.

And today, I'm going to share some of the exciting work we're doing with our National Survey on Drug Use and Health pertaining to equity.

Next slide, please.

So what you can see here in this lovely slide are a couple of the product covers related to our NSDUH data, and I'm going to tell you a little bit about the survey before I get into greater detail.

So, just broadly speaking, the NSDUH, the National Survey on Drug Use and Health, is an annual household interview-based survey on substance use, mental health, and treatment. The respondents to the NSDUH are non-institutionalized civilians aged 12 and older, covers all 50 States and the District of Columbia, and the data are typically collected from January through December. So all throughout the year.

Now, just so you know, and you probably are aware, we are always working to improve the way we collect data and to improve the NSDUH. And one way that we do this is by adding additional questions on various emerging topics. And just to give you an example, in recent years, we've added questions pertaining to kratom use, to vaping, to medication-assisted treatment, and also pertaining to recovery. So a wide range of new topics added, despite trying to keep the survey to a manageable length.

In addition, recently, we expanded our criteria for assessing suicidality in youth, and we've also updated our substance use disorder criteria. So we went from using the DSM-IV criteria to DSM-5. And so that has created some interesting findings as well.

And finally, in response to COVID, we supplemented our in-person field interviewing with a hybrid model, and that relied on Web surveys, and that will continue into the future. So lots of progress. Lots of changes. Always evolving.

Next slide, please.

So this slide pictures one of our most recent publications, and the rest of my presentation I'm going to highlight some of the findings from three of these recent reports. So there is our latest behavioral health barometer report, which features NSDUH data from 2019. but then also we have two 2021 equity reports, which cover both substance use and mental health service use, respectively. And those are based on data from 2015 to 2019.
Now I'm going to take a moment here. You may be wondering why I'm not talking about 2020 data right now, and we all know that there were certain special things happening in our world in 2020. And so after this presentation, I'm happy to answer questions about the 2020 NSDUH survey year as well as future years and, hopefully, fill in any gaps for you as to like why we're not talking about those 2020 data right now, even though they're out.

Next slide, please.

So let's begin. Let's look at data for youth aged 12 to 17. In 2019, we found that 8.7 percent, or about 2.2 million youth, used illicit drugs in the past month. We also found that past month illicit drug use was similar among the female and male youth, and then compared to the national average, past month illicit drug use was higher among our Hispanic youth, at about 10 percent, and lower among non-Hispanic Asian youth, which comes in at about 2 percent. So, and you can take a look at the figure here and confirm all of those numbers.

Next slide, please.

So, as for youth mental health, in 2019, we found that about 15.7 percent, or 3.8 million of our youth, had at least one major depressive episode in the past year. Now past year MDE, major depressive episode, was higher among female youth than among males. And when we compared to the national average, past year major depressive episodes was higher among our Hispanic youth and lower among our non-Hispanic black youth.

Next slide, please.

So now if we add in adults. So if we look at people who are aged 12 and older. So that includes that 12 to 17 and then beyond. The estimate of past year substance use disorder, or SUD, was highest among our American Indian or Alaska Native respondents when you compare it to any of the other racial/ethnic groups except those NSDUH respondents who reported two or more races. So I think that's a very interesting finding.

And the estimate of past year SUD was higher for white respondents than the estimates for black, Hispanic, and Asian respondents. So if we look at those comparisons. And then, finally, the Asian respondents had the lowest estimate of past year SUD compared with all of the groups.

Next slide, please.

So if we're looking at mental health among adults, and this is just among the adults, the estimate of past year serious mental illness, or SMI, was higher among those reporting two or more races -- similar to that previous finding -- than among adults in any other racial/ethnic group, and the estimate for past year SMI
was higher among white adults than among black and Hispanic adults.

Next slide, please.

Finally, the last bit of data I want to share because I know too many numbers can be a little bit overwhelming, the estimate of past year co-occurring SUD and any mental illness -- so not just serious mental illness, but any mental illness at all, or AMI -- was higher among adults reporting two or more races, and that comes in at about 5.8 percent, than among any other racial and ethnic groups except American Indian or Alaska Native adults.

Also, we found that the estimate of past year SUD and AMI was higher among white adults than among black and Hispanic adults and lowest among Asian adults.

Next slide, please.

Now I know many of you are like me and you love to get your hands on the data yourself. You want to get in there and see what's what. So we in CBHSQ promote the free access and use of our Nation's best, in my opinion, substance use and mental health data through our data archive site, or SAMHDA.

Now I feel like this is one of our best-kept secrets for some reason because every time I go and speak to crowds, they're like "SAMHDA? What?" I'm like, "Yes, SAMHDA." In this spot at datafiles.samhsa.gov, you can find our public use data files, our file documentation, our access to restricted use data files, and all of this is with the intention of supporting a better understanding of all of these critical areas related to public health.

And I really hope that each of you, whether it's during the rest of this conversation today or after, will just go visit that site. Check it out. If you have questions, Michael.king@samhsa.hhs.gov, and if you're in Region 4, I also expect to hear from your or see you at some point in the near future.

Thank you, everyone.

**Agenda Item: Council Discussion**

DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you so much, Michael.

And it looks like we have some questions. So, Barbara and then Aaron.

DR. BARBARA E. WARREN: Hi, Michael. Thank you.

CAPTAIN MICHAEL KING: Hey.
DR. BARBARA E. WARREN: Thank you. Yeah, I've been going on, and the data since CBHQS was formed is so much better. I've been doing stuff for SAMHSA for most of my career. It is like so much better than it ever was. However, I am tired of asking --

CAPTAIN MICHAEL KING: I knew there was something.

DR. BARBARA E. WARREN: I am tired -- you have great LGB data, but you have no transgender or gender diverse data, and I am really tired of asking about this.


DR. BARBARA E. WARREN: Just wait? What am I waiting for? I've been told "just wait" for 10 years. What am I waiting for?

CAPTAIN MICHAEL KING: I can't -- I can't give spoilers, but in the very near future, we have changes in the works. In fact --

DR. BARBARA E. WARREN: Oh, yeah.

CAPTAIN MICHAEL KING: -- they may be actually already with OMB, and so just -- just wait. I don't want to say anything to get anyone in trouble. Like I'm not sure what I'm allowed to say, but it's a lot closer.

DR. BARBARA E. WARREN: All right. I'm going to believe you. I'm going to believe you now. And I'm going to -- I'm going to believe the new SAMHSA leadership, but I will -- I'm just going on record, and I know we're recording these things. I'm going on record on as saying I have asked this systematically for almost 10 years, and I've been told the same thing.

So I believe you now, but I don't want to wait so long. I just want to go on record.

CAPTAIN MICHAEL KING: You've got my email, and you can come back to me.

DR. BARBARA E. WARREN: Okay. All right.

CAPTAIN MICHAEL KING: If you don't see something different in the very near future, you come back to me personally. I will --

DR. BARBARA E. WARREN: Okay. I'm excited now to hear that. I'll be looking for it.

Thank you.

DR. MIRIAM E. DELPHIN-rittmon: Yeah. And I'll just add a couple because
in many ways, Barbara, your question gets at two of our priority areas. You know, equity is an important cross-cutting area, and so we are defining equity broadly, beyond race and ethnicity. And also data. You know, data, quality monitor -- like all of that. So this hits our data strategy as well.

DR. BARBARA E. WARREN: Got it.

DR. MIRIAM E. DELPHIN-RITTMON: And so I'm really looking to be able to better get in there and disaggregate our data by key --

DR. BARBARA E. WARREN: Right.

DR. MIRIAM E. DELPHIN-RITTMON: -- demographics so we have a sense of the nuance behind our funding.

DR. BARBARA E. WARREN: Right, right.

DR. MIRIAM E. DELPHIN-RITTMON: And how our programs are performing from a process and output perspective. So stay tuned there.

DR. BARBARA E. WARREN: I will.

DR. MIRIAM E. DELPHIN-RITTMON: We're excited about that.

DR. BARBARA E. WARREN: I will, but I'm also very interested in intersectional data. You know, especially the --

DR. MIRIAM E. DELPHIN-RITTMON: Absolutely.

DR. BARBARA E. WARREN: -- race/ethnicity, sexual orientation/gender identity data because all of the health disparities go up when you look at that.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, absolutely. So definitely an area that we're interested in as well to really get at that intersectionality. Because you're right. I think that's often where we see some of the disparity patterns and trends emerge, and we want to be able to be as targeted and specific as we can.

Aaron?

CAPTAIN MICHAEL KING: Can't hear you, Aaron.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, your volume --

CAPTAIN MICHAEL KING: Aaron, you're muted.

DR. AARON WHITE: Oh, you guys missed the best part.
[Laughter.]

CAPTAIN MICHAEL KING: And the punch line is --

DR. AARON WHITE: I just really enjoyed this discussion. I think it's so important. I think, first of all, we rely on the NSDUH data quite heavily to look at patterns of substance use and mental health. I think it's very important that we at least take the basic step of looking at the data by race and ethnicity. It seems like it's taken us a long time to get around to that.

I'm guilty of that, too. I've published a lot of papers on trends, and often, you'll see in my own papers, my earlier papers, just general trend lines. But the reality is because the majority of us are white in this country, the general trend lines still reflect mostly our story.

Interesting things happen when you just take the step to look at it by basic categories of race and ethnicity. For instance, we all have heard that drunk driving fatalities have been going down for 30 years. Well, only if you look at the general trend line. They've actually been going up for blacks, particularly black males, but black males and females for about a decade.

And we're also realizing that you have to look within these categories, too. We're not a monolithic people. But people who identify as Asian American aren't monolithic either. And so you have people who were born here, people who moved here, people who have the allele that makes it harder for them to process alcohol so they get a flushing response.

I mean, it's important to look within these categories, too. And I think that's where these intersections come into play, you know, the intersections between all these various factors that can influence our health and well-being.

That's not really a question. That's a comment, and I have one more of those. We were shocked when the new NSDUH data rolled out, and all of a sudden, the prevalence estimate for alcohol use disorder in the United States doubled from 5.3 percent to 10.5 percent. It added an extra 15 million people.

And we knew that there was a chance that switching to DSM-5 criteria would end up capturing more people. We know from previous analyses that DSM-5 captures a little bit more than DSM-IV, but we were bowled over by the doubling. And the abruptness of that change, I think, is too abrupt. I think it's important for SAMHSA to provide -- and I know it's in the -- you can get this from SAMHDA because we did. But it's important to provide people with the prevalence estimates for DSM-IV.

I know we're not going to be able to do longitudinal analyses including 2020.
because of change in methodology. But it is still important just for people to see what the DSM-IV estimates are. Because when we look at DSM-IV AUD, it turns out to be almost exactly the same as in 2019.

That was important for us to know. There wasn't a doubling of alcohol use disorder necessarily in the United States in 2020. It was all about the change in methodology.

Also, with DSM-5, there are levels of severity. It's important for people to know the levels of severity for these conditions. And so I'm imploring you to please make these data easier for people to find so that not everybody thinks all of a sudden in 2020, you know, everything went south. I mean, everything is going south anyway. We don't need to make it look even worse than it is.

So that's my comment. Thank you.

CAPTAIN MICHAEL KING: Thanks for that comment.

I will say that related to the DSM-IV/DSM-5, we've had a lot of internal discussion about how we can, I suppose, increase understanding of what that number really means. And so one way that we've thought about it internally -- and this hasn't been approved or anything. This is just one possibility. But that we do a data spotlight, which highlights some of those estimates just as a way to get the message out.

DR. AARON WHITE: I like that.

CAPTAIN MICHAEL KING: And there are a couple other options. And so that's one of the easiest ones because while you may be aware that those criteria capture a lot of different kind of stuff, and you're right. Like many people in the public just look at the number, and they just see the number as hugely different and without really scratching below the surface. So we're working on that, and I would say stay tuned.

DR. AARON WHITE: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you for the questionnaire. And Marsden?

DR. MARSDEN H. MCGUIRE: Hi. Thank you. A quick question, and I missed the very first part. So, Michael, you may have mentioned this, but the methodology of the survey. And the reason I'm asking that is there are so many faults we can find with the categories that are laid out for self-identification of race and ethnicity and so on. We're all aware of that. I don't know what the solution for that is.
However, there are a lot of people that choose not to respond, given the opportunity, and I'm wondering is that a significant group that has interesting features to it, or is that not part of what you analyze?

CAPTAIN MICHAEL KING: Let me see if I'm hearing the question right. You're asking about nonrespondents to the race/ethnicity items in the survey?

DR. MARSデン H. MCGUIRE: Right. Who might have answered --

CAPTAIN MICHAEL KING: Yeah, who maybe answered the survey, but --

DR. MARSデン H. MCGUIRE: -- have answered the questions, but not self-identification in terms of race or ethnicity.

CAPTAIN MICHAEL KING: Right. So the NSDUH, up until 2020, was an in-person household interview survey. So there was an interviewer in that household. So they could assist with prompts, et cetera. Now in 2020, we introduced a multimodal methodology because we had to. Because no one was going door to door that second half of 2020.

So, and I don't have those data at my fingertips, but I know that we do look at -- we analyze nonresponse to our items, and we look for any sort of patterns related to that. So I don't have the answer for you, but I know that we look at it. And if there was a concern, that it would certainly be documented in our published materials, and I apologize for not having that answer for you right now.

But I can tell you that I have no anxiety about the fact that we do look at that, and it would be notated in places, if we had an issue.

DR. MIRIAM E. DELPHIN-RITTMON: Okay, thank you for that question. Any other questions for Michael?

[No response.]

DR. MIRIAM E. DELPHIN-RITTMON: Okay. So we are going to go on to our next question. I'm so pleased that we have Dr. Jeff Coady with us, who is going to share on our harm reduction grant and then -- and stakeholder feedback as well that we've received.

So, Jeff?

**Agenda Item: Harm Reduction Grant and Stakeholders' Feedback**

CAPTAIN JEFF COADY: I want to thank you. Very much appreciate the
opportunity to be able to talk about our harm reduction activities.

It's a very exciting opportunity I really think for SAMHSA with our recent grant as well as the overall strategy, which we'll talk about in today's presentation.

So next slide, please.

So we know that COVID has had a significant impact on overdose deaths in our country, and really, the past 12 months between October 2020 and October 2021, we saw about a 16 percent increase in overdose deaths. However, we do know that there are strategies that are effective, strategies that can make a difference not only in terms of reducing overdose deaths, but also promoting the health of people who use drugs.

And while harm reduction is where many of these strategies are found, it is not a new topic. It's been around for 40 years. The 1980s is really when it started to emerge. It is sort of a new topic for SAMHSA in terms of our efforts.

Next slide, please.

Harm reduction is also reflected in the HHS Overdose Prevention Strategy in which many of you are familiar there is four particular topic areas of which SAMHSA is involved in all four -- primary prevention, harm reduction, evidence-based treatment, and recovery supports.

Next slide.

So within harm reduction specifically as a priority area, we have objectives and examples of different activities. As we look at harm reduction, we look at what is the research and demonstration that's going on within HHS?

So we look at fentanyl test strips in terms of how effective that can be in terms of notifying an individual because of contamination of fentanyl throughout the drug supply, using the test strips to be able to have knowledge and awareness and then, obviously, change some of the decisions and behavior related to the drug use. And NIH and FDA are involved in that area.

In terms of integrating best practices and evidence-based harm reduction, we're going to hear about the SAMHSA as well as the CDC Harm Reduction TA Center. The sustainable funding for harm reduction, I'll talk more about our SAMHSA grant.

And lastly, reducing stigma. CDC has an overdose campaign that they are embarking upon, but harm reduction is really an area, even within substance use disorders, that is often misunderstood and has a lot of stigma attached to it. So, hopefully, we'll be able to explain a little bit more about harm reduction, take
some steps toward that.

Next slide.

So harm reduction is a public health strategy at its heart. It is an approach in terms of being to reduce overdose as well as to support individuals who are using drugs in terms of their health. And to think about that concept, I mean, I think that's even the fact that we're talking about it and framing the conversation and recognizing all people have dignity, and our ability to meet them where they are and to respect that dignity and to provide them with the care and services that are needed, that really is sort of at the genesis in terms of the foundation for harm reduction.

So really supports both individuals as well promotes their health and prevents overdose, like I mentioned, but it does so, it meets individuals where they are at. It doesn't necessarily necessitate that there are some preconceived assumption or notion that you will go to treatment, that you will do X, Y, and Z to get what services you need. It really is about sort of the mutual aid and an individual, wherever they are, and promotes any positive change along that trajectory.

We know that oftentimes when an individual might get naloxone, it might take multiple attempts for that individual in terms of engagement with peer or other service providers, they can choose to go into treatment. And we know that through repeated engagement, there is a huge difference in terms of individuals' likelihood to engage in treatment. There's a huge engagement aspect in the celebration of any positive change where that might be in an individual's life.

We'll recognize that harm reduction can be a pathway to recovery, that it might be through the harm reduction services and the care that an individual receives, that that might begin the beginning of that pathway to recovery. I mean, so we have to keep all options open. It might be through increasing protective factors. It might be through access to housing, access to other care, that an individual begins to start to take those steps toward recovery.

So the more doors that we could open, the more service that we can provide and avail to people no matter where they are at in terms of their addiction, the more opportunity that we can reduce overdose death, as well as engage individuals and allow them the access to services and perhaps eventually to treatment and recovery.

Next slide.

Evidence base. Harm reduction has an evidence base behind it that produces results. Like we had mentioned, individuals who use syringe service programs are five times more likely to initiate substance use disorder treatment compared to those who've never used an SSP.

Page 66 of 90
So if you think about an on-ramp, you're really extending the on-ramp to our treatment system through harm reduction. We're sending an on-ramp to other services to keep an individual healthy and to keep their dignity and pride up through harm reduction services.

We also know that buprenorphine treatment and low-dose buprenorphine treatment and linkage to social services have been identified in terms of contributing to the success of syringe service programs. We know that there's also reduction through the HIV/hepatitis C with people using drugs through syringe service programs and those benefit both to the individuals and community in terms of the syringe service programs.

We know that they're cost-effective. They can provide obviously multiple modalities of care and treatment, including medication-assisted treatment. And we also know it's a great method to dispense naloxone and that we see many effective strategies in terms of the saturation of naloxone in the community, resulting in decreased overdoses through the use of harm reduction organizations.

Next slide.

So within SAMHSA, we have three particular activities going on. Number one is our harm reduction, our NOFO, our Notice of Funding. Number two is our Harm Reduction Summit that we concluded but continue to work upon. And three is the work of our TA center.

Next slide.

So Kurt, in his presentation, had mentioned our grant program and that the applications have already been received and are being processed, and we anticipate an award date by about May 15th of this year. And then, as hopefully, we're going to start to see some of the services by May 30th. And we're looking at about 25 awards, up to $400,000 per year.

And one of the things that Kurt also had mentioned is that within that grant application, there were 10 points awarded to engagement with priority populations, consistent with the President's executive order. And that would consist of where we're seeing high rates of overdoses in terms of both in terms of race, also in terms of location. And I think this really provides an opportunity to really focus on where the harm reduction programs are going to be and for the populations that they need to be serving.

Next slide.

So what will our funding specifically do? Well, our funding is really kind of based
upon the research in terms of what we're trying to accomplish. Number one, we want to reduce infectious disease. That's obviously something that has long been sort of storied in terms of where harm reductions originated at, in terms of HIV prevention, hep C prevention. And obviously, consistent with that is our overdose prevention and making sure that that, obviously, is first and foremost is to reduce overdose deaths.

Another aspect in terms of really distribution for naloxone. Using the harm reduction organizations in terms of their outreach, trust, and engagement because they've been in the communities for many periods of time. They have the trust with people who use drugs. They know to distribute naloxone and fentanyl test strips and help then meet people where they are and connect them to services while providing education and counseling, referrals to HIV, SDI, and viral hepatitis services.

But we're also trying to really build the capacity of our harm reduction system. I mean, often, historically, harm reduction systems did not have consistent funding so this really provides an opportunity to build that capacity within our communities within our harm reduction programs.

And really not only build the harm reduction programs, but connect them to our larger continuum of care because we recognize that we have our prevention coalitions, our harm reduction, our treatment, our recovery, and really, that really reflects community. Not one of those particular aspects of the continuum, but the entire continuum really reflects the community and that we can wrap these services around people and bring those services to individuals in the community.

Next slide.

So in terms of some of the metrics that we're looking to identify -- back one. There you go. Thank you.

So in terms of some of the metrics that we're looking to collect with the harm reduction is both what are the referrals to services? What are the linkages to services and support? What are the evidence-based interventions that are happening in terms of at the community level, as well as some of the organization and policy changes that happen after the awards have been given?

That's on the left side. On the right side, you can see really some of the grant funds in terms of some of the items that can be purchased. As we start to see, you know, the increase in harm reduction vending machines, in terms of at those locations where individuals are transitioning into different sort of settings. For example, individuals who might be released from jails in terms of the importance of ensuring that they have harm reduction supplies. At different locations within the community that we know people who use drugs might have close proximity and access frequently to the vending machines.
And obviously, other services related to HIV and STD prevention, as well as sharps, fentanyl testing strips, wound care, vaccination services, and really bringing, again, a whole array of services to individuals.

Next slide.

So during the time right before we released the NOFO, SAMHSA had partnered with the Office of National Drug Control Policy, ONDCP, as well as the Centers for Disease Control and Prevention, CDC. And we held a -- really, a historic 2-day summit. And this summit was historic in many ways because it really included the voice of the community, people who use drugs.

We had a great, diverse representation from the harm reduction community. People who are using harm reduction services, providers of harm reduction services, and really, I think what we have brought together at that is not really the harm reduction community, but also representatives from prevention, from treatment, from recovery because if we're truly going to help ingrain in terms of the fabric, in terms of our continuum of care, we really need to have everyone at the table working together. See where the linkage points are. See where some of the tension and touchpoint might be. And how we can talk through this in a way, I think, that really, at the end of the day, is really going to help the individuals that we serve.

So it was a historic summit that we had and really had some great and lively conversation and I think really beginning to develop trust with a group of partners that we haven't had relationships previously.

So, at the conclusion of that -- next slide -- meeting, yeah, we formed a steering committee. And that steering committee has been working hard for the past probably 2 months. We have representatives from the harm reduction community that are on that, in terms of diversity and in terms of race and in terms of sexual orientation, in terms of location. It was a really rich group, as well as we have representatives on it, again, from prevention, treatment, and recovery.

And together, they've been sort of synthesizing the information from the summit. And the results of that are going to be drafting some harm reduction definition of principles as well as pillars or supportive strategies. This is very consistent with the process that SAMHSA took about 10 year ago in terms of helping develop the recovery definition pillars and principles.

So we're using a similar process. I know the group is close to getting done, and like I said, they're doing phenomenal work. I'm really excited to see from their voice in terms of what should be coming forward. And then continue to work that through SAMHSA, as well as it'll go through a public comment period and, hopefully, releasing that in terms of late this year.
Another area that we've been working in is with our Harm Reduction Technical Assistance Center that we've done in collaboration with CDC. And as we started -- the funding started to come for our Harm Reduction TA Center, one of the things that we heard from the field was, hey, there is an existing system that works that provides TA. How can Federal partners work closely together in a way that's aligned?

So SAMHSA decided then to help fund the TA center that existed by expanding their services. So I think, one, it's a great example of our Federal agencies working together and then, building upon the success and the trust that that has, to expand our services and outreach in terms of harm reduction. Because the TA center that CDC had, it primarily sort of focused on syringe service programs, which is definitely necessary, but we also want to sort of extend that to more community-based harm reduction services and strategies.

So our TA center is getting definitely a lot of activity, and there's a lot of outreach and a lot of excitement. In terms of the increase in the field, trying to see what are the evidence-based strategies that we can implement? And they really walk-through harm reduction coalitions, whether they're first starting off in terms of what needs to happen, all the way up to those who are a little bit more mature in terms of how to help look for different grants opportunities and sustainable funding. So wherever a coalition might be, we want to be able to assist them and help them take that particular next step.

Next slide. I think that's the last slide, actually. It is.

Okay. Thank you very much.

**Agenda Item: Council Discussion**

DR. MIRIAM E. DELPHIN-RITTMON: Okay. Thank you. Thank you so much, Jeff.

And I realized I did not mention that Captain Coady is doing double duty as the Acting Director at CSAP and also the Region 5 Regional Administrator. So I definitely want to put that out there as well.

CAPTAIN JEFF COADY: 24/7/365, we're always open.

[Laughter.]

DR. MIRIAM E. DELPHIN-RITTMON: And just awesome. So thank you, thank you, thank you.

Page 70 of 90
Any questions? Great. Cristina?

DR. CRISTINA RABADAN-DIEHL: You know me, I always ask a lot of questions.

DR. MIRIAM E. DELPHIN-rittMON: Oh, no, it's wonderful. That's why we're here. We love it. That's why we're here.

[Crosstalk.]

DR. CRISTINA RABADAN-DIEHL: So, first of all, a shout-out and thank you for including stigma as part of the harm reduction. I think that we all know, particularly, you know, in the context of diversity, equity, and inclusion, we know that stigma is one of the biggest barriers and particularly in some of our communities. So thank you very much.

I was really -- I was really paying a lot of attention when you were listing the evidence-based strategies and particularly the success of syringe services programs on those individuals and their likelihood of reaching out to seek treatment. However, as I am reflecting on the current situation, I mean, we do know that heroin, for example, is one of those drugs that in addition of being injected could also be, you know, smoked and snorted.

As a matter of fact, if you go back into the report that SAMHSA launched I think it was a couple of years ago regarding the opioid crisis in our Hispanic community, when we really look at the use of heroin by our youth, the Hispanic kids grades 8, 10 to 12, were the highest users among all of the racial and ethnic groups on heroin without a needle.

So I think that we need to pay a lot of attention of that. And my question is it was about a year ago, because I remember I joined the council exactly in March last year, and one of my questions was about what about fentanyl test strips, right? And I remember I was told something is coming. And it was, indeed, in the month of April when SAMHSA announced that Federal funds could be used by States and others to develop the strategies on fentanyl testing strips.

However, in the last year, at least in my State, in Maryland, I really have continued seeing a lot of resources, meetings, regarding overdose reversal through Narcan. But I have not seen so much, frankly, on overdose prevention through the use and distribution of fentanyl testing strips. So I was wondering if perhaps in this year, you can give us some examples of what is happening in the country as far as implementation distribution of fentanyl test strips?

Because I think we are all aware that, you know, it's wonderful that we have Narcan for overdose reversals, but for that, you need to be next to someone who...
is using. A lot of the people who are dying, including my son, were alone when they had an overdose. I can assure you, and I always say that I am sure that Jonathan, had he had access to fentanyl testing strips, will still be with us today.

CAPTAIN JEFF COADY: Thank you for the comments, the questions, and sorry for your loss as well.

You know, I think we have in terms there's fentanyl test -- FTS, Fentanyl Test Strip Working Group right now that really I think all across harm reduction, we're really looking at the policy, the research, and the practices. So I don't know of the deliverables of that workgroup, but I think that's information that they're sort of looking at as well as we look at this whole area of harm reduction and, really, because much of the research, it's not as current as we'd like it. So we're going to really, I think, see a robust partnership with our Federal partners looking broadly at this.

In addition, I don't know if any of my colleagues -- I mean, this is something that although right now the grants are in CSAP, it's something that we work both across all of SAMHSA with. So I don't know if -- Dr. Olsen, if you're on, if you have any more information on the FTS Workgroup that might be helpful to add. If you're not, that's good, too -- and that's okay. Not good, but it's okay.

DR. MIRIAM E. DELPHIN-RITTMON: I know there is a study that's going on through that workgroup, Jeff, that's looking at this. That's looking at the usage of FTS and impact. So I'm not sure how far along they are in terms of any of the outcomes, but I believe that was one of the deliverables, actually, that's even listed as part of the HHS Overdose Prevention Strategy, an assessment of the impact of the fentanyl test strip changes.

DR. CRISTINA RABADAN-DIEHL: Thank you for that.

And also just, I guess, my final comment. One again, I think the multi-stakeholder approach of this working group and trying to figure out a strategy is important. And having the community of individuals in recovery is crucial, but I would also like to make a pledge for you to include families of individuals that actually are affected by substance use disorders who have not made it yet into the recovery community or those of us who have lost a loved one. Our perspective is a very important one, I think, and not all the time we are being represented.

Thank you.

CAPTAIN JEFF COADY: Thank you for that. Appreciate the comment.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah. And I want to thank you as well for that comment. In some ways, it relates to our next presentation as part of our
overall priority area in recovery. And then also I am sorry for your loss as well, but thank you for your advocacy and work in this area.

So, Sally?

DR. SALLY SATEL: Hi, thanks. And again, Cristina, I'm so sorry, too.

Just a quick question. If one wanted to ask you to consider or ask the NSDUH organizers to consider kind of a new question, what would be the -- what would be the mechanism for doing that? I mean, I can tell you specifically what I want to know, but that's the general question is I think you should ask about X, Y, Z. How does one kind of submit that suggestion?

CAPTAIN JEFF COADY: This is for NSDUH?

DR. SALLY SATEL: Yes.


DR. SALLY SATEL: Oh, did I get the wrong -- it's the wrong person?

CAPTAIN JEFF COADY: No, we both are --

[Laughter.]

CAPTAIN MICHAEL KING: I'm sorry, and I actually had -- I just had to step away, but I just came back. And so could you repeat the question? I apologize.

DR. SALLY SATEL: I'll repeat it. It's really -- yeah, and that's okay.

I was just wondering what is the mechanism for suggesting to the survey creators that they maybe introduce another question? I mean, I know the last thing people want to do is keep adding like a Christmas tree onto things. But -- but still, there are some questions that I think would enlighten epidemiologists a lot and the public and policymakers if they could be added.

CAPTAIN MICHAEL KING: Yeah.

DR. SALLY SATEL: So how would one do that?

CAPTAIN MICHAEL KING: Yeah. So, in fact, you're at it. This is a wonderful mechanism to make that suggestion.

DR. SALLY SATEL: I didn't know because I will ask -- I'll tell you what I want to know.
CAPTAIN MICHAEL KING: Yeah. Tell me what you want, what you really, really want.

DR. SALLY SATEL: Okay. It's very brief.

CAPTAIN MICHAEL KING: Sorry.

DR. SALLY SATEL: You know, there's almost like an iconic pie chart that came out I want to say 2014 or '15, and the question is where did you obtain -- if you -- among drug misusers -- it's such a broad term. But anyway, among drug misusers, where did you get, obtain your last pill, I guess, within the last 30 days? That's the gist of it. And the question that I have and that so many people I know have is where did you get your first pill from?

Now I understand memory and recollection is going to be imperfect, but the implication that a number of -- that I hear a lot is that people, even though we're largely past the opioid prescription phase of the crisis, that you still hear that people's -- the impression is people started their opioid trajectories with pills that they got from their doctor.

And I'm not saying it never happens, but I think it's a lot less common than is portrayed. Really don't know that, though. We know that 22 percent got their last dose from -- only 22 percent got their last dose from a doctor in this famous pie chart, but not where they got their -- it's effectively the pill that started them on the trajectory.

So that's it.

CAPTAIN MICHAEL KING: Yeah, initiation.

DR. SALLY SATEL: Yes.

CAPTAIN MICHAEL KING: Yeah, well, so to go back to your question about how do we add new items to the NSDUH? A forum like this is one of the many avenues by which we get those ideas to -- for what to add and what not to add. So also our Federal partners often will suggest items. So I will say the Center for Behavioral Health Statistics is our one center that does not have its own special NAC. We may be correcting that in the future, especially now that I've said it on a national NAC. I'm probably in trouble now.

DR. SALLY SATEL: It's being recorded.

CAPTAIN MICHAEL KING: And it's being recorded, but I know that. So, and it's very important for me, given I guess my pedigree in the region, to have the feedback from the public. And I think -- I don't think Miriam disagrees with me
either. I think this is -- this is valuable.

Your input and your opinions are important to us, and so all of these avenues are things that we want to explore. And so, at least while I'm with SAMHSA, I want to make sure that we're doing that and I know Miriam is all about getting input from the public. So this has been recorded. I know that folks in CBHSQ are watching, and we'll be having a conversation about this.

DR. SALLY SATEL: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, thank you for that. Great, great recommendations and ideas.

And Michael, we will definitely be in conversation. Yeah, we should talk about that. I mean, it's so, I think, important to get community feedback and input. And so definitely a NAC is -- we can definitely work on that.

Jennifer?

DR. JENNIFER A. HOBIN: Hi, thank you. Yeah, just very quickly going back to fentanyl test strips, I just wanted to make the point that this is a very active area of NIDA interest and research right now.

We've got a number of studies that are currently active, looking at -- you know, looking at the sensitivity and specificity and the limits of detection on fentanyl test strips, positive and negative behavioral health consequences associated with their use, some studies looking at overdose interventions that involve FTS education and distribution, among others. And then we also have a couple of FOAs specifically focused on fentanyl out right now that are soliciting research on FTS.

So happy to follow up and share any information that would be of interest to folks.

DR. MIRIAM E. DELPHIN-RITTMON: All right. Great, Jennifer. Thank you for being on.

So that table in the Overdose Prevention Strategy, so that block must be all of what you're talking about, the part where it talks about the pilot work and the research around the fentanyl test strips?

DR. JENNIFER A. HOBIN: It's at least some of it.

Any other -- any other questions for Jeff?

[No response.]

DR. MIRIAM E. DELPHIN-RITTMON: Okay. All right. Thank you, Jeff.

CAPTAIN JEFF COADY: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: So we're going to continue on, and now we also have with us Dona Dmitrovic, who is a senior adviser with Office for Recovery. And Dona is going to talk about the Office of Recovery, which we are still so excited about.

So, Dona?

**Agenda Item: Office of Recovery**

MS. DONA M. DMITROVIC: Thank you, Miriam.

Good afternoon, everybody, and thank you for the opportunity to provide an update on the Office of Recovery. As a woman in long-term recovery, I am really honored to be able to support our recovery work here at SAMHSA.

As Dr. Delphin-Rittmon just said earlier, we have four cross-cutting principles across all of our priorities, and that includes recovery. And during National Recovery Month, we announced the establishment of our new Office of Recovery.

As many of you know, in 2010, SAMHSA brought together leaders in mental health and substance use communities to develop a working definition of recovery. This definition, "Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential," has withstood the test of time.

This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery, nor a necessary outcome of the process. Recovery pathways are highly personalized, building on the strengths and resources of individuals. Pathways may include professional clinical treatment, use of medications, peer support, support from families, programs in schools and in faith-based organizations, and many other approaches.

SAMHSA has had a long history of supporting recovery from both substance use and mental health disorders. A true recovery orientation means building on existing strengths, both individual and system. Passionate and committed staff, leadership with a sophisticated understanding of recovery, and systems that
already exist to promote recovery will help to provide and promote the necessary infrastructure of the decades of work of SAMHSA's recovery policies.

But SAMHSA's recovery definition demonstrates recovery happens in communities and does not happen in a vacuum, and I think both Jeff and Michael talked about that earlier. We know that all of our work happens in communities.

There are many systems that are affected by individuals experiencing mental health and substance use disorders and their families, friends, loved ones, and allies. SAMHSA will be able to further raise the profile of recovery for mental illness and substance use disorder by having one institutional entity that will lead the agency in this work. The office will coordinate with all centers and offices to ensure, as the national leader of recovery initiatives, that SAMHSA has the capacity to bring together voices of our recovery communities that includes both mental health and substance use to ensure that the millions of Americans who have yet to find recovery and that the millions in recovery are able to sustain and strengthen their recovery.

So the Office of Recovery will ensure that the voices of individuals in recovery are involved in policy, programs, and services within the agency, and there is a recovery focus to agency programming. Our strategy will be well planned and executed with input from the field, and I emphasize that because anything we do is going to include stakeholders. So we'll have folks from the recovery field that will be involved in everything that we do.

Our strategy, the strategic vision of SAMHSA will also be followed as we build out this Office of Recovery. And I do want to emphasize that this is a priority. The Office of Recovery will be under the Office of the Assistant Secretary. So it's elevated. And we are inclusive of both mental health and substance use, and I can't stress that enough.

So the dedicated team will have a deep understanding of recovery to also bring together the voices of our mental health and substance use communities to drive the overarching goals and objectives of our work. These are just some of the objectives that we have come up with as we started to plan for the Office of Recovery.

And the first one is to ensure that recovery is the guiding principle in all of our policies, programs, and services; to promote the involvement of people with lived experience throughout agency and stakeholder activities; identify health disparities in underserved populations and ensure equity for recovery support services across the Nation, foster relationships with internal and external organizations in the mental health and substance use recovery field; promote training and public education opportunities on recovery; explore opportunities to partner with the philanthropic and private sectors to support innovative programming to address disparities and advance recovery transformation; and
support implementation of any dedicated recovery resources to States for recovery support services, in particular working with the Peer Recovery Center for Excellence.

Next slide, please.

So this is just a graph of the proposed staffing for the Office of Recovery. Currently, we're in the process of developing human resources capital for the office, and this is the recommendation that we believe we'll need in order to be successful as we start out the Office of Recovery. Of course, I think big, and I think that, eventually, we'll be able to have a huge office, but we'll start here.

It includes a Director, Deputy Directors, executive assistant, and special assistant. We'll have a public health adviser, who will really be working with the technical assistance teams. Whether that's the Peer Recovery Center for Excellence or some other TA Centers, we'll have someone dedicated for that.

We also will have public health analysts that will work with our center's leadership. So these staff will be liaisons that will be housed under the Office of Recovery, however will be dedicated to the center. So they will be working with, for instance, CSAT on working with their recovery-focused grants and the Recovery Branch to make sure that we're working in sync with each other and having communication as to what is happening within each one of these centers.

And then we will also have a statistician who will really look at data and evaluation. As you know, it is a priority of SAMHSA, and we want to make sure that we are able to really be able to validate the work that we're doing as far as recovery supports and what outcomes we are seeing as a result of that.

So, right now, we're at the point where we have the job descriptions ready. They have been approved. We're just waiting for final approval of the office structure before we can post these. And I don't want to put a timeframe on it because I tend to say it will happen next week. It might take a little longer than that, but it is in process, and we hope to have people applying for and hired in this division soon.

Next slide.

So, finally, I just want to give you a little update on some of the current activities that we have, and it includes an agency-wide workgroup. We have 17 cross-cutting workgroups within SAMHSA because they really hold these lines of communication open between staff that maybe don't see each other every day. Of course, hopefully, now communication might be a little easier as we get back into the building. But I want to say that this workgroup for recovery actually has a membership of, over staff, 60 staff across the board.
So what we've been doing is really keeping the lines of communication open and then looking some of the priorities that we might need to focus on initially here within the Office of Recovery. We've been reviewing and updating our recovery materials, working with our Office of Communications. So we really want to ensure the prominence of recovery at SAMHSA, as well as on our website.

So while we haven't had to do a lot of changes, we do -- we have made some to change the language to be updated to what we're using now in the field.

SAMHSA's programming includes discretionary grants such as the National Consumer Technical Assistance Centers, our targeted capacity expansion grants, the State consumer networks, Recovery Community Services Programs, and other discretionary grants for States, tribes, and community-based organizations really that have created innovative practices and programs to promote long-term recovery.

We have lessons learned that have been able to be applied to help build a community of professional capacity; help create a movement of peer support specialists and recovery advocates; draw attention to local, State, and national discriminatory policy barriers to sustain recovery; foster the need for recovery research; and educate the public, families, and allies about the reality of recovery from substance use and mental illness.

I've met with external stakeholders to hear their ideas and concerns around systems transformation in the Office of Recovery. We put together some short-, mid- and long-term goals, but the reality is this is really about the recovery community. And while we can help guide, we want to be sure that the Office of Recovery has value and is not just an office that was just stood up and has no meaning to the field.

So just for your information, the three priority areas I heard from our stakeholders included helping to support standards or guidelines for peer recovery support services, recovery housing standards, and I think this is really telling, post COVID and self-care for peer workers. So we just don't go back to work after being isolated for 2 years, but we really need to think about how we can help people as they transition back to the workforce. So these were the top ideas for some products that SAMHSA could support.

And lastly, and really in my view probably the most important, was the ability to provide data that demonstrates the effectiveness and value of recovery and recovery support services. As one of our priorities, we feel strongly that gathering the right data and having the research about our practices which show that people can and do recover from mental health and substance use disorders and live productive and happy lives. And we are also part of the data and evaluation cross-cutting workgroup, where we can ensure that recovery is at the forefront when we talk about these things.

Page 79 of 90
And that's it.

**Agenda Item: Council Discussion**

DR. MIRIAM E. DELPHIN-RITTMON: Thank you so much, Dona.

Any questions? Barbara?

DR. BARBARA E. WARREN: I don't have a question. I have to just give Dona a shout-out because we go way back, and this is wonderful. This is really wonderful. Dona and I were a part of the original RCSP program in the late '90s, the Recovery Community Support Program that morphed into community recovery services, that morphed into -- including Tom Hill, right?

MS. DONA M. DMITROVIC: Yep, mm-hmm.

DR. BARBARA E. WARREN: Who just recently retired from a very illustrious career in recovery support. And I'm really thrilled to see Dona, and I just wanted to give you the chops out loud for what you're doing now because you're really an iconic leader in this field, and it's really exciting to see that SAMHSA is really embracing this fully.

MS. DONA M. DMITROVIC: Thank you, Barbara.

DR. MIRIAM E. DELPHIN-RITTMON: Fantastic. Thank you, Barbara.

Marsden?

DR. MARSDEN H. MCGUIRE: Yeah, hi. That was a really terrific presentation. I work in the VA, and we have a fairly robust set of recovery-oriented services. We have for a while. Very proud of this.

One of the interesting things, though, about veterans, which is shared with nonveterans in this area is stigma with regard to seeking services. And so one solution within VA has been to create primary care mental health integrated services, which don't have the language of mental health as explicitly. It's you can get the service, but it's kind of hidden within a primary care frame.

So, to me, that raises the question, and there's really not a right answer to this, obviously. But I just think it's fascinating. How do you engage people with using language that is designed for one set of folks who might be willing to engage and say, "Yes, I have a mental health condition and need some assistance," versus those who may have that condition but aren't really willing to address it explicitly?

So, in VA, what we've done not only historically, but have access through the
primary care framework for those folks. But now building something more broadly, which essentially is an updated or expanded version of recovery-based care, but we're calling it whole health care. It's sort of a wrap-around that works with the primary care frame that still can serve these folks in the same way that recovery does for those who go through the -- you know, into the more traditional mental health services.

And I just wondered if that makes sense to you, as an expert in this area, and if that's something you've seen or observed as being successful in other settings than, say, the VA?

Thank you. I hope that question made sense.

MS. DONA M. DMITROVIC: Thanks. I think I understand what you're saying.

So, well, of course, stigma, as you recall, that's the thing that kept coming to my mind, that people don't -- people will not talk about their issue because of the stigma that surrounds. And I don't have the answer for that, but I think it's something that we absolutely need to take into consideration as we start to move forward the work of the Office of Recovery.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, thank you, Dona.

I think that's right on. I think it's something that we just need to continue to explore, to include looking at different models. And I think part of that might be, Marsden, the model that you mentioned and the ways in which language makes a difference and has an impact on help-seeking and connecting with services and supports.

So we'd love to hear more about that, your approach and what you're seeing in terms of people connecting with a shift in that language.

DR. MARSDEN H. MCGUIRE: Yeah, I think this is a question that I think can be informed by data, and since this is a program, the whole health program framed around primary care and, hence, primary care mental health integration, it is one that we'll have maybe in 6 months when our next meeting is, I can present something preliminarily on that. It would be kind of fun.

But recovery language may not work for folks who don't acknowledge they have a mental health condition is my bottom line. So trying to work around it.

Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. So, so we will likely be following up because we'd love to see that data, and perhaps for our next meeting, we could have a presentation, if that would be of interest to you.
DR. MARS DEN H. MCGUIRE: It would. Can I bring a friend who might be as expert as me?

DR. MIRIAM E. DELPHIN-RITTMON: Absolutely.

DR. MARS DEN H. MCGUIRE: Okay. Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Absolutely. Any other -- any other questions?

MS. VALERIE KOLICK: There's also a question in the chat from David.

DR. MIRIAM E. DELPHIN-RITTMON: Oh, okay. Let's see. Okay. So what is the current pathway for inclusion of persons with lived experience in an advisory capacity at SAMHSA? Will that be in the Office of Recovery?

So --

MS. DONA M. DMITROVIC: We have had conversations about that. Of course, there are some regulations and things that we have to look at, but definitely, I believe that at one time there was a consumer advisory committee. And looking at what our ability is, if we can't have a separate committee, for sure ensuring that people with lived experience are on all of the NACs. I'm going to push for that anyway, and I know Miriam believes in that as well.

DR. MIRIAM E. DELPHIN-RITTMON: Cristina?

DR. CRISTINA RABADAN-DIEHL: I just wanted -- just a brief comment. I wanted to join Barbara in congratulating you because it's not only about the amazing work that you are going to be doing, Dona, and your colleagues at SAMHSA, but it's also the fact that there is a dedicated office to that sends a message of hope. And I think that that's really what hits home, right? Especially for all of those millions of families that are struggling every day with substance use, either their loved one or themselves because, as we all know, this is a family disease.

The fact that SAMHSA is taking this so seriously, right, and is saying we are having an Office of Recovery because we know it is possible, it's just a very powerful message. So from where I sit, you know, from that family perspective, I wanted to thank you.

MS. DONA M. DMITROVIC: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. Thank you so much.
And you know, some of our discussions have been around -- really related to your comment earlier, Cristina, around the importance of including family members in the work. And so stay tuned there as well because we -- that is some of our interest and intention, and we're excited about that. Because as you've mentioned, family members have a unique perspective and can play a really valuable role in the work.

So, thank you.

DR. CRISTINA RABADAN-DIEHL: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Any other questions or comments for Dona?

[No response.]

DR. MIRIAM E. DELPHIN-RITTMON: All right. Thank you so much, Dona. Thank you for the questions, everyone.

MS. DONA M. DMITROVIC: Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: So it looks now we are at the public comment section of the meeting.

MS. VALERIE KOLICK: Miriam?

DR. MIRIAM E. DELPHIN-RITTMON: And I believe I turn this over, right?

MS. VALERIE KOLICK: Oh, sorry, Dr. Delphin-Rittmon?

DR. MIRIAM E. DELPHIN-RITTMON: Yes?

MS. VALERIE KOLICK: We do have time for a council discussion. So if you want to open it up? Yep.


MS. VALERIE KOLICK: It can be about any topic.

DR. MIRIAM E. DELPHIN-RITTMON: Valerie is keeping us on course. Yes, so this is good. And I love when we have open time like this. Some of our thinking around putting together the agenda, we wanted to give a number of updates in key areas and discuss some of the work in SAMHSA, but love when we have open time like this on the agenda as well.
Anything folks want to bring up or talk about that we haven't discussed?

MS. VALERIE KOLICK: We can -- oh, Dr. Satel, did you have something? I kind of see your hand waving.

DR. SALLY SATEL: Yes. I just wanted to mention Tom -- Dr. Insel's new book. It's called "Healing --" and I don't have it in front of me, but I think it's "A Path from Mental Illness to Health."

Anyway, it's just really a good book in terms of laying out a blueprint, with a lot of overlap, of course, with the programs you're talking about. But, but what's really striking about it is that he -- I mean, he certainly does -- he certainly believes we should be progressing in pharmaceutical work and neuroscience, and I completely agree with that.

But he is very open about the limitations of that and how the translation into actual clinical work is unfortunately not -- I think it will really progress at some point, but right now it's not. And that's why there is even, in a sense, extra importance on doing the kinds of efforts that SAMHSA does that he frames them in this way, which is it's a little slogan, but I think it's profound also. It's, "People, place, and purpose," and just how important that is.

Anyway, the book is really worth it for the revelation alone, I think. But it's also, like I say, a good compendium of good discussion of programs and places that have done it great and some -- a lot of them is in the United States. So, anyway, that's my two cents.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. Thank you for that recommendation.

It looks like Dr. Gordon put some information about the book in the chat. So there's a link and the title. So thank you for bringing it up.

DR. SALLY SATEL: Yeah, thanks.

DR. MIRIAM E. DELPHIN-RITTMON: And Dr. Gordon, good to see you again. I know we spent some time together yesterday on the hearing, but glad that you're with us.

DR. JOSHUA A. GORDON: Yeah, Dr. Delphin-Rittmon, that was -- I had my hand raised. I'm sorry to jump in front of Aaron. I'm sure we can give him a moment.

I just wanted to say to everyone if you didn't get a chance to see the hearing yesterday, it went really well. We have a lot of friends on the HELP Committee in Congress. They're really interested and engaged around SAMHSA's efforts and
using evidence-based approaches.

So I thought it went well, and your fearless leader, Dr. Delphin-Rittmon was duly interrogated and really responded fantastically. So I thought the hearing yesterday went well, and people should know that.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. Thank you. It was -- it was good going through that together. And it's true, we have a lot of support, and there's a lot of energy around mental health right now and interest in making an impact there.

Aaron?

DR. AARON WHITE: Thank you. Well, I raised my hand before I heard about the new book and the hearing, both of which I have not seen.

But I just want to make a comment that I, as everybody else here, I spend a lot of time in meetings talking about the data and the issues. And I have this worry that we spend too much time describing the problems and talking about the variables and not enough time talking about the solutions.

And you know, this notion of purpose and meaning in life, which is not a super scientific concept, but wherever you -- it seems that wherever we find people that have more purpose and meaning in life, they're better able to cope with stress and roll with the changes and less likely to develop problems of all sorts, less likely to commit -- to die from suicide, et cetera.

So just a reminder from me that I think we should try to incorporate whenever we can discussions about the solutions. Otherwise, we're just going to spend the next 20 years together describing what's going wrong in the country.

Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah. No, thank you for that. Thank you for that.

I mean, in many ways, it's about being strength-based and talking also about the things that are working and things that are going to make an impact. And just a tiny bit of a preview, we -- the full leadership team, we were together earlier this week, and this was some of our discussion as well, about the mental health promotion part of the work and who we are.

And yeah, it comes -- the health, home, community, and purpose component of the work.

DR. AARON WHITE: Thank you.

Page 85 of 90
DR. MIRIAM E. DELPHIN-RITTMON: And so we see that as an important part of who we are. Our work ultimately is geared towards helping recovery and wellness, but there's some of the upstream work that's important as well around mental health promotion and what works, and how do people thrive. And what are some of the ways in which people thrive in communities? What does that look like in health?

So all of that, so thank you for that.

DR. AARON WHITE: Thank you. I'm so glad you mentioned all that, I mean the health promotion. And again, just like there's no one size fits all for recovery in general, there's really no one size fits all in terms of finding meaning and purpose and thriving. It looks different for different people.

And I do think it's important to understand the patterns in the data so we can find places to assess and intervene and promote wellness in that way. But I think sometimes that that gets a little bit lost in the discussion because we're constantly finding new data telling us that we have things to worry about, and I like the discussions about promotion and wellness, too.

So, thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Thank you. Thanks for bringing that up. Barbara?

DR. BARBARA E. WARREN: Yes, thank you for that, Aaron.

As a diehard existential humanist, I absolutely believe that, that that's part of the equation for people, and I also think that it's a good thing to follow up on Dona's presentation on recovery because recovery comes in many shapes, sizes, and forms. And I think SAMHSA making that an integral part, not like sort of an outside, lived-experience advisory part, but an integral part of the work lends itself to what you are talking about as well and the wellness approach.

But what I really wanted to talk about, and I brought this up the last time, and yes, I think -- I think there's a lot of -- there's a lot of treatment stuff that we're learning about. I'm saying this sort of in the vernacular -- that has to do with some of the neurobiology and also some we were talking about health equity and inclusion. I mean, even people with meaning and purpose in life and even people who are really determined, there's a lot of structural barriers sometimes that set people back, including issues of racism and heterosexism. And those are things we have to address, too, as part of the wellness.

But the thing I'm going to throw out there, we threw this out the last time, and I've mentioned this before is I'm really interested in the applications of psychedelic
and indigenous and plant medicines to mental health and to recovery, substance abuse treatment. And I think it's a little bit sticky still with SAMHSA because we're talking about the use of drugs that were previously kind of vilified and the issues of how marijuana now has transformed from gateway to medicine and where that lies.

And I would really like to see some focus on that and some way to sort of address how that gets integrated into our treatment toolbox and isn't just something we kind of still whisper about in the context of SAMHSA.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, thank you for that. I mean, that's definitely an area of work that we're looking at now as well. We know some of these medications are under consideration for FDA approval as well, and so stay tuned. I mean, all of that is we have work that is happening there. I think potentially even a cross-departmental -- well, it's in process. So stay tuned, but we'll definitely keep everyone updated.

But this is definitely an area that is evolving within the field, and it's important for us to be -- to be responsive and aligned with what is -- where the field is evolving. We should have more information by our next meeting as well, potentially.

Any other -- any other questions or comments?

[No response.]

MS. VALERIE KOLICK: We can move on to public comments.

DR. MIRIAM E. DELPHIN-RITTMON: Yeah, yep. Yeah, why don't we go to public comment? And Valerie, do you lead that part, the public comment section?

MS. VALERIE KOLICK: I can.

DR. MIRIAM E. DELPHIN-RITTMON: Okay. It says DFO manages this section.

**Agenda Item: Public Comments**

MS. VALERIE KOLICK: Yep. We only have one public comment, and do we have Dr. Phil Skolnick online?

DR. PHIL SKOLNICK: I'm on the call.

MS. VALERIE KOLICK: Okay. If you want to, go ahead and ask your -- or make your comment, that'd be great.
DR. PHIL SKOLNICK: Thank you. Thank you for having me.

My name is Phil Skolnick. I'm the chief scientific officer at Opiant Pharmaceuticals.

Opiant's research and development efforts led to the approval of Narcan nasal spray, and our current pipeline is focused on the development of novel pharmacotherapies to treat addictions and drug overdose. By way of background, prior to joining Opiant, I served as the Director of the Division of Therapeutics and Medical Consequences at NIDA, where our primary mission was to develop novel therapeutics to treat addictions.

I'm here today to request SAMHSA use molecule agnostic language in its grant programs that provide funds to purchase opiate reversal agents by qualified entities. In a 2017 publication, NIH leadership asked to "work with private partners to develop stronger, longer-acting antagonists to counteract the very high-potency synthetic opioids that are now claiming thousands of lives each year."

Opiant, with the support of both NIDA and BARDA, responded to this call. We are now in late-stage development of an opiate overdose product for community use. This product, which is now called OPNT003, uses nalmefene, a very high-affinity new opiate receptor antagonist, in combination with a nasal absorption enhancer.

Currently, grants such as the SAMHSA State Opioid Response Program only allow funds to be used for the procurement of naloxone-based reversal agents. Given that we and others are developing innovative non-naloxone-based reversal agents, there is a concern that organizations using SAMHSA funds may not be able to purchase the reversal agent that is best suited for their community's needs.

SAMHSA's State Opioid Response Grant Program is a critical pathway used by both States and territories to help distribute reversal agents and save lives. Last year, 54 State and territorial grantees reported reversing approximately 90,200 overdoses with agents purchased with these funds. These data, as well as the continually rising number of opiate overdose deaths, demonstrate that the language in the State opioid response grant, as well as other grant programs, should be updated to ensure these entities can purchase any FDA-approved reversal agent.

I note that SAMHSA has already utilized this molecule agnostic language in the FY '22 harm reduction program grant announcement, which allows funds to be used for "FDA-approved overdose reversal medication." This language ensures that these funds can be used to purchase any reversal agent currently approved by the FDA, as well as those which may be approved in the future.
Similar language now exists in SAMHSA's FR-CARA grant. It is critical that SAMHSA update the language in their relevant grant programs to ensure that funds can be used to purchase any FDA-approved overdose reversal agent, giving communities the choice of agent best suited to fit their needs.

Thank you for your work in this space and for your continued leadership in the fight against the opioid epidemic. I'll be happy to answer any questions.

[No response.]

DR. PHIL SKOLNICK: No?

DR. MIRIAM E. DELPHIN-RITTMON: Thank you for that public comment.

MS. VALERIE KOLICK: Thank you, Dr. Skolnick.

Okay, I will turn it over to Dr. Delphin-Rittmon to offer our closing remarks.

**Agenda Item: Closing Remarks/Adjourn**

DR. MIRIAM E. DELPHIN-RITTMON: Okay, thank you, Valerie.

I just want to again just thank everyone for -- I mean, we had such good discussions around each of the presentations, and so just really, really thank everyone for your feedback and for the discussions that we've had.

I also want to thank all the presenters, but I really appreciate, you know, this is always a wonderful meeting to be able to come together and share together around just a number of key areas. So, again, appreciate everyone's input and feedback.

Our next meeting, we have one coming up, let me see, next meeting will be August 2022, and it looks like we have one in September as well. So looking forward to those meetings coming up, and we'll keep everyone posted about any -- yeah, I believe we send out the minutes ahead of time, and we'll send out materials. But again, just thank everyone for your participation and discussion today.

So have a great rest of the day, everyone.

MS. VALERIE KOLICK: Thank you, everyone. And this is the closing of the 71st special advisory committee. Thank you.

DR. MIRIAM E. DELPHIN-RITTMON: Val, thank you. Take care, everybody. Thanks a lot.

Page 89 of 90
[Whereupon, at 4:43 p.m., the meeting was adjourned.]