U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR SUBSTANCE ABUSE PREVENTION

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MEETING OF THE
CENTER FOR SUBSTANCE ABUSE PREVENTION
NATIONAL ADVISORY COUNCIL

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August 8, 2012

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The meeting of the National Advisory Council of the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA), convened at SAMHSA headquarters in Rockville, Maryland, at 10:00 a.m., on August 8, 2012. The meeting was conducted as a Web conference. Frances Harding, Director, CSAP, presided.

MEMBERS PRESENT:

Frances M. Harding, Chair
John Clapp, Ph.D.
Steven Green
Kwesi Ronald Harris
Michael Montgomery

DIRECTOR, CSAP: Frances M. Harding

DESIGNATED FEDERAL OFFICER: Matthew J. Aumen

SAMHSA STAFF PRESENT: Kevin Chapman, Suzanne Fialkoff, Costella Green, Tia Haynes, Ginger Mackay-Smith, Richard Moore, Fred Volpe

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

(10:00 a.m.)

CALL TO ORDER

MR. MATTHEW J. AUMEN: Hello, everybody. My name is Matthew Aumen. I'm the designated Federal Officer for the Center for Substance Abuse Prevention National Advisory Council, and I'd like to officially call the meeting of the Center for Substance Abuse Prevention National Advisory Council to order. I'll now turn the meeting over to Ms. Frances Harding.

WELCOME AND OPENING REMARKS

MS. FRANCES HARDING: Good morning everyone, all the council members, SAMHSA staff, and public attendees that are on the phone today. Welcome to CSAP's National Advisory Council meeting.

My name, as just mentioned, is Fran Harding. I'm the director of CSAP and the chair of the CSAP National Advisory Council.

Could we have the council members that are on the phone introduce themselves?

MR. RONALD HARRIS: Yes, Ronald Harris, Chicago, Illinois, African-American Male Resource Center here at Chicago State University.

MS. HARDING: Welcome.

MR. HARRIS: Thank you and good morning to everybody.

MS. HARDING: Good morning.

MR. MICHAEL MONTGOMERY: Michael Montgomery from Maine.

MS. HARDING: Hi, Michael.

MR. MONTGOMERY: Hello.

MR. STEVEN GREEN: Yes, Steven Green from Arizona serving the Indian community.

MS. HARDING: Welcome, Steven, and really good morning to you.

MR. GREEN: Yes, it's 114 out here today, Fran.

MS. HARDING: Hey, just made us feel good.

MR. GREEN: I'm glad to contribute in that way.

MS. HARDING: High humidity day.

MR. GREEN: Yes.

MS. HARDING: Well, thank you.

MR. GREEN: Yes.

MS. HARDING: I would also like now to have all of the members of the CSAP staff that are in the room if they could introduce themselves. You'll have to speak a little loudly.

MR. RICHARD MOORE: Hi. I'm Richard Moore, the Director of the Division of State Programs.

MS. COSTELLA GREEN: Costella Green, Division of Community Programs and a branch chief.

MR. KEVIN CHAPMAN: Kevin Chapman, serving as Grant Special Assistant.

DR. SUE FIALKOFF: Sue Fialkoff, director of the Office of Program Analysis and Coordination.

MR. FRED VOLPE: Fred Volpe, team leader in the Drug Free Communities Program.

MS. HARDING: Great. And we have a number of people on the phone from SAMHSA. Can they introduce themselves? They cannot, so you have to trust me on that.

I should have started off by saying welcome to our first videoconference meeting. We may experience a few bugs along the way. Hopefully this will be our pioneer voyage into what we now know is going to be more of the future of several different types of meetings and trainings with government. So after this is over, Matthew will be in touch with you to see how it went and what are some suggestions for how we could do better. And I asked the staff to take notes on that very same thing.

At this moment, we do not have a quorum to be able to have any official vote, so I will not go into the acceptance of last meeting's minutes. However, we'll hold that off until later this afternoon after lunch when we do anticipate to have a quorum so that we can do this and the business at hand with our grants, if that's okay with everyone?

BUDGET UPDATE

So what we'd like to do is to direct you to the subject matter of our budget. We're going to have two updates for CSAP. One will be on the budget and one will be on the progress of this strategic initiative.

We have Sue Fialkoff with us who is our director. We're going to go through the budget with you. I'm not 100% certain how we're doing the Q&A with that, but I'll let Matthew deal with that.

And I also want to remind everybody that in about an hour or so, Administrator Hyde will be joining us on the phone. And we certainly will stop where we're at in the agenda and listen to Pam.

So Sue, if you would walk us through our budget for 2013 or where we're at in the whole area? Thank you.

DR. FIALKOFF: Oh, thank you, Fran. I hope you can all hear me. If you can't, someone will speak up.

We're kind of in a holding pattern right now about the budget. The fiscal '12 budget was enacted I guess late last year, and our fiscal '13 President's budget was released this past February, which we discussed at our meeting earlier this spring. In our fiscal '13 President's budget for SAMHSA, we did request a restructuring of the budget to support the Substance Abuse State Prevention Grant, which included approximately $404 million, which included about $344 million previously under the block grant and about $60 million previously under the Strategic Prevention Framework launch, which supports the SPF-SIG and the (inaudible) program.

Where we are in the budget process right now is that the Senate Committee has reviewed our budget, and the House Committee also has. They both restored our budget to the way it was before, when we had a separate launch of the SPF and for the 20% set-aside of the block grant. Now, the Senate Committee report actually was good news for us because it only cut CSAP less than 1%. There's approximately an 0.8% reduction from the fiscal '12 enacted level, despite reductions in several programs. The House report took a bigger cut out of prevention, actually cut about 35% from the fiscal

‘12 funding in prevention only. Overall for SAMHSA it was about 5%. The House report did not provide any details about which programs within CSAP or within any of the centers they were proposing to cut.

Having said that, neither of these two reports is our budget; neither of them is law. The next thing that has to happen is the Joint Committee report, which would give us a much more accurate view of what our budget for the ‘13 might be. Complicating that is that this is an election year, and we are very likely to be starting the year with a continuing resolution for at least 6 months. A continuing resolution means basically “do the same thing as you did last year.” And it may be at a flat level. It may be at a reduced level. We'll just have to wait and see about that.

And that is really all we know right now. We are formulating the ‘14 budget as we speak. We’re always in the middle of three budget years, executing ’12, congressional action on ’13, and formulating ‘14.

So it's really not any definite news that we can tell you. I'm sure that when you participate in these Joint Council meetings tomorrow that the administrator will talk more about the budget process.

Can I take questions?

MS. HARDING: Yes.

MS. FIALKOFF: Okay, does anybody have any questions, specifically ones that I can answer?

COORDINATOR: Would you like questions from the phone...

MS. FIALKOFF: Yes.

COORDINATOR: All right. We will now begin the question and answer session. If you'd like to ask a question please press Star then 1. Please unmute your phone and record your name clearly when prompted. To withdraw your request press Star then 2. Once again if you do have a question please press Star then 1. One moment please. Press Star then 1 if you do have a question at this time. We’re still waiting for the first question. I show no question.

MS. FIALKOFF: All right.

MS. HARDING: So they were just told by council members you don't need to press anything. You can just speak throughout this meeting while you're on. Just so just so you know that so we're not going to put you through the paces here.

Council members, are you able to hear? Were you able to hear the budget update? I'm asking only for voice clarity here in the room?

MULTIPLE RESPONSES: Yes.

MS. HARDING: And we can hear you very well.

MR. MONTGOMERY: This is Michael Montgomery. Yes, I can hear it, but what's happening with the slides?

MS. HARDING: We're having some technical difficulty with the slides. The only slide we had for budget really didn't give nearly the same amount information that Sue just gave you, so you're not really missing that.

We are trying to fix it so that when we get into the conversation after lunch to talk about the actual updates for the two program areas, we'll have slides for you.

MR. HARRIS: This is a question Ron has. Are those the same slides that are in the PowerPoint?

RESPONSE: Yes.

MR. HARRIS: Okay, because I got that okay.

MS. HARDING: As I mentioned and probably will a few times today, this is an experimental, first time, trying to negotiate.

Do you know what the good thing is? By Friday we will have our third NAC, National Advisory Council, and I'm sure we will have this all worked out, which is a good thing because Pam will be running those meetings, so that you're helping us get some advice.

I want to remind you that we will stop— We might actually get through with all of our agenda items before Pam joins us, but if she ends up being early, we certainly will stop for her.

Also, this is a good infomercial of sorts to remind you that hopefully all of you received the email on the National Behavioral Health Quality Framework. Did you all receive that from SAMHSA this week?

MULTIPLE RESPONSES: Yes.

MS. HARDING: Okay, great. If you have general questions about that we can answer those. The more detailed questions will be answered tomorrow at the Joint Council meeting.

More importantly, and I'm sure that Administrator Hyde will mostly bring this up as well, she is requesting that the NAC members send in your comments and suggestions and questions on the Behavioral Health Quality Framework by the end of August. It's really important that we hear from you about the framework. We're very excited here at SAMHSA that we are moving in this direction, to actually have a framework to be able to build the data around so that we can all share the successes and also learn at a much more specific level to the work that we do collectively under behavioral health here at SAMHSA, so that you can use the data and we can use the data, and all is organized in a way that makes sense to all of us. So we're very much looking forward to having the framework finished and would very much like your active participation while we build this. Any questions on that at all, if you've even had a chance to take a look at it?

Okay, hearing none, we're going to proceed. Thank you, Sue.

PREVENTION STRATEGIC INITIATIVE UPDATE

One of the items, when we had our conference call a few months ago, we thought what we wanted to do is, we shared with you at length last time the Strategic Initiative #1 for Prevention of Substance Abuse and Mental Illness. We thought it would be very helpful if we took time in all of our meetings to update you on some of the activities that are progressing with the strategic initiatives. So it's under those strategic plans that you read about but never hear any progress about.

Happily, we have just completed an exercise where we are mapping out the vital few—if you remember, the strategic initiative is separated into vital few, critical task, and ongoing activities. Obviously the vital few are the activities that we are spending the most attention on in the particular year

that they appear. The critical tasks are items that we are focusing on in general because they're important, but they're not taking the top priority of our attention. And the ongoing activities are those activities that will always be a part of SAMHSA's work, particularly in prevention for CSAP and CMHS.

So the updates that I have today pertain mostly to three of our vital few activities. The first one is Goal #1, which is—if you have your strategy in front of you, or if you don't I will remind you—with primary prevention as the focus, we are going to build emotional health, prevent or delay onset of and mitigate symptoms and complications from substance abuse and mental illness.

In particular I wanted to update you on the activities that have been taking place in Objective #2, which is, prevent substance abuse and improve well-being in states, territories, tribes, communities across the nation.

This again is focusing on the whole broader category of building emotional health. The first is that we are in the process of selecting states to receive the Partnerships for Success II grants that we talked about last time. We are hoping that we will fund somewhere between 11 and 18 states. We received a good amount of applications. And these grants are state driven and will be funded for 3 years.

We also have released a second RFA on Project LAUNCH. We're in the review process of them. And the exciting news, and I think that you'll be interested to know, 40–46% of our applications this year for Project LAUNCH that have successfully come into SAMHSA were from tribal communities. This represents an increase of 6% than the previous RFAs that we've given out.

So I'm very pleased with that. Having the honor of directing the new Office of Indian Alcohol and Substance Abuse, we are broadening our focus and are targeting the tribal community. Seems to be taking hold in the area of prevention.

The next thing I wanted to update you on is that we are in the process of the ending stages of putting together a state policy committee for the Institute of Medicine. The policy committee will be held to selected states to assist in their work to develop a statewide prevention infrastructure to prevent mental and substance abuse disorder among children, youth, and young adults. We are planning this for

sometime in September. SAMHSA has undergone, as everyone in government, a new planning process for meetings and conferences, so some of our dates have not been finalized yet.

I'll take a little moment to brag about this. And it's not so much bragging about the academy but bragging about the work that's being done in SAMHSA. We truly have developed an integrated team of both substance abuse and mental health professionals here within CSAP and CMHS, Center for Mental Health Services. They're working to put this together.

If you remember, we talked a lot about the integration of substance abuse and mental health last time. And I think that fact that we have such a stellar agenda for this academy shows how effective and, over time and if you're patient, the coming together of our field both in a local and a federal level is truly starting to materialize. And we’re seeing some great strengths. So I'm particularly pleased about the proposed agenda. And as soon as that is finalized, if you're interested we can share that with you.

And not to be confused with the academies that we are having, we are also having a National Prevention Leadership Academy. This year we’ve postponed the actual face-to-face academy until spring of 2013. In the meantime we are putting together four Webinars focusing on preparing the prevention workforce, new federal legislation and the impact on prevention particularly around Affordable Care Act, which we’ll be talking about later this afternoon, and integration of prevention and mental health, and prevention and primary care, which is something else we’ll be talking about this afternoon, some of the topics that the council members were interested in.

So those are the updates. A few others around critical tasks, still staying with Goal #1, six to eight of our 2009 cohort grantees for Safe Schools/Healthy Students have elected to implement the Good Behavior Game in the fall of 2012. SAMHSA has been looking very closely at the implementation of the Good Behavior Game, and the preliminary data that we’re seeing has been very encouraging.

We just finished a training last week of our conference, excuse me, our grantee participants of learning how to implement the Good Behavior Game into their school. You may know that the Good Behavior Game focuses on strengths and changing of attitudes and behaviors around young people in schools and giving them coping skills for building a more, what we would call in our prevention-ese,

which we talked about last time, too, some coping skills to deal with a much healthier perspective around mental wellness and substance abuse.

And last but not least, the Third Annual White House Summit on Bullying Prevention just ended, just occurred on Monday and Tuesday of this week. SAMHSA staff were facilitating a couple of panels, which was a great honor for us. And our own Secretary Sebelius was in attendance as well to give some remarks and her support. As you hopefully remember, our President and his administration has come out very strongly in support of bullying prevention programs and for several populations of high risk across the country.

Are there any questions from the council members on any of this before we go to Goal #2? I'm feeling like I'm doing a lot of talking and not giving you a chance to comment. Okay, hearing none, many of you have learned even if you've only known me a while that I'm usually never lost for something to say.

Let's move on to Goal #2. And Goal #2 is focusing on the prevention, or reducing consequences of, underage drinking and adult problem drinking.

You may remember from our conversations last year—last meeting we spoke about our vital few, we are focusing on underage drinking and not adult problem drinking at this time. Although you might be interested to know that we have been working in partnership with NIAAA and CDC around their efforts to focus on adult problem drinking.

That falls in one of those categories to help you understand those three categories of where we rate the work that we’re doing with our strategic plan—vital few, critical tasks, and ongoing—that the adult problem drinking category filters with the ongoing activities. So everything that we do in the strategic initiative that you have a copy of is going on in some form. It’s just kind of the level of attention that SAMHSA’s giving it overall.

Under Objective #1 in Goal #2, which is to establish the prevention of underage drinking as a priority for states, territories, tribal entities, colleges, universities, and communities at large, we have done a lot of work and have had a lot of progress with our ICCPUD committee. If you remember ICCPUD is

the federal committee that is made up of several—and if Steve Wing were here he would tell me the number—nearly 19 members of federal government representatives on that particular committee. It's the Interagency Coordinating Committee for the Prevention of Underage Drinking. I just want you to know I did that without a script. That should be one of those impressive moments.

We’re doing two things. One of the activities that Administrator Hyde may or may not allude to when she's on the phone is that we have done—

Sorry, I'm reading and talking at the same time, which never works for me. I'm sorry, thank you.

This is a difficult time, right before an election, right in the middle of downsizing our budgets, and trying to develop priorities where both our resources and our staff are focusing on working in the area of underage drinking, which is not an overly pleasant topic for all Americans, has given us an opportunity to work with the ICCPUD representatives on actually doing some real good prevention work.

And one of the activities that all of the ICCPUD members have agreed to—and again, these are various members or participants, and we can get you a list of if you're interested, everything from Justice to ONDCP to CDC, all of the HHS agencies and such—have agreed to do a series throughout the year of those starting in September or most likely starting in October of our new fiscal year, every other month having a new Webinar around issues concerning underage drinking and different populations as it pertains to each of the agencies that are a part of this committee.

That means that NIAAA will take an opportunity to focus their Webinar on probably something like their latest research around underage drinking. Department of Transportation wants to do a Webinar on the effects of underage drinking and driving and some of the driving laws.

SAMHSA will most likely be focusing on more of the underage drinking programs that we’re seeing happening in our communities and our states, most likely will be asking representatives to come on the Webinar and discuss what they're doing, what's the evidence-based program they’re working with, how are they bringing environmental prevention into the community of which they’re working in, and most importantly, what are the outcomes that each of these programs are seeing in the practice.

So hopefully that gives you a little bit of an idea of the kind of Webinars that are proposed to be working.

And in the beginning both our Surgeon General, Dr. Regina Benjamin, our Assistant Secretary for Health, Dr. Howard Koh, and our Administrator Pam Hyde will be kicking off the first Webinar again as soon as we have the dates secure of when we’re able to put this together. I'm guessing it will most likely be—well, if I were Steve Wing he would say September, but since I'm not, I'm going to say October—but somewhere along there, that's when we'll have the big kickoff of the Webinar series.

And at the same time, because our government and we are not sitting by and doing only one thing, the committee is also continuously working with the Surgeon General's Office to begin an update of the 2007 Call to Action for Underage Drinking for the country. The Surgeon General has totally embraced this concept of updating the 2007 report, which I think she should be commended on, because as you may know, she wasn't the sitting Surgeon General when this report first came out. But after intense review of the 2007 Call to Action, most of what is written in that report still pertains today for useful guidance for the country. So the update will be a minor update of bringing both the new science for underage drinking, more emphasis on environmental prevention and its effectiveness with looking at underage drinking in the country, and a whole host of program successes that I can’t even envision right now of doing.

So we'll start that work in January of 2013, and we suspect that will take a good part of the year.

Okay. Any questions or interests or anything that you'd like to see happen in these two vital few categories and goals for our strategic plan here? Good.

Well, one of the other areas in underage drinking that is a bit noteworthy falls under one of the critical tasks that we have in Goal #2, which is expanding our work into higher education. We had a great, successful meeting in March or April of this year with The Network Addressing Collegiate Alcohol and Other Drug Abuse. The Network is a volunteer group of higher education, college and university representatives. Usually it's either the dean of the college, vice president of student affairs, or a director of the health or wellness center of the college. They meet on a monthly basis.

They are a very large organization with thousands of volunteers on each of their campuses working towards, particularly, underage drinking, although they have wandered into other areas of interest, which I'm very excited about, which is focusing on suicide prevention, focusing on several other drug abuses, particularly with some of the increases we're seeing, especially on the college campuses around prescription drug misuse, and focusing on overall emotional health and particularly bullying.

We have solidified a great working relationship with The Network. SAMHSA is seriously considering a closer relationship with higher education as we go forward.

We're working very closely with the Office of National Drug Control Policy and again NIAAA to move forward together in our partnership to address particularly if there still continues to be the first drug of choice on a college campus, which is alcohol use, and particularly underage drinking.

Along with that we're also looking at focusing on having a discussion—and I'd be very interested in hearing your opinion—on SAMHSA bringing the subject of binge drinking more into the forefront as a critical task for us to enter in on focusing on with our strategic initiatives. If we did this, we would most certainly be working very closely with The Network of the Collegiate Alcohol and Other Drug Abuse committees to help us with that endeavor.

Does anyone have an opinion about that?

MR. HARRIS: Yes, Fran, this is Kwesi. I think that's an excellent initiative to be pursuing.

And as you talk about with the collegiate network, I would maybe even suggest that we also engage in some kind of dialogue or open up the communication if we haven't already with the national (inaudible) councils of the various Greek letter organizations, fraternities and sororities, that are on the campuses. Because oftentimes when you think of binge drinking, not that it is exclusivity only mainly to fraternal and sorority life, but you tend to hear episodes of those types of things coming to bear.

And so we can bring that type of leadership. And I'm sure though the collegiate network may have already done it, but I just think it'd be a great engagement from SAMHSA's perspective to reach out to really show we're not just operating in a one-dimensional nature. We're reaching into other areas where we may never ever have been.

And when we start talking about making resources available now, those groups get to apply for some of those grants to become more of a social force on the campus. Just a thought.

MS. HARDING: I think that's a very good thought. And I do think that The Network has made some progress and movement in that area. But when we had our meeting, and it was a 3-day meeting where all of the leaders of the Strategic Initiative #1, both on mental health and substance abuse, spent time with The Network, they're very anxious doing exactly what you're saying, partnering with SAMHSA to be able to have that type of an outreach, and working together we'll be able to get to a much more targeted, focused area of concern, depending upon what their data is showing them of their need. Very similar to the work that we're doing in our communities. So we agree with you.

MR. HARRIS: Yes, particularly start thinking about the target market and going on with the beverage industry. We know that a lot of times there are subliminal messages that are directed at the younger or the youth segment of our communities. And so if we can begin to move things around whenever the media advocacy, the whole notion of looking at environmental racism and looking at this from a social justice perspective as well, I just think it puts us at a cutting-edge or ahead-of-the-curve perspective because they would never see that coming. If it were to come out of a body set as SAMHSA, it just gives more fuel and more anchorage in communities that are greatly impacted by underage drinking.

I know here in Chicago we launched a campaign some months ago when Colt 45 malt liquor was pushing this new flavored malt liquor. And they were using Mr. Calvin Broadus, who once went by the name Snoop Dogg, and just recently has become Snoop Lion. He had an epiphany, I guess, when he visited Jamaica and hooked up with some other folk.

But nonetheless we saw it as a direct attack on the youth segment of a community, particularly African-American youth, and we kind of pushed that back. It didn't get the thunder that they had hoped for. And so we're doing things like that. The reality is we know these industries are in business to make a profit, but we've got to be a countermeasure of really the alternative, so members can at least say, "I had a

choice." A lot of times when it comes down the pipe, it doesn't even appear that a choice was even offered. It was like you've got to do it or not, you've got to just do it.

And so I think that's a great step in the right direction for SAMHSA's in particular in the area of prevention.

MS. HARDING: Thank you. We agree with you, and it might be a more intensive topic for our next meeting is to really take a look at where our advances are with higher education, in particular working with The Network. And along with many of the other things The Network brings to bear is that very large cadre of volunteers that have been trained on the college campus to get the word out and to be able to make an impact almost to the level of every dorm or every off-campus apartment.

So we're very excited to learn about their work as it pertains. And as I said this, is a great, great opportunity for us to springboard into showing how emotional health is a large part of choosing to binge drink or falling into that all familiar norm on a college campuses of drinking to excess. I think this will be one of our bright lights moving into the future here of some hardships of trying to keep our programs going.

Welcome, John. I hear that John Clapp has joined us. What a wonderful time for you to be jumping into this conversation.

DR. JOHN CLAPP: Yes, I apologize. I had technical difficulties on my end here.

MS. HARDING: That's all right.

DR. CLAPP: But glad to be on. Yes, but just like to maybe add a little bit to that conversation about . . .

MS. HARDING: Thank you.

DR. CLAPP: . . . binge drinking and college drinking. Having worked at the Higher Ed Center for the past couple of years, which, I'm sure as most of the people on the call know, has been defunded starting this fall, there will be a kind of a dearth of services available to campuses.

Also having been a researcher on the NIAAA side for a number of years and working with them on some of their current college drinking initiatives, I think one of the key roles that SAMHSA can play

is helping make sure that the science that gets generated at NIAAA and NIDA gets put into a format, whether it's disseminated through grants or the network, that campuses can use in a user-friendly way.

And the most recent research out there looking at implementation science around this issue kind of shows that most campuses aren't really implementing programs that work or that we know work. So I think that's a natural place SAMHSA could come in and make an impact.

MS. HARDING: That sounds great, John. I don't know that we've really spent some real-time focusing on that. I can see that as a very natural growth from our partnership with NIAAA and the work that we're doing in utilizing the network.

Would you be interested, if we're able to, when we query the counsel to help us with guiding us through some of the materials and some of the science that we might be able to interpret for . . . ?

DR. CLAPP: Oh yes. Yes, absolutely. I'd love to work on that.

MS. HARDING: Oh, great. Matthew will get back to you on that after this meeting and after we're able to share the minutes of the meeting with our partners who couldn't join us today, so that we can get a robust, maybe a conference call around September-ish, so that we can put this together, because that sounds like a great direction that fits right into our new environment here of being very cost-effective, a way of getting materials out and needed resources to the field.

DR. CLAPP: Right, right.

MR. MONTGOMERY: Fran, this is Michael. I'd be interested in a little discussion about how—I'm familiar with binge drinking and its relationship to problems with college students. I'm curious about how that rises in priority compared to other forms of alcohol abuse. And I'm not contesting it. I'm just curious about how binge drinking becomes a higher priority than some of the other ways that people begin to abuse alcohol.

MS. HARDING: I don't know that it's a higher priority, Michael. I think that on a college campus, it's certainly one of their high priorities. We are seeing an increase in binge drinking whereas we're not seeing an increase in underage drinking.

We’re not happy with the percentages of underage drinking across the country, and we certainly need to continue to put pressure to bear. And that's what the work of the Webinars and the work we’re doing with ICCPUD is going to hopefully produce.

NIAAA is in full partnership, and one could say maybe even almost in the leadership influencing role, when it comes to developing our agenda for moving forward with underage drinking. But the binge drinking is particularly something that came up in our meeting last summer, last spring, with The Network. And that, combined with SAMHSA’s numbers from our NSDUH data that is showing in this population, 18 to 21, I think, 17 to 21, a small increase in binge drinking. And that's also showing the greatest problems and connected with related injuries on campus.

So we could very easily, Michael, bring that data to share with you and to set up a conference call with some of The Network leaders. And maybe even if you could become part of the subcommittee that John is shown interest in helping us with, we might be able to further flesh that out.

MR. MONTGOMERY: Yes, thank you. I’m really interested in it in terms of when we have limited resources where we should apply our resources. That’s kind of my question there.

MS. HARDING: Right. And please don't misunderstand. I'm not saying that SAMHSA has devoted any extra resources nor will we, by the looks of the 2013 budget, than we already have. It's with our underage drinking contract, public education program is the work that we’re doing. That's why I like John's proposal to look into, because it’s more material development, technical assistance, and guidance.

So we are not in the position, and didn't mean to give the opinion or thought, to develop a new program that we’re going to be funding. This will all be through our normal work through the Drug Free Communities and the SPF and again through our underage drinking public education campaign.

And definitely thanks to you. You guys can talk. Yes, we have additional information.

STAFF MEMBER: I was just saying we do plan to make some awards in the STOP Act communities throughout the country and hoping that we can partner in terms of the items that the general manager says. I think it's a great opportunity for us to combat all of those issues on campuses, but to also

focus in on the Surgeon General's Call to Action again. And that's what we are promoting to the STOP Act.

MS. HARDING: Did you guys hear that?

RESPONSES: Yes.

MS. HARDING: Great. Thank you. Anything else? Fred, do you have anything to add?

MR. VOLPE: Just one point on this because many of the . . .

MS. HARDING: Tell them who you are.

MR. VOLPE: Fred Volpe, and I'm a team leader in the Drug Free Communities Program. Many of our community coalitions, most of our community coalitions, have underage drinking campaigns that are focusing on literally thousands of kids across the country. But some of our coalitions are really hooking up very closely with their universities. I'm familiar with Florida and they're a good example.

And I think we're making some progress. Also hopefully we could have some data and information from them that might be useful with this.

MS. HARDING: Great. It's sad that we're still focusing on underage drinking to the extent we're focusing on underage drinking, through all the years that we have worked on it. That might be that negative news. The positive news is that we are making great advances. And the more advances—and all three of you on the phone or four of you, you understand this. But the more attention we can bring and the more angles that we can help our countries see the little wins.

What we need to do more of is share some of those little wins. And that's an area that SAMHSA is also taking under advisement around the strategic initiative, to look at where are we going to begin to show better outcomes and taking the outcomes that we have in those what I call sometimes those small successes at a community level and share them with the rest of the country, which is what we sorely are lacking at this point, so all of that conversation can be brought to bear by looking at the subcommittee.

Actually about a year ago we talked about the whole, for lack of a better word, marketing value of the successes that we are having in our fields. And we have some guidance from the National Advisory

Council, which we have actually adopted some of that. So I think that we just need to keep focusing on that.

Administrator Hyde is increasingly aware and supportive of the fact that, as we move closer to primary care, we move closer to 2014 and health reform, we need to have this information available so that we can show our general health partners that we are an asset to them as they move forward to becoming a healthier nation or a healthier community or a healthier family and individual.

So that's how all of this interrelates with us. And The Network has had some extreme successes coming from the Higher Education Center that John has alluded to. And SAMHSA is going to do our absolute best to keep some of the work and some of the intent of what the Higher Ed Center was trying to do going, until we are able to come up with a more solid assistance and generate support throughout the country. We don't like to see when some of our valuable resources begin to fade away due to resources. And I think the stronger SAMHSA can become in helping people see our successes and how the implementation of our science is effective and it's having success, it will help in far-reaching numbers than where SAMHSA themselves can reach.

We have about 15 minutes or so before Pam, Administrator Hyde, comes on and talks with us.

I just had one more area, Goal #3, which is our goal to prevent suicide and attempted suicides among populations at high risk, especially military families, LGBTQs, and American Indians and Alaska Natives. We have just a couple of short updates for that goal as well, so that you know what we've been working on.

One is the biggest thing that we're working on, and we're very excited about this because we have a date, and that is September 10, in cooperation with the National Alliance for Suicide Prevention. We will be launching the revised National Strategy for Suicide Prevention with the Surgeon General. It's in collaboration with the Office of the Surgeon General and the Action Alliance Versus Suicide. We're very excited about this, and we are looking forward to September 10. And all the NAC members, you'll probably hear about this again tomorrow in the Joint NAC meeting. And you certainly will have a heads up if in fact this is a solid date and time so that you can log in and experience the relief. One of the good

reasons for watching this this rollout is because this is exactly the type of rollout that we're going to be expecting when we do the revision of the 2007 Call to Action report.

So any advice between September 10 and next year on how we maybe change it or adapt it to underage drinking would be helpful.

We also have just recently released a series of videos or DVDs—I'm dating myself—stories of hope and recovery. And I have not yet had the pleasure to see these videos because they literally have just recently been released. But it's a video guide for suicide attempt survivors. These are individuals that have come to open up and share their stories of what drove them to want to commit suicide, what prevented, what in some cases intervened on the act of a failed attempt, and what have they learned since.

I'm told that it is incredibly inspiring and very moving and not to mention informative. So I will let you know where to log in on those and more information as it becomes available to us in SAMHSA and send it out to our NAC members for your own review.

I am trying to work very hard with our Center for Mental Health Services particularly in the suicide area to the point where a group of CSAP professionals are going to sit down with some of the staff in the Center of Mental Health services to talk out, What did you do to make the alliance successful? And how are you able to put together and get some attention on some of the materials that Center for Mental Health Services has?

They seem to have had great success with the Action Alliance, which is a public/private partnership, and volunteers of individuals coming together to talk about the programming and topics that we talk about with the NAC. So we're very excited.

And another one of the good positive things that have come out of SAMHSA's desire to make SAMHSA a united unit of specialty and experts in the field here to help the American public understand, appreciate, and have the science and guidance of how we developed prevention programs that address both mental and substance abuse disorder prevention issues.

I could talk forever. But I think that those are the major successes and advances we've done in the last 6 months. As you can see, no moss is growing under anyone's feet in SAMHSA, particularly in prevention.

We still continue to struggle, like everyone in government, in how we make the choices we make, of where we put our staff. There used to be an expression “do more with less.” That's not even applicable anymore because that's the norm as we go forward.

Are there any areas of the strategic plan that you would like to know more about since we have about 10 minutes or so to actually have some conversation?

COORDINATOR: If you’d like to ask a question please press Star then 1...

MS. HARDING: This is just for the council members. Thank you.

COORDINATOR: My apologies.

MS. HARDING: No, okay. The other goal for Strategic Initiative #1 is to reduce prescription drug misuse and abuse. We did not highlight the progress and success of that. And you're going to maybe find this a bit humorous. It's because there has been so much work going on in the last 6 months around prescription drug misuse. We didn't quite know how to pull SAMHSA out of it and give credit, because this is the one area the country has so very quickly come together on, and almost all of the Health and Human Services agencies have some type of project or program.

I can tell you that if you remember when we spoke about the Behavioral Health Coordinating Committee last time, this is the committee of all of the 11 HHS agencies that come together on a quarterly basis under the direction of Dr. Howard Koh, the Assistant Secretary for Health, and Pam Hyde, our own Pam Hyde for SAMHSA, where we have five subcommittees.

One of the subcommittees is the Prevention of Prescription Drugs. Now what's interesting with this is that when we 2 years ago put this committee together and came up with the five areas of concern, prescription drugs were just beginning to be recognized and looked at. And now, my own personal opinion, it has become one of the most valuable subcommittees that we have on the council because there are eight agencies that are working weekly on this.

The subcommittee is chaired by Dr. Nora Volkow of NIH's National Institute on Drug Abuse, and Dr. Peter Lurie, who is representing the FDA. So I get the honor of facilitating this group. And we have sent a letter to the secretary a list of programs, initiatives that her agencies would like to forward and begin to work on together. So as soon as we get the nod from the secretary, we will share with you some of those issues that we're going to be doing across collaboration with our HHS partners.

DR. CLAPP: Fran, this is John, and this is just more of an information for the rest of the committee and . . .

MS. HARDING: Yes.

DR. CLAPP: . . . you all. One of the last things the Higher Ed Center will be doing this fall is holding a 2-day meeting in October in Washington on nonprescription drug issues on college campuses. So we're going to work with ONDCP on that and NIDA. And we're certainly hopeful that we can get some SAMHSA representation as well.

MS. HARDING: Absolutely, John. And we can give you specifically the staff that we would recommend. I know that Dr. Peter Delany, who's currently the Director for the Center of Substance Abuse Treatment, because he's still on his detail swapping with Dr. Clark, would be very interested in this conference, as well as some of the CSAP and CHMS folks. So I will share this.

DR. CLAPP: Thank you.

MS. HARDING: You're very welcome. Could you send your information through Rich Lucey when it gets firmed up, or if it is firmed up now if you haven't already done so? If I know Rich, he's probably already on top of it but just in case.

DR. CLAPP: Yes, I will. I'm not sure that they have the exact date yet. So I'll get in touch with Rich as soon as we have it.

MS. HARDING: That would be a great. And we will share with all of the council members, especially if you happen to have the ability to have call in numbers to people to listen to certain segments or anything along that line.

DR. CLAPP: Okay, yes.

MS. HARDING: Thank you. Thank you, that was good.

Any of the other council members have any information that you would like to share along those lines? This would be a great opportunity since we're waiting on Pam within the next 5 to 10 minutes? Does anyone at the table have and the news you would like to report out?

Hearing none, if you promise me not to go away, we can give you a little break for 5 minutes. Just don't go away from your phones, so when Pam gets on you can unmute them and be participants. Because I'd hate for Pam to come on and we have no one on the line. So shall we just take a breath for 5 minutes or so and if you think something just feel free to call back in? We're not going anywhere. Our phones are on. But we'll try to keep our chatter to a minimum as well. Okay?

DR. CLAPP: That's good. All right.

MS. HARDING: Okay. Thank you.

SAMHSA ADMINISTRATOR'S REMARKS

ADMINISTRATOR PAMELA HYDE: Hello. So I'm here.

MS. HARDING: Oh, good, Pam. We were told you were trying to get in.

ADMINISTRATOR HYDE: Yes, technology's fun.

MS. HARDING: Yes. We're learning that here also. Actually we'll have to get together and share stories.

ADMINISTRATOR HYDE: Yes. So, good. So everybody's still there and ready for lunch?

MS. HARDING: Yes, they are. There you are in between them at lunch.

ADMINISTRATOR HYDE: Okay, well I won't take very long then. I just wanted to say hello to everybody and thank you for being on this call.

And in this process, all of us are learning a little bit about this. I just was with the Women's Council and said to them what I will say to you, which is, we are learning that as the world changes so must we. And we're trying to figure out and learn how to be more technologically savvy and how to do meetings by technology. We're also obviously in a learning curve so please bear with us. Those of you who do this kind of stuff a lot I would say, if you would like to advise us, please be advisers and let us

know. In the meantime bear with us as we're learning how to do this. It's especially tricky because we've got conferences going on or committees going on sort of all over the place.

And tomorrow, just want to highlight for you a couple things. I can see you're doing it after lunch as well, but tomorrow we're going to do a presentation on health reform and where SAMHSA is and get your feedback about things we need to be working on. Obviously also, the state impacts or impacts on the health reform of state's important.

I just did some comments with the Women's Committee about how critical the August 1 announcement was. And you all would be interested as well—and Fran you may have talked about this already—but the new screening and preventive services that are going to be available for women in any new plan that goes into effect after August 1. So when your plans go into effect that you are already in, that could be August 1, it could be October, and it could be January 1. But whenever that happens now, there's a whole set of preventive services that we are going to have eligibility to them, one of which is tobacco screening and cessation efforts. So for without a co-pay with no cost to the individual, so a woman who might be interested in not smoking any longer but hasn't had the money really for efforts of that should have access to that.

And depression screening is going to be in there as well. That particular one doesn't have as much substance abuse and alcohol screening.

One of the things that we continue to work on is trying to line up the screening efforts based on what the USPSTF says—so that's the Preventive Services Task Force, that has the screening tools. And they are looking at more of the substance abuse and SBIRT screening tools to make sure that they are going to line up with the evidence that they require to bless those things. And as that happens, we will be more able to get those measures into programs like I just described.

That's also true for NQF. So we have National Quality Forum—we have significant work going on with them—and NCQA, which is another major group dealing with measures development. All of those things together are crucially important because the measures we use and the measures we try to put

in things like the announcement. That happened this week for preventive services. They all have to be blessed in some way or another by either the USPSTF or by NQF or someone.

So that's part of the work that SAMHSA's doing. And to the extent that you wonder sometimes why a reg comes out or a rule comes out or an announcement comes out that says what will screened for depression for free, but we don't screen for alcohol for free, or we screen for substance abuse for free, but not for depression for free or whatever.

So I just wanted you to know that we're working mightily on that on all of your behalf. So that's critical and wanted you to be aware of it.

So I digressed a little bit.

Tomorrow we're going to talk about some of the health reform work that we're doing and what that's going to mean to people over the next few months, because it's going to be a really critical time for states to make decisions. And we'd like to get our advisors' input about that.

We've also asked, and I don't know if you've done it yet, Fran, but we've also asked that each of our councils take up the National Behavioral Health Quality Framework as a topic over the next little bit. That framework is actually going to be presented to our National Advisory Committee on Friday. And we really welcome you any of you who have the stamina to go through yet one more set of electronic listening. But that's only for about an hour. But it's a really important hour. I think it's from 11:00 to 12:00 Eastern Time on Friday. And the presentation will be where we are in the process with that National Quality Framework. We are presenting it at a Health Reform Coordinating Committee, which is the group inside HHS with the secretary that talks about aspects of the Affordable Care Act that are about ready to pop out. So we'll present that to her and to that committee at the end of August. And then we will present it to the public for comment sometime in September. So we're really interested in each of our councils getting an opportunity to learn about it and wrap your teeth into it and give us some feedback. And it's an evolving but very, very important process for the country's efforts around quality. And we're still leading that charge around quality and behavioral health issues.

So let's see. One of the things that we're going to be talking about tomorrow is really important for states and what they're experiencing out there as both budgets and health reform hits and all of the political conversation as well as the substantive conversation.

And then, as I said, on Friday we're going to be doing not only the quality framework but we'll also be doing a little update on trauma-informed care work that we're doing and also on disparities work that we have reported on a couple of different times. So if anybody is interested in that you're more than welcome to listen in on Friday.

The next one of these that we do, we'll do again in person. We are definitely not suggesting or hoping to do this kind of electronic interaction all the time, because I do believe that it's important sometimes to be face to face so we can really talk and get together.

But I encourage you not to let the technology stop you in terms of either trying to jump in or asking the operators how to jump in or telling Fran you'd like to jump in.

So that's really all I want to say to you, is just thank you for the work you're doing. Thank the staff for doing this work and getting this done and all of the people working in the councils, and again thanking you not only for your advice but for your perseverance in this new technology age that we're trying to deal with.

So Fran can I just take couple of questions if anybody has them and then we'll let people get on with lunch?

MS. HARDING: Yes, ma'am. They can ask questions without having to do anything, the NAC members.

ADMINISTRATOR HYDE: Great.

MS. HARDING: Just ask away. Does anyone want to say hello, have any updates for Pam?

ADMINISTRATOR HYDE: Yes, tell me who's there. Who's on the lines?

MR. GREEN: Pam this is Steven Green from Gila River.

ADMINISTRATOR HYDE: Hey, Steven.

MR. GREEN: And I'll just give you a brief update that our health and social standing committee for the tribe has assigned me to spearhead the tribal action plan.

ADMINISTRATOR HYDE: Great.

MR. GREEN: Yes, yes. It’s a lot of work. Thank you.

And I just wanted to mention to Fran, too, that I think as we move forward with the tribal action plan, it will help contribute to the goals under the vital field goals, I think 1, 2, and 3 as well.

ADMINISTRATOR HYDE: Right.

MR. GREEN: We’re looking forward to that. And we’re very fortunate that we have a 3-year grant from the CDC to concurrently conduct a community health assessment needs as well.

Some of these things that we’re doing as well as a prevention survey will really fit into the tribal action plans, so we’re pushing for it.

ADMINISTRATOR HYDE: That's great. Perfect. Have you talked at all, Fran, about the tribal action plan in the Office of Indian Alcohol and Substance Abuse, or have you had a chance to talk about that with people yet?

MS. HARDING: No, I haven't. We are going to do that this afternoon.

ADMINISTRATOR HYDE: Okay, great. All right. Thanks, Steven. Who also is on? Number one, one of the fun things about electronics, you don't know exactly who's around. So who else is on of your members?

DR. CLAPP: John Clapp, San Diego State in the Higher Education Center for Alcohol Drug and Violence Prevention.

ADMINISTRATOR HYDE: Hi, John.

DR. CLAPP: Hi, how are you doing?

ADMINISTRATOR HYDE: Good.

MR. HARRIS: Good, good. How are you doing Pam? This is Kwesi Ron Harris over here at Chicago State University African American Male Resource Center.

ADMINISTRATOR HYDE: Fantastic. Thank you.

MR. HARRIS: Sure.

MS. HARDING: Ronald, did you come back?

Oh, he just did. Oh, I'm sorry...

MS. HARDING: Sorry. Sorry, Michael.

ADMINISTRATOR HYDE: Don’t we have Michael Montgomery?

MS. HARDING: Yes. So you’ve heard from all of our members. More are coming on this afternoon after lunch . . .

ADMINISTRATOR HYDE: Okay.

MS. HARDING: . . . so that we could have a full quorum to be able to do our review of the STOP Act.

ADMINISTRATOR HYDE: Okay, great. All right. Well, any other questions or comments that people wanted to make?

Okay, well, Steven you mentioned something. If there’s something else we need to talk about off-line we can find the time to do that.

MR. GREEN: Okay. I'll certainly look forward to that, and we can figure out in the next couple of days if you like.

ADMINISTRATOR HYDE: I'll have Debbie reach out to you.

MR. GREEN: Okay, thank you Pam.

ADMINISTRATOR HYDE: All right, thanks, Fran. Anything else you would like from me?

MS. HARDING: I don't think so. We had a robust conversation around the underage drinking initiative, particularly around higher education. So I'll share that with you and especially as it pertains to the colleges specifically to binge drinking. So it’s an interesting offshoot of what we ended up talking about yesterday.

ADMINISTRATOR HYDE: Well, that's great. Fran and I have had many conversations, but we had another one yesterday just about stepping back a little bit and looking at what we know out there

about what all the various prevention efforts are accomplishing and what would that mean about our additional efforts. So it's good timing to have that conversation so thank you

MS. HARDING: It was great.

So thank you, Pam, especially for taking time out for all of the NACs particularly the CSAP NACs for today. And hopefully we'll be seeing or hearing from some people tomorrow.

ADMINISTRATOR HYDE: Great. Well, any time your council's meeting and if there's anything you would like from me— I believe in advisors, so please let me know. And thanks, Fran, for working with our group.

MS. HARDING: You're very welcome.

ADMINISTRATOR HYDE: All right. See you all. Have a good lunch.

MS. HARDING: Thank you. Okay, well, the administrator has proven herself to be very punctual in both her beginning and the end. It's around 11:40 Eastern Standard Time. So that's when we promised you we would take a break. We'll come back at 1:00 pm Eastern Standard Time, 12 noon Central Time, 11 Mountain Time, and 10 am Pacific Time. So enjoy your lunch and/or breakfast depending upon where you sit.

DR. CLAPP: I'm going to breakfast, yes.

MS. HARDING: Just wanted you to know we're trying to keep alert here on who we're talking to. At least we're all on the same time as the same times on the same day. This is Wednesday. I almost forgot myself. And we'll see you back at 1 o'clock.

We will talk about the tribal action plans, actually more or less about the plans, more about the Office of Indian Alcohol and Substance Abuse. We'll have the updates from the two division directors, one on the community update and the other on states and how everything relates to health reform and the Affordable Care Act. And then I think we have open discussion and then we'll go into our grant review and we'll fit in the public comment before that.

Hopefully it will be as quick as it was this morning. We will start on time because now we know what we're doing. See all of you back at 1 o'clock.

[Whereupon, the meeting recessed for lunch.]

MS. HARDING: Hello. This is Fran Harding. Do we have, besides the two of you, anyone else online?

MR. GREEN: Yes.

MS. HARDING: Can we do a quick roll call?

DR. CLAPP: Yes, John Clapp.

MS. HARDING: Hi, John.

MR. HARRIS: Kwesi.

MR. GREEN: Yes, Steven Green.

MS. HARDING: Kwesi and Steve? Steve or Steven?

MR. GREEN: It's Steven.

MS. HARDING: Steven, okay. So we're only missing . . .

MR. MONTGOMER: Michael is here.

MS. HARDING: Oh, wonderful. And has anyone else joined us the afternoon besides our four faithful? Faithful Four we're going to call you.

MS. HARDING: Okay, well, if it's okay with you, let's get started. Welcome back. We have a lot of chatter here in my own office.

Okay, we're also excited. We must all have had good lunches. So thank you very much for coming back. I know this has been an interesting exercise of coming into the 21st century in a big way.

We're going to continue with the agenda to move this along. Then we're going to be soliciting after a short presentation your recommendations as we move forward in taking prevention into the world of emerging health issues, healthcare, the Affordable Care Act, general medicine, insurance—however you want to classify it—from where you sit in preparing for 2014, which has been our goal for the last couple of years.

Of course, the big difference since the last time we met is that the bill has passed. We now have health reform living. And now we really do need to continue our effort in preparing for all of those

thousands of new potential clients and consumers who will be able to avail themselves of our services. So we thought that it would be a good idea to have our Director for State Operations and our director for our Drug Free Communities to fill us in from their perspective how the work they're doing directly relates to health reform in a bigger, broader way.

Then we'd like to ask your opinion after each of the presentations in a short dialogue so we can see what your opinions are. Are we on the right track from your perspective? Is there something more you want us to look into? Is that agreeable?

MEMBERS: Yes, that’s fine. Sure.

MS. HARDING: Okay. When these two conversations are done around 2 o'clock, we anticipate having a conversation about the new Office of Indian Alcohol and Substance Abuse, which will then take the conversation about the tribal action plan. The reason why we’re waiting for 2 o'clock is Virginia, or Ginger, Mackay-Smith is going to lead us in that discussion. She has been tasked to lead that office temporarily, and she is the most qualified to tell you about the work that she's been doing and where we’re going with that.

HEALTH REFORM UPDATE

All right, so given the agenda for this afternoon, if I could ask Richard Moore to take us into— Now, are you getting slides now, or can you see the slides now those of you on the phone?

MEMBERS: {Affirmative.]

MS. HARDING: Oh wonderful, wonderful. So those of you that can, they can follow along and those who cannot, Richard will speak very clearly and repeat anything that you might have missed.

MR. MOORE: Okay. Hi again, guys. Richard Moore, Director of the Division of State Programs. Fran covered information this morning about the strategic initiative as a whole and some of the activities that we are focusing on this afternoon. I'll take an opportunity to talk to you just a little bit about the activities that we’re engaged in as it relates to the Affordable Care Act and health reform. And I'll share with you some of our programming action steps that we’re taking, and we’ll try to provide you a basis of why we’re doing it as it fits in with the Affordable Care Act and health reform.

As you already know, our strategic prevention initiative is the Prevention of Substance Abuse and Mental Illness. And our first goal under that area is to prevent substance abuse and improve well-being in states, territories, tribes, and communities across the nation.

This fits very well with the National Prevention Strategy as well as the Affordable Care Act and health reform priorities that are designed to strengthen and support national effort in assessing the strength and needs of primary care and behavioral health service systems and to address unmet service needs and clinical gaps across the nation.

The national goal is to build healthy and safe communities, to empower people to make healthy choices, and to expand quality preventative services in both clinical and community settings and to eliminate health disparities. Now the National Prevention Strategy has identified several priorities for the actual effort to improve the nation's health and well-being. Three of those seven National Prevention Strategy priorities directly relate to SAMHSA's mission of the prevention of substance abuse and mental illness. The three that directly relate to us are tobacco-free living, preventing drug abuse and excessive alcohol use, and mental and emotional well-being.

And we also tie in somewhat to the other four of healthy eating, active living, injury and violence-free living, and reproductive and sexual health.

For our areas of funding we use the SAMHSA 20% portion of the block grant and discretionary funds in conjunction with other federal prevention programs to build emotional health of early childhood to young adulthood.

We also have put a focus on implementing universal, selective, and indicated prevention services and activities for mental and substance abuse disorders among the most vulnerable and impoverished populations within states, territories, tribes, and communities.

At this point in time we are committing $344 million under the Substance Abuse Prevention Block Grant towards these activities. We also have a new initiative that's been reviewed right now called the Partnership for Success II. And we've committed about $40 million for that.

The two priorities that we are focusing on, and we're trying to do a national priority so we can have an impact on at a national level, and we're focusing on underage drinking and prescription drug abuse and misuse.

We are also attempting to include in our effort the expansion of the SPF process, the Strategic Prevention Framework, because one of the things that we want to do is we want to expand this process across the nation.

In addition to those two we continue to support the DFC grant as well as Partnership for Success. And this year we have committed about $55 million to and continuation funding of those activities.

We want states to use the prevention block grant and discretionary funds to have at least 80% of all states and tribes and territories using and adapting every state's prevention practices. And we also want them to implement universal, selective, and indicated programming strategies as part of their process.

Now, in terms of the block grant and how it is supporting activities under the Affordable Care Act and health reform, we've made some changes to the block grant over the 2 years. We've actually implemented a uniform application process where states can submit their SAPT block grant as well as their mental health block grant under one umbrella. It's still separate, but we've attempted to make it easier for states to put their plans together and submit them.

Now there are four areas that we want states to focus on in terms in terms of putting their state plans together. We want them to fund priority treatment and supportive services for individuals without insurance or for whom coverage is terminated for short periods of time. We also want them to find priority treatment and support services for individuals not covered by Medicaid, Medicare, or private insurance, and for low-income individuals that demonstrate success and improving outcomes and supportive recovery. We want states to have good plans that fund primary prevention, universal, selective, and indicated and support activities and services for persons not identified as needing treatment.

Now, one of the new changes in the Uniform Block Grant is that, for 2014 through 2015, we've identified the fact that states can do planning around the use of the mental health block grant for the

prevention of mental disorders as long as it is directly related to impacting the health and wellness of target populations in the statute. These include adults with serious mental illness and children with serious emotional disturbance. And another part of the change in the block grant is that we are emphasizing that states collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery and support services, and to plan the implementation of new services on a nationwide basis.

Lastly, I want to share with you what we are doing in terms of providing technical assistance and support to the states. And one of the things that we are focusing on is to train and organize SAMHSA staff to provide targeted technical assistance to states and territories in their efforts to develop and implement state-specific health reform, behavioral health systems.

You're welcome to use the block grant fund and SAMHSA's array of technical resources to assist states in transitioning to full implementation of the act by 2014. This includes enrollment, the establishment of affordable insurance exchanges, and the establishment of essential health benefits that focus on behavioral health services and intervention.

And some of the activities that we will support are the Native American Center for (inaudible) consolidated TA contract, the Center for Application of Prevention Technologies contract, as well as state epidemiological outcome workgroup activity. And we'll also have a added emphasis on data and evaluation activity.

So this is just a brief outline of the things that we're doing here with our block grant as well as our discretionary funding for the Affordable Care Act and to help states transition and implement state systems under the Affordable Care Act and as well as health reform. If you have any questions for me I'd be more than happy to try to respond to them. Any questions from the NAC members?

MR. HARRIS: None for me.

MEMBER: Yes, none for me. That's a very informative report.

MR. GREEN: Yes, I would, This is Steven Green. I would echo that as well.

MS. HARDING: Does it sound like we're on the right track as far as beginning to help the country meet the needs of bringing and embracing health reform in 2014? Would you do something differently?

MEMBER: I think what you laid out is very comprehensive and especially, given the dynamic nature of all this, it makes a lot of sense to me.

MS. HARDING: One of the things I want to bring your attention to, again to underscore what Richard has said, is around the training that is currently going on in SAMHSA around the block grant application, understanding health reform, the properties, and what are the connections and the issues that states need to take a look at when filling out the application.

Because of the economy and reducing all of our budgets, we are in-sourcing several staff to help us out with out with the extra work that we're asking federal employees to do what contractors used to do.

Richard has done an excellent job in organizing training throughout SAMHSA, in particular the block grants' project officers, who will have direct responsibility to help our states understand the connection with health reform.

And for us, as exciting as it is, what we talked about last time was to have a National Prevention Strategy, and that we are so visibly present in three different areas directly with tobacco, mental health, and substance abuse.

So we're very proud of the work and hope that you, the members of the National Advisory Council, will begin to see the fruits of our labor so to speak and be able to comment on the influx of accurate information on what by some can be considered a complex problem of learning how we become closer to health reform, what prevention's role is in that, what will be covered, as Pam mentioned this morning, about the new screening for women and anything else that happens between now and 2014 and thereafter.

So I just wanted to underscore that because we see that as one of the pivotal changes in SAMHSA that will reduce the confusion out in the states, especially as they try to maneuver the new block grant application.

MR. MONTGOMER: Fran?

MS. HARDING: Yes?

MR. MONTGOMERY: Fran, this is Michael Montgomery. Can you comment on any issues that are arising from some of the states, such as the one in which I reside, that have administrations that are hostile to healthcare reform, and how the federal administration is encouraging the kind of ancillary activities like SAMHSA to participate?

MS. HARDING: I can make a statement and I'll let Richard answer it from his perspective. I can tell you a short story.

Almost a month ago Administrator Hyde was at the NASADAD meeting talking to state directors for substance abuse and mental health, the day before health reform was approved. And she asked how many states were preparing their business plans and their states particularly around substance abuse and mental health issues with their Medicaid folks, and are they ready for what's to come?

And I won't tell you how many, but very few of them raised their hands. My comment on those that are resisting is, we feel that there will probably be an influx soon of states now trying to play catch-up in figuring out how are they going to align their needs and their services around to get the benefits of health reform.

So from SAMHSA's perspective, at least from the prevention and treatment perspective and services, our job here is to ensure that every American, in particular right now we're talking about the states, and we'll talk about the communities in a second— It's our job to make sure they understand the law, they understand their position in the law and how they connect.

Other than that, Richard, unless you've gotten some direct comments from some of the staff already, because I feel that the comments will come in in a couple of ways. One, through Administrator Hyde's level of feedback, but that also we're anticipating as states begin to fill out the applications for 2014 and 2015 that we'll begin to start hearing some of those questions.

MR. MOORE: Right.

MS. HARDING: Richard, do you have anything to add?

MR. MOORE: Yes, you're absolutely correct, Fran. A couple of things are happening. We are expending resources to put resources up on the Web to assist states in terms of addressing the issues.

Fran's very accurate in the fact that there are still some states that are having difficulty with Medicare and Medicare adjustments that they'll have to make, as well as establishing those as affordable insurance exchanges. But we have a process that we're working on in terms of trying to work with the states to provide them the types of technical support that they'll need as they begin to make this transition.

In addition to that. one of the things that we're planning on doing, and specifically the block grant, is we are going through our 90-day public input right now. And as we get comments back from the states, we're compiling them and we're analyzing them. And then we're trying to develop appropriate responses and support for those types of questions that are coming, so we'll be proactive in terms of helping the states deal with issues that they're experiencing right now.

MS. HARDING: My suggestion is that if you're on the phone tomorrow at the Joint Council meeting that this question comes up again because it's a really good question. And Pam would probably have more information to share with you than what we might have right now.

At our next NAC meeting we'll have a lot more data, and we'll pay particular attention to the sea change out there in the country and as it relates to us.

So right now CSAP's responsibility and role, as Richard has pointed out, is to give out all the information, try to reduce the myths, make some sense out of some of the facts and the movement, and direct them where they need to go to get some assistance.

But SAMHSA's large picture actually is working at, of course, another level with several other partners. So I think that it'll be interesting to see how Pam answers this question tomorrow.

MR. MOORE: Okay, thanks.

MS. HARDING: Yes. You're welcome. Okay any further questions on states?

MR. GREEN: Yes, yes. Fran this is Steven Green. Just in terms of some feedback on the block grants, I just wanted you and Richard to know that Arizona's Department of Health Services Division of

Behavioral Health is meeting with all the tribes and has met with us just for our own feedback regarding some of those changes. And so it's happening at this level too.

MS. HARDING: Oh, that's excellent news. Are you from your position happy with the changes that we've made? Are there some critical areas we should take a look at? And if you don't have time to want to talk about it know you can contact Richard directly?

MR. GREEN: Okay. I will take you up on the option of contacting Richard in the near future.

MS. HARDING: Okay.

MR. GREEN: But, yes, we're happy with the process. We're just grappling with the state of Arizona's process of evaluating how those dollars are going to be handed out.

MS. HARDING: Okay, okay. I heard a little bit about it, and there are some isolated issues like similar to that in some of the other states as well.

So I know that we're working. I'm just really happy to hear that the message is going out and you're being asked.

MR. GREEN: Sure. Yes.

MS. HARDING: And that's a real step in the right direction.

MR. GREEN: Yes, absolutely.

DRUG FREE COMMUNITIES

MS. HARDING: Great. Thank you for sharing that. Okay, so without further ado, we have Fred Volpe here who introduced himself this morning. I'm calling him the director of Drug Free Communities Programs, not the division.

We've been joined by acting division and rejoined by acting division leader Charles Reynolds, but I'm just kind of teasing folks here.

If Fred could walk us through the next level of where we're at and how communities and what their role how we're seeing their role in the whole health reform movement and ACA and anything else that falls under that?

MR. VOLPE: Sure. Our block grant commitment is significant and it is aimed at states. And much of the technical assistance that's going to be offered to the states does trickle down to the actual communities, and beyond the fact that it is their goal to ensure that states can provide technical assistance. So our contracts ultimately do reach the community.

Our Division of Community Services really includes the Drug Free Communities Program, which is in partnership with the Office of National Drug Control Policy and the CADCA Coalition Academy, which really is our technical assistance support for community coalition development.

We also offer the STOP Program. At the present time we have well over 700 communities funded through our division in the United States and in all states, and their activities have really increased, stepped-up particularly in areas like underage drinking. We also have many coalitions that have been involved in tobacco cessation and currently prescription abuse as well as marijuana issues.

So at the present time our coalitions are very much concerned. They're very concerned at the local level about health reform implications directed to them.

The most significant areas I think that they keep coming up with—and in our presentation to these communities, we're often asked to present SAMHSA's position, which we do with approved SAMHSA slides and presentations. We'll often meet with individual coalitions as well as clusters, groups of coalitions in a particular region or in the state. And we hear about their concerns.

There are differences, of course, between rural areas and urban areas that are striking. In the urban centers, there's a lot of concern about the integration of primary care and behavioral health services, what's SAMHSA's position on this, are we helping effect of this the development of health homes and a special concern about screening programs such as SBIRT, which are aimed at the indicated and selective populations.

Would we be able over time—and many of the coalitions are asking this question—over time to better identify populations at risk in their community as well as individuals, in addition to them continuing their major campaign directed at the population as a whole? So more interest is being brought.

And as we learn about our own funding activities with the states and as we develop decent science and understanding about the effectiveness of SBIRT, this is information we want to get immediately to the community.

Another piece is their obvious concern about 2014 and what the Medicaid enrollment activity is going to look like in the community. And this is particularly the case in larger communities where they want to be in a position to assist health systems in identifying populations that are underserved and also promoting the enrollment activities.

So we have groups emerging. And again I look more to the urban centers for this, but also rural areas want to know what the enrollment situation looks like.

There's also a great interest in the insurance exchanges and how they will be administered and offered. And that I think is universal.

The importance of health and substance abuse promotion activities, really a key issue right now for communities, how they can create a condition where they're on the positive side if you will, the promotion side of the prevention issues. This is coming out more and more.

And a great deal of interest in social norming. And the belief is, I think, among our best coalitions the social norming programs in developing this technology and understanding how we do this could have a real impact on the population as a whole and of course health status of the community, which ultimately could lead to cost savings, etc.

And I just would finish with the possibility that many of them are looking to insurance companies as new customers. I have a coalition in Florida that got a nifty little grant from State Farm insurance to deal with motor vehicle accidents.

So, the concept of community-based prevention campaigns affecting population as a whole is getting a lot of work. And I think it ultimately will be a real plus for the communities.

We look to other partners, CDC in particular, with its prevention or community transformation grants that have been put out that many of our coalitions working with other groups are applying for in

addition to, and by the way the funding from that coming from the Prevention and Public Health Trust Fund so that we're starting to see resources directly put into our community systems.

MS. HARDING: Thank you. Any comments on the relationship of communities with where we're trying to use the programming we have with our Drug Free Communities Program and our SPF-SIG communities that are connected in health reform?

MEMBER: Just a quick question actually. I was just curious when you're discussing the social norming was that in the context of SBIRT, or were you talking about more community-based social norming campaigns?

MR. VOLPE: More community-based social norming campaigns, SBIRT being really the screening feature.

But we've been busy training our project officer staff in bringing folks up to speed on the latest social norming activities that are taking place in the country.

MEMBER: Okay, thank you.

MS. HARDING: I will mention that since you brought up SBIRT we are having increasing discussions here in SAMHSA around the use and promotion of the SBIRT tool and other brief intervention tools. I know that, John, on college campuses they do something similar and some of our prevention programs do something similar.

It's a continuous conversation about where does SBIRT fall? Is it treatment used for treatment program screening? Is it for prevention screening? Is it a mental health screening tool? Is it a substance abuse screening tool?

So health reform has really shaped opportunities in SAMHSA, particularly since we're in the prevention arena right today, and tomorrow would be a different discussion. It'll be broader, but for prevention really challenging us to take a look at the tools that are out there and available to us.

Our biggest fear with SBIRT and prevention, we support the use of SBIRT in several interventions, especially when you're looking at an indicated population, which is of course our individual focus population for prevention programming.

We support it, but we don't want it to become the only thing that our communities and our states use, because, as all of us on the NAC know, we must continue to strive to have a comprehensive approach to what we do in prevention or even just looking at the social norming issue that's not going to solve all the problems.

So the debate continues. It's an incredibly useful tool as you know. And as a matter of fact on the bias there is a larger percentage of individuals who are screened from SBIRT that need prevention services rather than treatment services. So we're trying to capitalize on that. And I think that the staff are doing a very good job.

A similar thing is taking place at the community level that we're doing in the state level, which is a lot of training and cross training with our own staff and SAMHSA, so that they, too, at a community level, begin to know where they fit with health reform and relate. I particularly have a passion for helping our field, particularly at the community level, understand their role in helping us bring us closer to primary care or general medicine, however, you want to refer to it. And it's become an exciting venture, because that brings in conversations about the public health model versus the IOM model, and how both of these models work in concert to get us closer to general health.

And our message from CSAP is that without doing this and without becoming closer as we get closer to health reform implementation, if we have not done our job well, we may be left out of the major conversations around healthcare.

And that's one of the things that we are trying to, that we're training very hard our staff so that they can, when they're out on their site visits working with the communities, offer them some suggestions and do almost a critique moving forward. So there's a lot of training going on. If you're running into some of our colleagues at SAMHSA CSAP, and all throughout SAMHSA, it is because we're all doing all this quick new learning of how we begin to move the field forward.

Okay, any issues at all? We've tried to give you very targeted but yet contained updates on how we're moving forward both on a state level and a community level. Obviously we haven't covered everything, but we're hoping we gave you enough of a feel of how we're progressing together with

substance abuse and mental disorder prevention and mental health promotion activities. Do you have any further recommendations for us to move forward in a different direction, have an emphasis on something different from what we've discussed, or anything?

Okay, hearing none, what we'll do with all of this, just so you know, you'll get a second bite of the apple because we will be sending you out, along with the minutes, we are going to also send your survey, very short survey, will not interrupt your day and ask you a few things, one on the mechanics of how the meeting is going and also some of these issues that we've touched on that you may, after thinking about this—if you're anything like me, I need to think about things first and then react to them secondly. So we'll move forward if that's okay.

OFFICE OF INDIAN ALCOHOL AND SUBSTANCE ABUSE

We have enough time, which I anticipated that we would, to focus in on something that is not on your agenda, but that came up in this morning's conversation, the focus on the tribal action plans. Less conversation about the tribal action plans, more conversation about—

As I promised, Ginger MacKay-Smith has joined us, and she is currently the Acting Director for the new Office of Indian Alcohol and Substance Abuse, which will have a role in the action plans but a much larger role in bringing our communities, our tribal communities, and the federal government and states and everyone together. So Ginger you're next, so go ahead.

MS. GINGER MACKAY-SMITH: Hello NACs. This is Ginger. I've been able to listen to some of the conversations so far today. And Steve, I was intrigued to hear you say that you're involved in working on a tribal action plan as well. I'd like to get in touch with you offline on that.

MR. GREEN: Absolutely.

MS. MACKAY-SMITH: As basic background, I guess, for everyone else, I'll just give you a couple of minutes of what we're talking about when we mentioned the tribal action plans.

The Tribal Law and Order Act of 2010 is an enormous piece of legislation that covers, in addition to many other things, Indian alcohol and substance abuse issues. And there are two major thrusts to that part of the Tribal Law and Order Act. The first, and the one that we have been focusing on most over the

past year and more, is real instructions from Congress that all the federal agencies who are working with Indian Country on issues of substance abuse ought to be working together in a more effective way.

So we have our marching orders to coordinate better, to ensure that the many resources that we are already developing, using, etc., are deployed in a way that is integrated, so that from the perspective of Native communities it seems like a coherent national or rather, I should say, federal voice as opposed to seven or eight different agencies all saying good and helpful things that can be confusing taken together. So that's sort of the first focus, which is that the existing federal agencies—and those of you who are used to federal-speak can read between the lines in here—that that means no new money has to be coordinated better.

The second thrust of the legislation is really the major point, which is that all these resources need to be put at the disposal of the tribes who are trying to achieve their own goals in terms of substance abuse issues in their communities.

The Tribal Law and Order Act is threaded throughout with a very, very strong sense of congressional respect for the sovereign status of the American Indian/Alaskan Native sovereign entities. And the idea of the Tribal Law and Order Act, which may be a little different from action plans over the last 20, 30, 40 years, is that these need to the tribal driven, tribal based, tribal directed, and that all the resources that the feds are coordinating and putting at the behest of the tribes will be done at the invitation. We will be involved at the invitation of the tribes.

So those are the two main goals. What we are trying to do here in SAMHSA, because legislation also gave SAMHSA the coordinating responsibility on the federal end of this, is to, first of all, get the word out there into all the native communities. And, secondly, we're trying to make good headway on the coordination aspect.

I'm telling you right now that our theory is that we're not waiting for it to be perfect. As soon as we've got one little corner coordinated, we're sticking it out there for two reasons. One is, otherwise it will be 2014, 2015, and all the tribes will have completed putting together their action plans, and we would not have been any help at all. And the second reason is that if we put it out there bit by bit, we have

an opportunity to get feedback from the tribes as to how we are coordinating, how we are organizing, how we are presenting and disseminating the information.

And we will need to be activating every single communication channel we have. And by we, I mean all the partner agencies, to make sure that we are doing that properly.

So that is the thrust of what we're doing. The action plan itself is, you'll be shocked to hear, intended to be a comprehensive strategic approach to the substance abuse issues as the tribe perceives them in their own community.

Fran, I think I will stop there and see if there are any questions from the group.

MS. HARDING: All right. Do we have any questions on TLOA, on the action plans, or any of the above or anything to do with tribes?

MR. GREEN: Yes, yes, this is Steven. Number one, I appreciate the overview, Ginger. And I agree with quite a bit of what you had to say. I appreciate the structure that is being offered as well, having worked in tribal communities for over a dozen years. Sometimes that is lacking. So that assistance on our end is going to be well received, and we'll probably do some invitation to work with you somewhere down the road, particularly on the tribal action plan.

The one comment I wanted to make is, it was unfortunate for Sheila River that we never got a letter from Pam Hyde announcing the tribal action plan. And I heard about it through a tribal colleague who works in another facility. So we're a little bit behind the eight ball, but we're moving forward. We're probably going to get a resolution, I would say late this month, declaring that we are going to move forward and steer our own tribal action plan in that, too.

You probably have heard from some of the tribes. And if you haven't, unfortunately, as you mentioned, there's no dollars attached to this. It is, you know, an unfunded mandate, and it's going to be difficult for some of the tribes, I think, to really step up to the plate and meet their expectations.

We at Gila River have been very fortunate. We've taken advantage of the Strategic Prevention Framework of block grant dollars that we've had in the past. We've done very well with the Mental Health First Aid stuff that came out of the Tucson tragedy. We've been fortunate to have the Garrett Lee Smith

Suicide Prevention grant for a total of 6 years. And we have a lot of resources and a lot of support. We actually run a bifurcated Medicaid system, meaning that we do the 638 piece, and we also do the state of Arizona's public behavioral health. And we have a lot of resources. And I think that Gila's River's going to be in great position to do this.

We're currently working on a community health needs assessment, which will go very well with the tribal action plan and its strategic component. We do quite a few other things. We do network sufficiency and adequacy evaluations every 6 months regarding our system of care. Again my concern is going to be for some of the other tribes that maybe aren't as advanced in responding to the tribal action plan.

MS. MACKAY-SMITH: Well, Steve, I think you're quite right about that. It is true that with this particular unfunded mandate, really the only way it's going to be able to work is exactly the way you've just described for a tribe that has resources to look at the various different components already at their disposal and think about how they can be knit together into a comprehensive overarching plan. Of course, the knitting together and the planning is activity that does not come without cost. But this is true of much of the prevention field as well.

And we hope to be taking some of our lessons learned from other populations, audiences within prevention, about how they've gone about the integration of separate, existing successful programs into one comprehensive approach, how to make that work.

The other thing I want to say is, I think you're quite right about the smaller or other tribes—some of them are not very small at all—who may not have these existing resources that they can draw on. And there are two things I want to say about that. One is a topic that I know the group has talked about before, which is the proposed Behavioral Health Tribal Prevention Grant that was included in SAMHSA's 2013 budget that the President sent to Congress oh these many months ago. And that is a grant that was designed with the tribal action plans in mind. That doesn't mean it's a grant for the TAP. It means if a tribe decides that putting together an action plan is a priority for them, the Behavioral Health Tribal Prevention Grant would be an ideal vehicle for doing that.

The other thing was that we are also learning more about the grant programs from our sister agencies. For instance, the Department of Justice has what I consider to be a fascinating experiment going on and where they have their Coordinated Tribal Assistance Solicitation. I had to translate the acronym in my brain—CTAS. What they've done, what Justice has done, is they have pulled together all of their programs across the entire department that have a tribal focus, and they created a single application vehicle for that. And through that application you can designate which of the different what they call purpose areas, which we would call grant programs, that a tribe is interested in.

But this seems to be again something that is sort of an administrative, bureaucratic change innovation, I would say, that the feds can make it easier for tribes to get to the resources that they can use than in creating a tribal action plan.

The last thing, I know I said there were only two things but I will say one more. The last thing I will say is that we've also been—and by we, I mean CSAP—talking with our other colleagues, particularly the block grantees and other connections we have at the state level. Because in many cases the programs and systems that they are setting up and using for prevention planning, etc., can also be extended to share in by tribes under the right circumstances. Where that will never happen is the block grantees and other prevention folks don't know about the TAP.

So we are trying to get the word about this opportunity for tribes out there to their nontribal partners in hopes that some of those resources will also be able to be made of use.

MR. GREEN: Yes. I think you're right on with that latter approach there is to integrate states, steering some of these block grant so the tribes can use them for their TAP plans. I do believe that the Arizona Department of Health Services Division of Behavioral Health is very much aware of the TAP plans, because we've made them aware of that for the same reason that you're talking about that we would like to use them to help us accomplish our mission in the TAP as well as the mission of SAMHSA.

MS. MACKAY-SMITH: Yes. Yes, absolutely.

MR. GREEN: But I do appreciate your feedback. Thank you so much.

MS. MACKAY-SMITH: Anytime. And we will be talking.

MR. GREEN: I look forward to it.

MS. HARDING: All right, good.

Are there any other questions for Ginger, suggestions, recommendations for her or not for her but for the program?

MS. MACKAY-SMITH: Well, one thing I wrote down is, we do need to communicate more directly with the tribes about these opportunities.

MS. HARDING: Yes. Yes, thank you for that feedback. That's very helpful. So how are we doing? Are you still with us? Haven't fallen asleep yet? You're still keeping engaged?

COUNCIL DISCUSSION

We’re at the part of the program where we really want to hear from you for the next 30 minutes or so for what are some of the—well, actually I’m going to broaden it actually more than what actually told you we were going to talk about.

Our original conversation was going to be about other emerging issues that you see from your perspective that either we haven't mentioned or you would like us to underscore, especially the ones we haven't mentioned yet part. If there are things that are happening, discussions that you're engaged in, areas of interest that we don't seem to be covering exactly the way you think we should, this would be the perfect time to advise us, educate us, and recommend that we go into a certain direction. So I know it's hard with so few members, and we’re kind of tapping you pretty hard today. But if there is anything, we all have at least one thing that we like to promote and to bring forward. If we haven't touched that area, this would be a good time to know that. Is there anything that you might want some further information on that we've got a lot of collective talent around this table that we’re happy to clarify, missed rumors, information that we haven't yet touched on? Are you guys all pretty comfortable?

MR. MOORE: Have you had an opportunity to actually take a look at the block grant application, or have you taken an opportunity to provide feedback to SAMHSA about the changes that have been made to the block grant? And specifically for Steve, who’s been doing the activities with tribal communities up in Arizona—and Arizona has done a great job—are you aware that one of the changes to

the block grants is that when the state puts their plan together, the state is required— It's a requirement that they have a discussion and agreement where the tribal communities within the state actually review and have an opportunity to provide input to the plan before it can be submitted for our consideration?

MR. GREEN: Yes, yes, Richard, this is Steven. We're aware of that. Arizona Department of Health Services has had an initial meeting with us. There will be subsequent meetings, so they are collaborating with us regarding the input to that plan, and we're very pleased to have that opportunity. And some of the tribes have intergovernmental agreements with the state of Arizona and some of them don't. They're including all of us whether we have an IGA or not. So I'm very pleased to see that they're being comprehensive in their inclusiveness.

MR. MOORE: Great.

MS. HARDING: Okay, one of the things that will be discussed tomorrow will be further topics of conversation. There's going to be a panel tomorrow, as there was last meeting. Last meeting we had a panel on school-based programming. Tomorrow our panel is focusing on federal health reform—basically what we've been talking about here, and our representative, speaking about prevention from a state perspective, is Mike Langer from the State of Washington.

Could you help me because I'm always asked and it's always difficult for me to help direct something that is of interest across the whole continuum? What are some topics that we could recommend for the next NAC panel, number one? And number two, any topics that you can think of which would be an outgrowth of the conversation that we had today? And basically what I'm doing here, which you probably already figured out, is reversing the agenda so that we can use this time while we're waiting for our public comment period and getting some useful information so that we can be— We're just doing things a little earlier.

MR. MONTGOMERY: Yes. I have one topic or a couple topics that are not related to what we've talked about today . . .

MS. HARDING: Oh, great.

MR. MONTGOMERY: . . . unless you can relate them to the strategic planning. But one is, has SAMHSA taken a position on syringe exchange and the retreat of the federal government from supporting the syringe exchange? That's one thing. And the other is the whole issue of crystal meth in the LGBT community. What are we doing in that regard?

MS. HARDING: Okay, I can look into both of those issues for our next time. We can invite our staff here at SAMHSA to give us an update. I don't know specifically what we're doing with needle exchange. There has been broad discussion, but I do know that there are people in CSAP who would know the specifics. So I hate to give you a broad brush answer and then have the specifics maybe a little different.

And then as far as crystal meth, the same response, not so certain in prevention. We're not seeing a need. There are many states or communities that brought up the need to focus a prevention effort specifically on crystal meth.

We've seen increased interest in bath salt and K2/Spice, and several other emerging kinds of interest—I will say not fear, but interest—across the states around synthetic drugs overall and that they seem to be becoming an emerging issue. So that may be a topic that you'll see soon if in fact we see this trend continuing, because we have a couple SPFs who I've spoken with. States that have a Strategic Prevention Framework have asked whether or not they can tweak their plans to focus the strategic plan on focusing on these issues, which of course the answer usually is yes. They will have to work with their project officer. And it's all about the data, and if the data supports the needed stuff to change, then Richard's people will have those individual conversations. So thank you. We can look into that.

MS. HARDING: I just wanted to add (inaudible) because we're having some trouble. I'm getting messages from people other than me who's sitting on top of the microphone.

UNKNOWN: I just wanted to say we have several DFC community grantees who are working on meth specifically. Again, it's a case by case situation, so they do work with their project officer specifically in their action plan to work on the problem in their communities.

MS. HARDING: So can we get . . .

UNKNOWN: I can. That's what I was going to say I can follow-up and get that information to...

MS. HARDING: We'll follow-up with you or you can write to her directly either way.

MEMBER: Okay, thank you.

MS. HARDING: You're welcome.

MR. MOORE: And we'll also get a latest policy on needle exchange. Because HHS did come out with a policy, a formal policy, a little bit over a year ago. And that is what we're following, not only within the treatment area, but we also follow that policy as far as HIV-AIDS prevention grants here in prevention in CSAP. So we can get a Web site address for you and get that information to you, okay?

MR. MONTGOMERY: I pretty much know what the policy is. My concern is—but I guess that's probably not SAMHSA's job—but somebody working to revisit the decision not to allow federal funding for syringe is exchange?

MS. HARDING: That would be a conversation I would have with Dr. Clark. And I would write to him directly, and because I am certain that this is not the first time he will have heard that question. So we can follow-up or you can follow-up directly to Dr. Clark. But either way I will certainly let him know this has come up during this conversation.

MR MONTGOMERY: Okay, I can follow-up. Thank you.

MS. HARDING: You're very welcome.

MR. HARRIS: Yes, Fran?

MS. HARDING: Yes?

MR. HARRIS: Yes, this is Kwesi. I had a question. I wanted to see if there's any conversation that maybe happened at SAMHSA as it relates to— Normally we're talking about the underage drinking and its correlation, as I'm thinking about it, as it relates to mental wellness and health with the whole notion of mental illnesses. And a lot of the work that I've been doing in this area with young people, we've even created a concept called hip hop detox, looking at how the lyrics are very toxic and how a lot of times even in the messaging and the music and through popular media outlets that there sometimes is permissiveness of alcohol abuse and over usage, other mood and mind altering substances and how all of

that can correlate to incidences that manifests itself in terms of mental instability, suicide ideations—all those kinds of things that are, sometimes we see them as in and of themselves, but then together triggers that can enact or bring about this outcome.

And so I was just curious, is there any opportunity to have conversations around those kinds of things to see how they cross pollinate or parallel to one another, because particularly when we look at the incidences of underage drinking and the pervasiveness of the imagery that comes through the music?

And so I was just curious around programs that focus on the advocacy to look at social marketing and how some of these things in popular culture can predispose a young person to go down a spiraling staircase under the guise of "it feels good, it sounds good, so it must be good" versus here literally a hook has been thrown into you and you're being guided into the fisherman's net?

MS. HARDING: I think that's a great idea, Kwesi. And the answer, the quick answer is of course we can help you identify individuals that have a call. And actually I was thinking, if you're willing, as one of the ambassadors of the National Advisory Council, I would think this is more of a community-level discussion . . .

MR. HARRIS: Sure.

MS. HARDING: . . . with our community divisions. And maybe we could put together, we'll do a reach out to find out who would be interested in such a call. And if you wouldn't mind, we'll send out a message to all of the NAC members. But if you wouldn't mind leading up a discussion like that either Costella—Costella's shaking her head. She'd be more than happy to work with you . . .

MR. HARRIS: Yes.

MS. HARDING: . . . to cosponsor such a call. We'll set the call up and she'll be there to help co-facilitate. And then you could get some direct feedback with some of your other council members. If you're willing to do that, we're willing to ask for resources and get the right people to the table.

MR. HARRIS: Yes, I think it would be an excellent charge. And I would be more than happy to work with Costella or anyone else who the National Advisory Council as well as from SAMHSA.

I just think a lot of times we miss opportunities, particularly youth culture. A good friend of mine Alfred, coach Powell we call him, just wrote a book *Hip Hop Hypocrisy*, and the lies begin to sound like the truth. And it's getting a lot of traction on college campuses. Another gentleman, Enoch Muhammad here in Chicago, created a concept called hip hop detox. Another gentleman, Dr. Lance Riggs, he's actually a visiting scholar here in Chicago, stayed in my apartment. He does a whole piece on rap music versus hip hop just to dispel the myths that there are differences.

In many (inaudible) driven down to (inaudible) folk have an audience that has the right information to make right choices. If nothing else, at least you can come back and say you didn't know.

MS. HARDING: Right.

MR. HARRIS: (Inaudible). You can honestly say that (inaudible) folks didn't tell me that fire was hot. We just chose to get burned. So a lot of times our young people are like fireflies. They gravitate to the fire, not even knowing that it's the light that lures them there, but it's the flame that's going to take them out. And it's okay to fly behind the flame. Just don't get consumed by it. So yes, I think that'd be great.

MS. GREEN: All right, Kwesi. I'll follow up with you and we'll get moving on this.

MR. HARRIS: Fantastic.

MS. HARDING: Yes, because this is the National Advisory Council that are protocols that we'll follow both with . . .

MR. HARRIS: Absolutely.

MS. HARDING: . . . the agreement from John earlier this morning of helping us with the higher education focus we can do. We'll do the same thing with this particular group. Who knows what might come out of a group like this as well? There are a lot of things. First of all, being able to document that this type of an effort is a major contributor to the business that we do. What exactly the *it* is and what are some of the outcomes we can start to look at to show that this type of a media public education event. So I'll let you and Costella do the work. Matt will work through the system what we need to do to notify the

whole committee that we're doing it and giving everyone a chance to be a part of it. And so we'll take care of the business end if you'll be available to take care of the creative end.

MR. HARRIS: (Inaudible).

MS. HARDING: We'll do a partnership here.

MR. HARRIS: So, a partnership.

MS. HARDING: Yes.

MR. HARRIS: As you were talking, something else came to my mind. I'm sure everybody has seen that the city here is on the radar for all the murders and all of that. But there's another piece that connects to that. There is a group here called Clear the Air, and it is really a statement of clearing the airwaves of the toxic lyrics. I don't know if anybody ever heard a song that talked about (Anina). And if you don't know what (Anina) is needed is in street culture that's a code word for a 9 millimeter. And so there's a song that's playing every day penetrating the most private parts of any of our anatomy, our minds, and this is being impacted on the most impressionable minds in our communities.

And so we've seen direct correlation to the gun violence that's going on because some of the music that is really is almost like you're being droned into being a Trojan horse in some regards coming, like-minded people but to carry out a particular aim that brings about like a really, a genocidal impact in your community.

So this ties into mental illness, mental wellness—all of that—and substance abuse that correlates with it. It's like a spiraling staircase with no stairs. Everybody's just falling.

So I think we'll have a breakthrough versus a breakdown this time for sure.

MS. HARDING: That sounds good to me. And I say, it's a topic that will have universal interest . . .

MR. HARRIS: Thank you.

MS. HARDING: . . . across the country. People used to think that this type of a focus is something for urban centers only.

MR. HARRIS: Oh, no, no. It's (inaudible).

MS. HARDING: Yes. When I went to Alaska this year, big problems with music, mostly because in part of the rural part of their state, which is primarily most of their state, they're bored, so the kids are grabbing what they can, and music happens to be something that unites all.

So great topic idea, thank you very much. We will go through what we need to go through to make this happen.

MR. HARRIS: Okay.

MS. HARDING: Is there any creative thinking on what we might be able to do or provide? I'm thinking going back to the science implementation, John, around bringing substance abuse and mental health more clarity and helping our colleagues understand, or doesn't have to be our colleagues, health colleagues in general that we're not trying to make everything the same, but that they certainly complement because we're dealing with some of the same families and some of the same kids and same schools?

Does anybody have any thoughts on how we can begin to look at this in a different way than we're trying to do here in SAMHSA now? Are we missing something or does anybody have an area do you think would be most helpful for us to dive into sort as a deeper dive conversation?

MEMBER: I think that—and you've already touched on this—some of the natural intersection between the mental health and the substance use issues, that would be a place to start would be in the SBIRT arena. I believe you'd mentioned that yourself, but it's actually one of those interventions or approaches that straddle prevention and treatment, but it also is amenable to a variety of issues and related issues so that might be a good place to start the integration.

MS. HARDING: That's a good idea, a good idea, thank you.

Okay, one second.

Okay, so we're back. At 2:30 our time in Eastern Standard Time, we are going to open this meeting up to public comment.

The rule of the National Advisory Council is, once we put a time to the public comment period, that's the time and I cannot change it. So I'd love to say, okay, let's start the public comments, but there

may be someone that is guaranteeing that we’re going to start at 2:30 and then they would have a missed opportunity. So I have a suggestion, but I'm happy to take a friendly amendment to the suggestion. From our clock, we have about 14 minutes for us of some silent time. If someone wants to see something that we haven't tapped in, but I think we've covered, this has been a great conversation from my perspective, of being able to put out there our progression of what the work that SAMHSA’s doing towards health reform and bringing us closer to showing you where the strategic initiative is continuing to be alive and well and that we’re actually putting it to action.

We can take another—now I just used up a minute—we can take a 13-minute break and just again like we did before, don't hang up. Go get yourself a cup of coffee, Steve, or those of us who need something lighter in the day, lemonade or whatever.

Would people be amenable to that and just take a break or a natural break and we'll come back? We could reconvene at 2:30?

MEMBER: (Inaudible) that's fine.

MS. HARDING: Good.

MEMBER: Sounds good.

MS. HARDING: Okay, so we'll see you—or hear you—back at in 11 minutes by our clock at 2:30 Eastern Standard Time. Thank you.

[Whereupon, the meeting recessed.]

PUBLIC COMMENT

MS. HARDING: Okay, we’re back. Thank you all for waiting and being so patient. We are now moving into the public comment period, and those of you who will have something to report out, if you’ll state your name and where you're from, and keep your comments to 5 minutes, we would appreciate that. Anything that is longer that you'd like to submit, you can submit it directly to Matt.

And you sent in an address on the online your email on the screen?

MR. AUMEN: It was in the notice that we had sent out.

MS. HARDING: Okay, so Matt's contact information is in your original invitation to this meeting. So, operator, could you coordinate the public comments if there are any?

COORDINATOR: Thank you.

MS. HARDING: Thank you.

COORDINATOR: We will now take questions and answers. If you would like to ask a question, please press Star then 1, or if you do have a comment please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question. To withdraw your request press Star then 2. Once again if you do have a question or comment, please press Star then 1. One moment please. Press Star then 1 if you do have a comment or a question. We're still waiting for the first response.

And we have no responses at this time.

MS. HARDING: Thank you very, very much, operator. That was very helpful. So hearing no comments from the public we're going to now move into our closed session for NAC members only.

No, we're not?

UNKNOWN: (Inaudible).

MS. HARDING: Oh, we can't?

UNKNOWN: Excuse me?

UNKNOWN: Reconvene in 15.

MS. HARDING: Fifteen minutes? Okay, sorry for the back and forth. We're waiting because we're going to move into closed session for this moment in time. We'll explain the delay.

CLOSING REMARKS

But for those of you, thank you very much for participating in the conversation for the National Advisory for the Substance Abuse Prevention, and we look forward to hearing from you next time, which I think is going to be in the month of March. So as you heard from Administrator Hyde, we will go back to a face-to-face meeting. And hopefully we'll see all of you in person around March.

So if we could go to closed session, and only the NAC members stay online please.

[Whereupon, the meeting adjourned at 2:40 p.m.]