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INTRODUCTION:

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Richard Frank [00:03:52] I'd like to welcome everybody to Brookings. And we're having a conversation today, that focuses on [background noise] policy. And this is part of an ongoing conversation here at Brookings. I'd like to introduce myself. My name is Richard Frank, I directed the USC-Brookings Schaeffer Initiative on Health Policy. Today, we'll be here to talk about mental health policy, and we'll start off with a fireside chat with Secretary Xavier Becerra. And that will be followed by a expert panel discussion that will feature Deputy Secretary Andrea Palm. In connection to the work we're doing here on mental health policy, Brookings last night released two papers on mental health policy, one addressing children's issues, and the other one addressing integration of behavioral health into general medical care.

In addition, that is accompanied by two papers from HHS. One is on their roadmap to mental health integration, and the other one is a recent blog that was put together by Secretary Becerra and his colleagues at HHS. To get this started, I'm pleased to introduce Secretary of HHS Xavier Becerra. He is the 25th secretary of HHS and has long been a champion of mental health rights. And he has made mental health policy a central part of his agenda at HHS. And he will be interviewed by Amanda Seitz from the Associated Press, and she is a health policy reporter there. So I'd like you to welcome Secretary Becerra and Amanda Seitz.

Amanda Seitz [00:06:30] Good morning, Secretary. Thank you so much for joining us. And thank you to our audience as well for being here today. We have a lot of ground to cover, this is a big topic, so I want to dive right in. The Brookings Institution today is releasing a paper that looks at the dramatic increase in depression rates among U.S. adolescents. I know you've been traveling the country, and I'm curious if you could share with us some of the conversations that you've had with parents, teens, providers and educators about this youth mental health crisis.

Xavier Becerra [00:07:04] So it's a crisis, and I don't know if my microphone is on or not, but it's a crisis that spans the country. It spans generations. I mean, I believe 90% of Americans believe America is suffering a mental health crisis. Its, young or old, it makes no difference. COVID obviously exposed it in ways that many people had not seen before. And for us, it was, it was existential. We knew that we needed to do something right away. So from the get go, we started to work on this issue. We established a coordinating council within the Department of Health and Human Services, so we could better make sure that our various agencies were on this together and not replicating services.

And fortunately, we have a president who's launched the greatest effort we've ever seen to try to tackle mental health challenges that we have. And he was, not just a statement, he, he made it very clear during the State of the Union that we were going to put more money behind that statement than ever before. And fortunately, Congress had delivered quite a bit. But, you know, it helps when you have a president who says we're going to finally live up to the legal requirement that we treat mental health the way we treat physical health. And so we continue to do a lot of work. We've had some success, but there's just so much to do.

Amanda Seitz [00:08:19] Have there been any stories that have stuck out to you in recent months while you've been traveling?

Xavier Becerra [00:08:25] I've been, I've traveled nationwide during this mental health tour that we've undertaken. Probably the most inspiring thing I saw was young people still under the age of 20 making calls with our new 988 lifeline, responding to mostly young people who were calling in and just watching, not just their enthusiasm, but the reaction that they were getting from people who were calling in. Sometimes it's better to have someone who's your peer respond to you because you're more likely to pay attention and maybe take the steer that they're trying to give you. And that was great. I've seen some cases where people have told stories about how they felt like they were alone. I've heard stories of people who lost loved ones and didn't realize that their loved one was hurting. It's everywhere, I could take up this whole session just talking about those stories.

Amanda Seitz [00:09:23] Well, I'm glad you brought up 988, because that's certainly one way that we've seen a lot of youth reaching out through the new text and chat streamlined options. I'm curious if you could tell us a little bit more now that the line is launched, what's next for nine, eight, eight? What do you envision down the road for it?

Xavier Becerra [00:09:41] So before I tell you what's next, can I just tell you what nine, eight, eight is?

Amanda Seitz [00:09:44] Yes, yes, the National Mental Health Hotline.

Xavier Becerra [00:09:47] Yeah. And see for us, 988 is more than just a number. It, it's a message. It's, if you're in crisis, if you're about to take the wrong fork in the road and you don't know where to turn. 988. We hope 988 really does become 911, but for those who really need to reach out to someone for some help now. And it's working, fortunately. A year ago in August, there were about 140,000 people who reached out through the existing lifeline phone numbers that were existing

throughout the country. They were all ten-digit phone numbers. And regionally, it depending on where you were, you'd call a certain number if you needed help and you could call, hit or miss if you got anybody to answer if you weren't put on hold. A year later, August of this year, when we launched, we launched in July of 2022, August 2022, when we got the numbers in, rather than 140,000 contacts, there were 216,000 contacts. And that was just with one month of service under nine, eight, eight versus a ten-digit number.

The other thing we changed was we just didn't make it a phone number. Today you can text or chat instead of making a phone call. I don't understand it— it's beyond me. But some people would rather text or chat, young folks would rather text or chat sometimes than actually hear a live voice. But it works. And we've seen the greatest uptake in terms of text and chat. We also have contact in Spanish and Chinese in other languages because we know that there are people who are hurting who don't speak English very well. We just saw Washington State start up a call center specifically for tribal communities. And so what we've done is we've sent the message, you know, we're, we're here to help. We want to help. And by the way, if you do call, you will get answered and you won't be put on hold. That's perhaps the most important thing is you hear somebody live. So what comes next? Make sure we have darn good services for those who do contact us. Because if you took the moment to call us, we owe it to you to give you the service that you need and the professional help.

Amanda Seitz [00:12:04] Thank you, Secretary. While 988 has helped to connect people who are in an immediate mental health crisis, people are still struggling to get care every day. 1000 counties in the U.S. are without a single psychiatrist. There are fewer than 10,000 practicing child psychiatrists in the country. Can you tell me some of the ways the administration is tackling these barriers to mental health care access creatively?

Xavier Becerra [00:12:32] So I could spend some time telling you about the resources that Congress gave us that we're devoting to workforce empowerment. We're giving a lot of local governments and sometimes directly to the providers of mental health, the option, they can use the money to either reward their work force that is feeling burnt out and tired, or they can use the money to provide more pay. We're giving them the opportunity to do what they need to do to make their workforce more resilient and hopefully grow it.

At the same time, we can tell you the money that we put into working with schools so we can actually have a caregiver, a professional at school sites, because more and more we're hearing about

suicidal ideation in our young people who are not even out of high school. And so we're trying to do more principally through Medicaid to see if we can provide a health professional on site in schools, so we don't have to worry about young folks not knowing where they can go and then going home and still not being able to share that with their parents to see where they can go. And so we're doing as much as we can. As I said, the president has made it clear, and Congress has given it some resources. We're still way behind.

Amanda Seitz [00:13:47] Is there a certain when you mentioned the funding, is there a certain success story that sticks out to you?

Xavier Becerra [00:13:53] Oh, gosh. Go back into my database here.

Amanda Seitz [00:14:00] You mentioned the schools. I'm curious how many schools are doing that type of work?

Xavier Becerra [00:14:05] Not many. I mean, most, most schools don't have a nurse at their site anymore. And so it's, it's a matter of trying to change that. I can't give you a specific story now, but I can, I do want to make sure I mentioned one other things. One of the reasons why it's become so difficult, and quite honestly, why I, I don't have the same number of stories that others do is that health care in this country is not a province for the federal government. You may think it is because of Obamacare and Medicare and Medicaid. The honest truth is that the Constitution left health care to the states. We get involved essentially to supplement what the states get to do. They have the authorities and how they govern health care. But because they want money from us, they're willing to do health care for seniors called Medicare. If they want help with their low income, they take Medicaid. And because we're giving them money, we can put strings on that money and say, well, if you're going to take the money, you got to do it certain ways. But otherwise, we wouldn't have an entry point to do health care throughout the country. We have to rely on the states.

So I tell folks, we don't have a national public health system. We have a nationwide public health system that relies on that patchwork of states, territories and tribal governments to do it right. And if it's not done right, then within those seams, people fall through the cracks. And that's why when 988 launched, the president had given us some $430 million to do 988 and get those patchwork, that patchwork of call centers together, make them seamless. The year before the president came in, a total of about 22 million had been invested in 988. It's a major investment by our national government to make a nationwide system work seamlessly. But we need the states to now take responsibility to

do that right, just as they need to take responsibility to do better mental health care for our young people the right way.

Amanda Seitz [00:16:02] And one more thing I want to follow up on that. You mentioned the workforce shortage in particular, and that is driving a lot of these issues. Can you talk about what the administration has, has done to beef up the workforce for mental health?

Xavier Becerra [00:16:17] Again, we supplement. And so I can tell you about the dollars that I'm giving you, but I could tell you we spent $30 million here and you feel that's great. I could, I could have said we spent $30 billion here and you would've said, oh, that's great. You wouldn't know what that means. What I can tell you is that we're giving the states, the local governments, the providers, the flexibility to try to make use of the money with some can, with some requirements. You got to show us that you're having success in doing certain things. Otherwise, we're not going to give you more money. But we're trying to let the states that control, that govern how we do health care move in a particular direction.

So, for example, in so many cases, it is mental health tied with some level of drug use. How do we try to avoid the clash of the two or the consequences of the two? So we may drive a state if it wants to apply for funding to say, but you got to do some work on drug prevention and treatment. And so we're doing more of that. We've also changed our strategy when it comes to drug overdose. We're not, we're trying to get away from the stigma that's attached to that. We're trying to make it so that people will come to us. And we've also added a new component to the prevention treatment model. We've added in between harm reduction, because in between you becoming an addict and getting the treatment, you may do a lot of harm to yourself that's irreversible. We're going to do what we can, working with local communities to prevent the harm from damaging you long term as you get treated.

And then the other component that we still have to work on with the states is the follow-up. How do we make sure that once you, you've gotten clean, you stay clean. And it's tough because when you we throw you back out into the world, it's not always very nice. And so we want to make sure that we can continue to follow up, to make sure you continue to move in that the right road towards prosperity.

Amanda Seitz [00:18:22] Are you sneaking a peek of my note cards? Because my next question was on overdoses. Unfortunately, they are at a record high level in the U.S., driven in large part by fentanyl. I'm curious, what strategies do you think are working to prevent those deaths and

how do you hope to see states and local governments use the opioid settlement fund money? And how, how will the federal government help facilitate some of those efforts?

Xavier Becerra [00:18:50] Yeah, so. One of the greatest things that we can do is stop relying on 21st century thinking and the anecdotes that kept us from, for example, supporting centers that offer fentanyl strips to those who are using drugs. We're not trying to encourage drug use. We're just trying to make sure that if you are someone who can't yet stop using that drug, that at least you know what's in it. Because if you found out that what you were about to put in your body had fentanyl, which could kill you, you probably would say, I really want I need a fix, but I don't need this because it could kill me. And so the evidence has shown that fentanyl kills. Evidence has shown if somebody knows they're about the put fentanyl in their body, they'll stop. And so that's at least that's the harm reduction, right? That's the prevention of the bad stuff. And getting rid of the stigma that's attached to saying you're helping someone use drugs because the evidence shows that it works. So we're trying to move towards that.

We're trying to make it easier for physicians who help those who are trying to get off an addiction, be able to provide the type of medication that will help them. It's very difficult because as you can imagine, if a physician is prescribing an opioid, they'll come under a microscope because maybe they're doing a little bit too much prescription of opioid. And there are some who do, and therefore law enforcement tries to go after them. So a lot of these physicians say, I don't need, you know, the heavy hand of law enforcement looking over my shoulder because I'm trying to help people. And so we're trying to make it so that properly done, you don't face the, the intimidation that you used to feel being someone who's trying to help someone get off of the drug addiction. And so we're doing everything.

Now in terms of the law enforcement, having served as the attorney general in California and working on these cases to try to get those who help spur the opioid epidemic to provide some help to abate what they helped create, I have reached out to my former colleagues, AG colleagues throughout the country to say, look, we do a lot on opioids and on drug addiction at HHS as you all continue to get these awards of millions and billions of dollars from these manufacturers and distributors, let's work together to make our resources go farther to try to help, not just a bait and, you know, remedy, but to prevent. And so we're going to try to work with them more and more.

Amanda Seitz [00:21:30] And one of the areas, too, that people have gotten some of the relief that you're talking about is through telehealth. Do you envision, what do you envision is next for telehealth with the, the public health emergency ending in regards to getting the treatment that people need?

Xavier Becerra [00:21:46] So for those not so much in the know, the reason telehealth has exploded or been able to explode so much is because some of the proscriptions or constraints to using telehealth have been for now shelved while we're in this public health emergency as a result of COVID. At some point pretty soon, I probably will declare that we are no longer in a state of emergency on opioids, I'm sorry, there is one for opiates but for COVID, at which point the telehealth flexibilities that states and providers have to offer, for example, telehealth services in rural communities to folks who have a hard time driving to a care center, those flexibilities will disappear because the current law that's right now in remission will spring back in place.

And unless Congress makes changes to those laws, those flexibilities will disappear the moment I declare that there's no longer a public health emergency with regard to opiate, COVID, excuse me. And so we're hoping Congress will continue to keep those flexibilities in place. In fact, we hope that they can expand some of them because we've seen how well they've worked. And if we don't get those flexibilities, you will know immediately, because there will be people who immediately lose access to care.

Amanda Seitz [00:23:18] Great. Thank you very much, Secretary. We're going to turn it over now to the audience to ask some questions.

Richard Frank [00:23:29] Okay. We now have some time for some questions from the audience and also possibly some from our televised audience. Sir.

Audience Member [00:23:44] Good morning, Joe Pyle with Thomas Scattergood Behavioral Health Foundation in Philadelphia. And I have two questions and a thank you. One, the president and you have set out a large agenda here, and I think we know about a lot of what does work. I think we still have a lot that we don't know. So I'm curious to hear what you think are some of those things we still don't know that would help this mission be successful? And then because we're a local funder, I'm curious what local communities, municipalities need to be doing to drive this agenda, agenda forward.

And then I guess on the thank you, because I'm not sure you'll comment on it is that you mentioned harm reduction and I just look forward to the DOJ's Philadelphia court meeting on January

9th, where they'll hopefully rule in the favor of safe injection sites as part of that battle against the opioid epidemic. So what do we need to know and what can local jurisdictions do to advance that?

Xavier Becerra [00:24:52] Joe, so you just mentioned what we need to know is how can we move faster forward on the things that will work to help us save lives, get people back on track with their life, and whether it is safe injection sites, whether it is other evidence-based practices, remember that because mental health hasn't had a place in America the way physical health care has, it's tough to know exactly what works the best. And so we still have to see the best practices unfold. We certainly know today that drug addiction is a disease. It's not just a bad thing that someone does. It's like alcoholism. It's like diabetes. And what we don't yet know is exactly how to best treat that disease. But we know it's no longer just somebody, you know, doing the wrong thing.

So we, what we know, what we don't know is how fast and how far we can go. We do know we need more money to find out how fast and far we can go. Local communities can help us by, I'm going to get in trouble, but by pushing their governors and their state public health officials to do more. Everyone always at the end of day turns to us, and especially when you have a president who says he wants to go so far. But again, I can't, I don't have authority to do something in a particular state like Pennsylvania unless the state says, come on in. And so if you're, if we wait for that, folks will die. And so and thank you for your, your comments about what we have been doing. And we also keep our fingers crossed that the best evidence will drive where we go on, on mental health and drug use services.

Audience Member [00:26:45] [inaudible] Local governments, both state and cities, can be faster, I guess I, in the 40-year plus that I've been in this field we've not gone fast enough [inaudible].

Xavier Becerra [00:26:58] So Joe's asking that we push faster. I'll give you a quick example. Empox, or monkeypox, as it used to be called. We put out vaccines before they were needed. But we couldn't tell the locals when and how and where to administer them. But we could send them. And we heard a lot of concerns and complaints about monkeypox and having the vaccines and the treatments available. We could only do what we could, as much as we could see. And if the states and local governments weren't sending us the data so we could have better sight, we were essentially in the blind to some degree. Some jurisdictions, were working closer with us, with us than others. And what I will tell you, it's very difficult when you see what's approaching and empox could have gotten really bad and you have the ability to respond, but you don't have the full coordination. I repeat again, we

have a nationwide system of public health. We don't have a national system of public health. And that nationwide system, which is a patchwork, requires us to not let the seams let people fall through the cracks.

Richard Frank [00:28:10] A lady in green sweater.

Audience Member [00:28:15] Thank you so much. Good morning. And thank you, Secretary Becerra, for being here. My name is Silicia Lomax, and I'm with a firm called Waxman Strategies. I just wanted to go back to, I think, part of your conversation on youth mental health in particular, I know that's been a priority for many folks. Earlier in the year, I know that you also sort of worked in collaboration with the Department of Education and Secretary Cardona sort of on some of this work and what those efforts look like in school. So just curious, are there more opportunities for collaboration with the Department of Education to improve mental health in schools and for students? And what's next? What else do you think can happen here, especially as far as implementation goes? I know there's funding out there, but, but implementation is a key part. So just on both of those things.

Xavier Becerra [00:28:58] Yeah. So what we're doing is I sort of mentioned it once again, we don't have jurisdiction in the schools. One, because they're local, schools are run by the local governments, not by the federal government, but two, because it's education, not health care. But we always stick our foot in the door, and we offer some money. And that's where, again, if we can get Medicaid, if a school can apply and receive funding for providing health care through Medicaid, the Department of Ed isn't going to give them Medicaid dollars they don't control Medicaid, we do. And so we're trying to get more schools to buy in to this idea.

And fortunately, we have a great partner in Secretary Cardona who wants to see that happen. So we're trying to open doors to schools so that we can provide assistance, because otherwise the schools are going to say we barely have enough money to do the three R's. Now, you want us to do not just health care, but you want us to do behavioral health? No we need help. And so that's why I keep saying, you know, kick those local governments to get their states to give them more resources that they need. We'll try to then sweeten the pot, offer a carrot, and hopefully it'll work.

Richard Frank [00:30:09] Do you have time for one more? Do we have time for one more? Oh, yeah. Okay. Last question. This one's from the home audience. Try to mix it up here a little bit. You mentioned peer supports earlier. How do you see the role of peers playing out in your vision of the HHS roadmap?

Xavier Becerra [00:30:38] You're never too young to help. And it is amazing the power of a peer. I mentioned to you the, the phone calls that were being answered by young people. They're not the professionals. They're not going to tell that individual what type of care they need. But they're catching people, right? That's what you want. You want someone who will just at first listen to you. I quite honestly, a lot of times people just need to be heard. Some people really do need the professional help, the medical services, the behavioral services. Oftentimes they just need to know that there is someone who's the backstop who will listen to them. It is often far more successful to have a teenager talking to a teenager than it is some adult who may be judgmental or may go straight into the therapy and treatment you need. That young person may say, gosh, I feel what you're talking about, I went through that, and a lot of these kids, young people, had gone through some of these things. So. If we're smart, we'll utilize every talented American who's out there regardless of their age.

Richard Frank [00:32:01] Great. I think you need to run. And so I hope you'll all join me in thanking Secretary Becerra and Amanda Seitz. Okay. We are now going to move to our expert panel discussion. So stand by for one minute.

Vikki Wachino [00:33:06] Glad to see some more chairs here as people get settled. We're excited to build on the conversation between Secretary Becerra and Amanda Seitz with a fabulous panel of experts. I'm Vikki Wachino, I run Viaduct Consulting LLC. And, and I'm excited to partner with Richard and the Brookings team at the USC-Brookings Schaeffer Initiative on Behavioral Health and excited to be able to introduce this panel of leaders to you today. So I'll do quick introductions and then we'll get to it. So first, Andrea Palm, deputy secretary of the Department of Health and Human Services, came to that role at the start of the Biden administration, following her leadership as secretary designee of the state of Wisconsin, where she oversaw the Department of Human Services and major public health programs in the, in the state. Prior to that, she served in a variety of leadership roles at HHS throughout the eight years of the Obama administration. And if I'm not mistaken, Andrea brings to that background a background in social work. So has seen these issues from, from a variety of perspectives.

Sitting next to Andrea is Jameta Nicole Barlow, who is a community health psychologist, a scholar on women's health and an, and an assistant professor of writing. She serves in multiple roles here at George Washington University. Down the roles, down the road where she holds multiple appointments. A big focus of her work is on utilizing decolonizing methodologies that disrupt cardio

metabolic syndrome and structural policies that adversely affect the health of black girls and women, as well as affect intergenerational trauma and perinatal mental health. And she brings to that role experience in the academic sector, government sector and nonprofit sector. And so I'll look forward to hearing more about all of that in just a few minutes.

Next, Dr. Howard Goldman, who's a professor of psychiatry at the University of Maryland. He has spent his lifetime working on mental health issues and brings to that not just a background in psychiatry, but also a strong interest and expertise in public health and social welfare, is the author of more than 325 articles on mental health and has also served in the leadership role in the journal Psychiatric Services.

Kenna Chic has also joined us. She is the former president of Project Lighthouse. We heard just a few minutes ago about the role of peers. Project Lighthouse is a peer organization. Kenna is a tireless advocate for people with mental health issues and people with disabilities. She served in a variety of roles trying to advance behavioral health and disability rights and is in particular recognized for her thought leadership on youth behavioral health.

Finally, Sandra Wilkniss, who's senior program director for Population and Public Health at the National Academy of State Health Policy. She has worked for, with state leaders for some time, both at NASHP and prior to that at the National Governors Association, worked at the federal level advising Senators Heinrich and Bingaman, both from New Mexico, and also has a background as a clinical psychiatrist, which is where she received her training. And she's worked in a variety of roles, bringing both a clinical and a practitioner perspective in academic state hospital and community-based settings. So please join me in welcoming the panel here to Brookings.

So, Andrea, I'd like to start with you. You oversee an agency that is not small. It operates some $1.7 trillion in spending, touches every aspect of the health care system, the public health system, and many human service programs. So as, as you oversee, it's not a small job and and big part of your role is really overseeing the operations of the department, if I understand correctly. So as you think about translating the President's commitment to advance behavioral health and you work with Secretary Becerra to do so, what in that, in that broad portfolio are really your most powerful levers to make a difference in the mental health of Americans?

Andrea Palm [00:37:49] And if I could just say, it is, it is the privilege of this agency to do this work in a way that uses our levers, I think, right. We, we as a federated collective of divisions with,

with missions inside of the broader HHS mission, it is our responsibility as leaders more broadly to lift up and connect those pieces. And from my perspective, that is our responsibility, it is our privilege, and it is the way in which we ultimately and finally really integrate behavioral health into health care, into social services, in a real recognition of them being such an important part of the social determinants of health.

And so from my perspective, sitting where I sit in the department, it's harder work to do it that way. But it is, it is the only way we are really going to get to where we need to be on behavioral health. And so when I think about it, I think about it like that. But in sort of the very tactical, you know, there are a number of really specific levers that we need to be looking at and maximizing and driving for change. And those include things like our reimbursement levers, right? If if you build it, they will come I think is really true in behavioral health. If there is a career pathway, if there is an opportunity for people to build a life that supports their families by being a behavioral health provider, that is an important part of how we make sure we have capacity in the system.

And so how we use our reimbursement levers through Medicare, through the way we think about provider networks and Medicaid, those things are very important. Our physician fee schedule that just recently came out includes thinking about how we make sure licensed marriage and family therapists are allowed to provide services in the Medicare program, how clinical social workers, how we think about the future of, again, that workforce when, when, when we know those workforce shortages are acute. And so those levers are really important, how we build capacity beyond the workforce, our HRSA teaching health centers program, important piece of the work we do, the resilience of the providers we currently have, the money that we're investing through HRSA to support a beleaguered workforce that that that needs to build their own resilience and support the clinicians that we already have, so capacity building, reimbursement.

But again I think you know whether it's that you take notice of this, the president's commitment to this, the secretary's commitment to this, the fact that we are both here today, the fact that we recently released this paper as a leadership team, I don't think in my experience at HHS as we have ever done anything where the entire leadership team with jurisdiction over various pieces of behavioral health have come together to, to, to display and to be articulate and to take responsibility for our commitment to do this work better. And so, from my perspective, that is the accountability I am, I am bringing to this that I expect of the leaders at the department. And, and, and they got to come to

the secretary and to me on a regular basis with progress. And I think that, that really matters. And those are important, the most important levers that we have.

Vikki Wachino [00:41:42] Great. And if people haven't had a chance to read it already in the most recent issue or posting from health affairs just last week, Andrea, Secretary Becerra, colleagues, as Andrea says, authored a piece that really flesh out this vision of behavioral health integration in the United States. Andrea, a quick a quick follow up as big as the department is, there's also other aspects of government. And sometimes when I read about the administration's commitment to behavioral health, I, I read about a quote unquote whole of government approach. Can you say a little bit about what that means?

Andrea Palm [00:42:16] Yeah. And you know, the secretary touched on some of it, right? We, we will launch next year Technical Assistance Center with the Department of Education that is looking at the intersection and the ways we need to reach kids and youth in schools. We are, we are looking at our NIH levers around a research agenda to understand integration, to make sure we're, we are driving the evidence so that we can make the case for why we need investments in, in things that work in the behavioral health space. We are working with HUD, recognizing again that the social determinants of health and the connection between behavioral health and, and staying housed or getting housing is, is inextricable.

And so how are we working with them to think about those issues, to use our levers together to address and make sure there are access to services, there are supports, and that we're doing the things we need to do in that whole of government way with, with our partners across the government. So there are a variety of initiatives and opportunities that we are, that we are looking to see is recognizing that we don't we, we as a self-contained entity have a lot of the, of the spectrum of what needs to happen, but we can't do it without our partners at DOJ.

And there are, the intersection between the criminal justice system and behavioral health is very clear. And so and as a former AG, the connection there is stronger than I've seen it and how we are working together on the crisis continuum, for example, is a really important part of how we think about preventing people from becoming incarcerated and that link between us and DOJ, both at the federal and at the state level, is really, really important. And so those are all levers we're trying to pull. There are only so many hours in the day, but we recognize that if we're going to lead in the space, we

have to leave it in our four walls. But then we have to engage our partners across the government in ways that really move the needle.

Vikki Wachino [00:44:22] Thank you for that. We're seeing both in the executive branch and in the legislative branch a real focus and priority on integration of behavioral health services into health care, into— as Andrea, as you said— into non-health care settings as well. Howard, as someone who's been a leader in this field and working on these issues for some time, this is not the first time we've talked about, about integration. What is, if anything, is different this time? And what do you think that the field needs to do to really make progress?

Howard Goldman [00:44:53] Thanks, Vikki. Thanks for including me on the panel. I was glad to see the interest in integration and as you noted, we have been there before, and it's been a great challenge. First and foremost, I think the changes and increasing recognition of the mutual advantage of health and mental health organizations and practitioners to collaborate and cooperate in care delivery, that hasn't always been the rule. But primary care doctors, for example, have recognized that many of their patients have anxiety and depression, increasing incidence of, of those kinds of problems. And they've accepted increasingly their response, as their responsibility to help their patients. They don't do it alone. We've developed safer and easier treatments to use, particularly for the treatment of depression and anxiety, and no longer requires complicated titration of doses.

So the technology is more amenable to delivery in an integrated setting, and innovators in service delivery have figured out a team approach— collaborative care— which delivers both pharmacologic treatment for depression and anxiety, and also problem-solving therapy, which is again simpler than the traditional approaches to psychodynamic psychotherapy that were so common in the past. And finally, I think it's important that none of these things will go forward without pay codes so that people can be reimbursed. And we've done a better job, for example, with collaborative care, getting a pay code for that and having insurers cover those services. So it's an array from attitudes to technology. I think that accounts for the increasing prospect for integration now compared to two decades ago or four decades ago or 100 years.

Vikki Wachino [00:46:49] Interesting. And also connects back to one of the levers Andrea identified earlier, which is—.

Howard Goldman [00:46:52] Exactly.

Vikki Wachino [00:46:53] Payment. Yeah right. So, so Sandra as we heard from Secretary Becerra, so much of this work really resides at the state level. How are states working to advance integration?

Sandra Wilkniss [00:47:05] Yeah, thank you. There's a lot left to be done, as we all know, and there is, there is a moment here. We have new opportunities and new levers. And I would say that on the state side, states are working with payers and providers to figure out how to support models like the collaborative care model and integrate into primary care. But I think two other, two other innovations are really important. There's a lot of experimentation in reverse integration. So we know that people with more serious needs usually enter the health care system through a community mental health center or outreach teams. And so how do we integrate care at those loci? And I would say that there's experimentation around the Certified Community Behavioral Health Center model, or a modified version of that, let's say, in the state of Massachusetts, which is also a community center health model.

But there's experimentation around bringing evidence-based practices for mental health and substance use, disorder services and supports, and really collaborating effectively with primary care to offer that whole person care approach. And the last thing I wanted to say, because it's been mentioned a couple of times, is I think we don't often think about it as an integrated care approach, but there is really strong evidence base for especially for people with complex care needs for things like housing support. So housing first or supported employment approaches, individual placement and support that really lend themselves to integrating behavioral health and health care in those services and supports and also meet the needs of some of those social drivers of health. And I think there's a lot of activity on the state level to really work across agencies, across sectors to realize some of those, those interventions on the ground.

Vikki Wachino [00:48:39] All right. So it sounds like this whole of government approach isn't just taking place at the federal level, but is at least some extent at, at the state level as well. So I want to talk about equity. We're in this moment of recognition of the need to advance equity throughout the health care system, throughout the behavioral health care system. Yet we have really longstanding disparities in access to services by race. How— and Jameta I'll turn to you first to answer this question— how do we meet this moment? How do we really deliver and make sure that that we're leveraging this policy interest, this energy around equity, and make a real difference?

Jameta Barlow [00:49:20] Well, first, I want to thank you for the invitation. And second, I want to say that we need to start asking different questions, right. We have some very long narratives, histories that we haven't addressed, particularly in certain communities. And because I study trauma and I look at it through this lens, I think all of us in this moment managing life through and after wherever we are in COVID, we all understand a level of trauma. But for some communities, most marginalized communities, thinking about different races, sexualities, genders, etc. have a different lived experience. And so their mental health supports are different.

And for so often, communities have depended on community organizations. And so I will say over and over, there's so many organizations, community members come together, particularly— I do a lot of work with Black girls and women— there's a long history from the early, late 1800s, early 1900s of Black women taking care of communities, whether it's the Colored Women's Caucus and circles, whether it's Black women's organizations. And that remains today. And so when I think about what we can do, we can invest in people who have best practices that are working in those communities. There are barriers. You've heard that from the secretary, we've heard that today on the panel. There are barriers as to what the federal government can do, what the state government can do. But what we can do is work with these organizations because they've been doing it for years. They've been doing this work to support communities. Is it perfect? No. But part of that is about infrastructure.

So I would look at two things. One, ask different questions. A lot of people, and particularly around mental health, it's about, do I have enough money? I'm doing things, I don't have enough money for food. I don't have enough money for housing. We have to start looking at whole government, whole communities, this whole approach, understanding that we're all connected, so that person who doesn't have money is making different decisions, it's causing a level of stress on top of trauma, that might be rooted and historical practices that have happened in specific communities. And so my argument would be that we ask different questions, we invest in community organizations that are doing that work, and we understand that it doesn't happen overnight. You can't invest in health inequities and think it's going to change in two years. It has to be a long, sustainable investment that works with communities and that tells communities what to do.

Vikki Wachino [00:51:59] Kenna, I'll turn to you next. What, what how would you respond to what Jameta said and what's your vision of how we get to equity in mental health in the United States?

Kenna Chic [00:52:10] Yeah. Firstly, I want to thank Richard and Vikki for your invitation to speak at this event. And I also want to thank everyone for your interest and passion in behavioral health. I think I'd like to start by grounding us in some statistics that are quite recent. One is that in the past year, 19% of Black youth have attempted suicide. That is compared to 12% in their white counterparts. 22% of Latino and Latinx youth have reported depressive symptoms, and suicide is now the number one leading cause of death in AAPI youth, who are also three times less likely to seek and receive support. And so understanding and thinking through the lens of some of these stark statistics that we're facing, I think it's also important to note how our systems are addressing these situations, and a huge part of it is actually looking at some of the new innovations and ideas in this space.

One thing that I think is especially promising is the idea and the interest in diversifying our workforce. It isn't enough to just have someone who looks like you, even though that is important in building comfort and trust in a therapeutic relationship, it is also important to have someone who understands you and your cultural background. And what that means, for example, is a lot of immigrant communities face extra pressure from supporting their parents in assimilating to a new country. And a lot of times it is on the youth in these communities to support their parents and also to raise themselves in some ways. And what's really interesting about this is when you have a therapist that then suggests to certain youth in these populations to set more physical barriers with their family, when you live in a one bedroom multigenerational apartment, that's not really possible, nor is it possible to set certain barriers when it relates to emotions and other boundaries, because in a lot of families that's not really helpful and it may cause more harm and disruption.

And so having a therapist that really has that background, who understands that's not something that I can really suggest, even though my training or what I know would indicate that it would help this young person is really important to nota. And so I think, for example, SAMHSA's fellowship program around minority health is important because those types of pipelines create systems where more psychologists of color and psychiatrists of color would be able to support youth and other folks who are dealing with certain issues and are actually able to understand it from their

cultural lens specifically. Diversity isn't just teaching someone to speak another language, it's actually ensuring that people who are in those roles of support are people who understand that background and can actually provide that support.

Vikki Wachino [00:55:22] A follow up to that. I mean, those statistics you presented, Kenna I mean, I think there's probably no one in the room which doesn't feel it in their gut that this is a very, very concerning national problem. Richard and I did some analysis in our new paper that show the rates of adolescent depression have doubled just since 2011. And so it seems like there was a real inflection point about ten years ago where rates started to increase, rates of specifically of youth mental health distress. As a, as a as a youth leader, as someone who is has worked as a peer and led peers, what's your take on what's happening? Why are we in this place?

Kenna Chic [00:55:58] How much time do we have? That is a very fun question to answer. And in the spirit of keeping my response short and punchy, I will distill it down to three points to focus on. And so the first one would be around our societal context. Do youth feel like they have a future? Do youth feel like they can build a life that they're excited about? One of the most starking quotes that I've heard, and I want to really emphasize it here, is if you want to save lives, you need to build a world that people want to live in. And so when we look at it, of course, you know, it is true that throughout history and throughout the way that our society has existed, especially for transition age youth, it is a very unstable time. We don't know what our careers will look like, we don't know what our futures will look like, where we end up and that's important to note.

But at the same time, I think in this specific cultural context, we're also seeing more wars that we're aware of because we have social media and news to give us that information. We're aware that there is climate justice issues and climate change, and that would impact how futures look for youth. An easy one is also will some youth think to themselves— in my work as a pure supporter of, I heard this a lot— will I be able to ever afford a house and get married and have children? And so if we look at specifically what the promise of whether it's the, say, the American dream or to look at what we want to give our youth as a society, sometimes we may not be living up to those promises, and that's scary for a lot of people.

And I think we're seeing more of that, especially with more events going on that are things like pandemics, that are things concerning democracy, other concerns. There is a large area of fear and hopelessness that exists in a lot of young people. A lot of times that hopelessness may drive them

towards advocacy and towards making a change, but it could also drive them towards feeling like this isn't really a world that they want to live in right now. And I think that's really important to note. So that's my first point.

The second point I think that's really important to note is also the way that we think about behavioral health and wellness in general. I think there is throughout the way that psychiatry and psychology has existed, a lot of the times the goal towards treatment is function. Are you able to hold down a job? For youth, it may be are you attending school? Are you having good grades and are you not disruptive in the classroom? And I think it's obviously extremely important to support youth who are struggling in that way. I think giving people behavioral health care shouldn't stop there. The metric shouldn't be if you're going to school, you're okay. If you have good grades, you're okay. We should note that youth can have good grades and go to school and still be extremely suicidal.

And so I think it's important to note that perhaps the way that we've practiced psychiatry and care, instead of looking at it through the lens of depression and anxiety scales, we could also look at it from flourishing skills and the recognition that are youth feeling like they have healthy relationships, do they feel like they enjoy their self-esteem? Do they feel like they're hopeful about their future? Because those lenses also matter when it comes to getting the support that they need and when it also comes to how they feel about whether they want to live and are in a society that they want to live in.

The third point I would say is in the past decade we've seen so much change and growth in behavioral health. We went from a society that whispers mental health and therapy behind closed doors to a society that's frankly saying, people are probably saying, I'm going to therapy or sorry, I can't make this coffee date, I have therapy right now. And I think that is absolutely amazing. At the same time, as youth grow more accepting of behavioral health care and the need and the importance of it, we're also facing systems where there are so many barriers to seeking care that when youth say, I recognize that I have an issue and I'd like to receive support for it, the response shouldn't be, oh, well, you're doing well in class, so you don't need it, or oh well, you can't afford it, so I'm sorry, we can't really help you.

And so I really think that as there's more awareness in behavioral health, we need to work towards breaking those barriers and making sure that people are actually able to receive the support that they need because there is this sense of trauma in trying to seek care and then being turned

away that we don't talk about enough in our society. And so I'm grateful for all the work that all of these panelists and everyone here is doing to really work towards ensuring that we are really addressing some of these barriers.

Vikki Wachino [01:01:30] Thank you for those insights. Jameta, in your work with Black women and girls, I'm sure you're seeing these, these alarming trends play out all the time. What's, what's your take on what's driving it?

Jameta Barlow [01:01:43] Yeah, I mean, I think definitely building off of this idea of trauma that we have intergenerational trauma, the fact that one in three Black women have been sexually assaulted and don't report it, right. There's this long history of how Black women were treated during slavery, the effects of colonialism and how even— I've written about this publicly— that a foundation of the civil rights movement started when Recy Taylor was raped and sexually assaulted, and that launched the Montgomery Bus boycotts but people don't talk about that. And so when you look at this trauma and that even today, there's this ongoing underlying trauma that there's no protection from criminal justice, and when you go to a therapist, they don't understand you and understand your situation. And so what you see is, why should I?

And so you have organizations and communities, you have groups like Therapy for Black Girls, Counseling Black Health, Black Women's Health Imperative, all of these organizations that are doing amazing work on advocacy, but also filling in the gaps, using technology, really addressing some of these issues and finding support, even in social media, it can be a double-edged sword, right? We're seeing that social media has contributed to an increase in individuals who might be experiencing body image issues, body dysmorphia.

And I would say that what we're seeing related to Black girls and women, I think, is going back to my original point about we're not asking the right questions. When you consider, for example, for Black communities, about 20% of Black communities are low income. Yet the answer to a lot of health inequity is to expand Medicaid. That does not get at health inequity. Health inequity is okay what about those who have employer-based coverage who are still having those issues? This is not a pathology, a pathological, pathologically pathological issue for Black Americans that they're always sick, etc. We have a very sick history that we have not addressed, and we're seeing the effects of that in our systems.

And so what can we do? We can work with these organizations to do that work. When I think about just the amazing work that so many Black women, they're just stepping up to take care of communities because of those gaps. But what can we do is as a researcher, as a scholar, is also ask those different questions. So when I think about that depression is one of the most common mental health conditions, but for Black women, it's even higher yet what's happening is that they're more often diagnosed with mood disorders and offered medication and therapy at lower rates than the general population.

So when we start to— I know you have a question later about access— when we start talking about how that relates to access, how that relates to treatment, it becomes complicated. And so in order to better understand that we need researchers saying not just expand Medicaid coverage, but let's also look at those who do have coverage. What is their experience? How can we create better systems and better practices? And I know the American Psychological Association is doing a lot of work around this. How can we create better practices to ensure that people are receiving the type of care in different ways in their community and with organizations who are reaching these individuals?

Vikki Wachino [01:05:13] Thank you for that. Now that we've delved a little bit into the causes, I wanted to talk about the solutions and what are the sorts of primary solutions on the table specifically for, for children and youth mental health. Andrea, we heard a little bit earlier from Secretary Becerra about the 988 texting in the schools. What, do you want to elaborate on any of that? Or is there anything else that that we should know about the actions the administration is taking to advance the well-being of kids and youth?

Andrea Palm [01:05:39] I think I'll say a couple of things. One, the roadmap is clear that we think about integration not just as integrating behavioral health into health care, but into our systems more broadly. And again, this is a place where the levers of HHS are important because we are, we have the privilege of having, within the four walls of HHS, the Administration for Children and Families, where Headstart lives, where childcare lives, where our programs for homeless youth live, where our domestic violence programs live. And the opportunities to be smart and creative and strategic about how we think about integration from that perspective so that we're supporting kids and youth where they are is a really important part of the roadmap.

And again, like not easy work, but work that, that we need to do and that we can really add value as we think about, for example, the ways we help Headstart programs interact with their kids in

a way that helps identify issues that equips them to be, to be partners for their families and kids around behavioral health issues. And CDC and SAMHSA are helping ACF think through what would, what would guidance look like for Head Start programs? How do we build into the Head Start bloodstream a focus and an ability to, to think about behavioral health and integrate behavioral into the way that Headstart does its business. And so there are a variety of things that we are doing in this space to really try to up our game as it relates to kids and, kids and youth. And I'm, and I mentioned our work with the Department of Ed earlier, so I'll stop there. But I think we believe that integration, most importantly, doesn't just stop at the, at the door of the clinic or health care setting, but that we've got to take advantage of the levers we have in the social and human service programs that are also within our purview.

Vikki Wachino [01:07:49] I want to come back in a minute to this idea, this very broad definition of integration. But before I do that, Sandra, what are state leaders working on and advancing with respect to kids' mental health?

Sandra Wilkniss [01:08:00] Yeah, thank you. And I am really humbled by the statistics and the comments of my co-panelists. So I'm sitting here trying to let that soak in. But in terms of actual implementation and sort of operationalizing solutions, I'll just, I'll just hit on a couple because there are several that we could highlight, but those that seem to be really in the forefront of the work and have and have promised for impact, meeting kids where they are, as Andrea pointed out, certainly in pediatric provider settings there are collaborative care models that the kind that that Howard described earlier are also for pediatric settings like Healthy Steps and Help Me Grow. And so there's opportunity to develop those further and increase more access to those.

And at the same time, to the point earlier, really bringing them into the learning health system, the federal government has a real commitment, the administration, Secretary Becerra to building out the learning health system and rapidly deploying interventions, figuring out what works and rapidly deploying those and figuring out how to pay for those, that that really has to be part of the equation here, because some of these things are promising, but we still need to evaluate them more. A couple other things in, where we have, you know, professional shortages and we do in pediatric psychiatry for sure, there are teleconsultation models that have really proliferated across the country. Again, worth studying and continuing to implement child psychiatric access program HRSA's pediatric mental health care access program. I think most states have these now in play and they really create an

opportunity to bring experts into provider settings and with kids and families to really triage the behavioral health needs.

School based approaches, I just I do want to touch on that because that's definitely at the forefront and it's a complicated space, yes, there's a state piece to this, but most of this stuff is determined at the local district level. And so really, the federal, state, federal cross agency, state cross agency, counties and locals all really need to come together to align systems. We know about the comprehensive school mental health systems approach, which is a tiered based approach with address, universal prevention and, and health and mental health promotion issues identifies at risk kids. Second tier, third tier is really bringing services, we talked about that before to kids who need, have those treatment needs, but also linking with systems of care, a lot of stuff that's been built out in the community. And that matches, what's really interesting about it is that it matches the educational tiered system, how we address academic needs. But this is an intervention, again, largely determined at the, at the district level. Schools know what they need to do, but there is not a sustainable and aligned financing strategy here.

I'll give you one example of a state that seems to be leading in some of this that shows how complicated it is and where we need to build and grow. According to the National Center for School Mental Health, a couple leading states, Pennsylvania's one of them, has done the following braided funding approach to really bring this into schools, insurance coverage through Medicaid, CHIP and private insurance, to your point earlier, for treatment services, county mental health and drug and alcohol allocations for student liaison services for prevention services in schools, and then the educational system resources for training and best practices such as youth mental health first aid, and connecting with this whole social emotional learning piece that's being developed separately in the education system. So I just wanted to highlight that there's a lot of promise there, a lot of moving pieces, and we have to continue to work together to leverage those.

Vikki Wachino [01:11:17] Thank you. So as we think about this, this idea that Andrea put forward and that we've seen from the administration over the course of the year of kind of building out access points and creating no wrong door in, in non-health care settings, so you mentioned Headstart. Childcare has been a focus, schools. Earlier this year, the administration made some degree of proposals around mental health access and housing and nutrition. It's really groundbreaking to think about, about building out access in those ways. And so I wanted to get a little bit more

perspective on it, first from Jameta and then from, and then from Howard. So Jameta, for you, is this part of the solution set, to starting to, to reach communities that have historically not been served well in in your view?

Jameta Barlow [01:12:07] Yeah. I mean, I think the incentives to get more health professionals or paraprofessionals should be the goal. I will say the current supply of psychologists and other mental health professionals is simply not enough. And so we have to think outside of the box. I think that's just the nature of it. We know that according to a recent APA workforce study, that that number went from 7140 to about 19,000 between 2020, 19, where we found a 166% increase of racial and ethnic minorities within the psychologists' workforce. So we're getting people out there, but it's still not enough. And so offering these incentives, offering any type of motivation to work, particularly in these communities, is needed. I don't think it should be either or, it should be both and. But I will also say that only 6.2% of psychologists, 5.6% of advanced practice psychiatric nurses, 12.6% of social workers, and 21.3% of psychiatrists are member of minority groups.

We have a long way to go. Right. And I say that because even though you can be someone who's not of the same race treating someone of a different race, but given the amount of vulnerability, just getting people, particularly people of color to therapy, you want someone who understands their situation and that they don't have to educate their therapists on their lived experience. And so when you couple that, when I'm thinking about integrating mental health services with communities, when you couple that with just the astonishing numbers of suicide among Black girls and women, I just want to mention is that it's Black children between the ages of 5 and 12 in 2018, they had the highest rate for the first time in the history of research on suicide ideation of completed suicides. 5 and 12. Right. This is a crisis. Everyone should be alarmed. And this is something that you don't hear it in the media. I think that there is this ongoing trauma that here's this problem that we can't touch, we can't address.

But when we understand how they're linked to, do I have enough money? Do I have a place to live? Do I have a job? And even if you're, it's not just a class level. It's if you're of any level of income, there's this, there's this disparity. And so we have to do a better job at supporting these individuals, because what we're seeing is they're making other decisions related to substance abuse, related to violence. And we also know that symptoms for certain mental health conditions look different depending— and a lot of people like the Association of Black Psychologists have written, have written about this— that it looks different, it shows up. And so then they're being criminalized in

the education system and the criminal justice system. So it becomes what is a mental health condition that could be diagnosed by a very well-trained therapist is now becoming a criminal justice issue. And so there's a missed opportunity all around because of the fragmented services.

Vikki Wachino [01:15:26] Thank you. Howard, I'm interested in your perspective on expanding access through these kind of nontraditional settings.

Howard Goldman [01:15:35] Thanks for the question, Vikki. You know, if we're going to be serious about the social determinants of health, whether it's in the evolution of health care problems, or whether it's underlying the problems of disparities and inadequate access and quality of care, we need to intervene at a variety of different levels. And they present to us as health care problems. But if they are at their origin due to problems of the social determinants of health, there are ways to intervene at the clinical level, at the health care level and at the policy and advocacy level. But they require that we be much better informed than we tend to be in our narrow sort of health care training.

Clinicians need to know about programs, some of them that we've heard about here today, like individual placement and support and evidence based supported employment program. Many, many clinicians who have patients and clients who want to work don't know anything about these programs, partly because they're paid for outside of the health care system. We have heard mentioned Housing First. You know, I used to teach general medical residents many, many years ago. And I used to train them to ask their patients how they paid their rent, where they lived, what kind of job they did, were they satisfied with it. I think we have to open up our thinking way beyond the boundaries of health care and the misfortune that we face, is that when we do that, we find programs that are available but that don't get paid for adequately. So when employment services are part of an intervention in early psychosis treatment, we can pay for most of the medically oriented services, but we can't pay for the supported employment. So this whole of government approach is essential both at the clinical level and also at the policy advocacy level. I hope we'll get better at it.

Vikki Wachino [01:17:50] Thank you. Thank you for that. I'd like to in just a moment, open this up to the audience too for questions. Before I do that, there is, it doesn't escape anyone's notice that underlying all of this work is our workforce challenges. And I think almost each of you have touched on that at various points in the conversation. Before we turn to the audience, I wanted to just give Kenna in particular a chance to talk about workforce. From your experience as a peer, from the

work you've done advancing the rights of people with, with mental health issues, where do we go on workforce?

Kenna Chic [01:18:26] Thanks for that question, Vikki. And I'll keep it short because I know a lot of people are itching to ask questions and I'm very excited to hear from you all as well. I think an important aspect of peer support is actually really interesting in the fact that it wasn't necessarily a practice that was accepted even five years ago wasn't, wasn't necessarily a practice that was very widespread. And yet now we're all having conversations about it. And I think that is vitally important.

I think one aspect that is important to note as well is that a lot of times, even though there is more acceptance towards peers and the importance of peers, there is still this both financial divide and also this professional divide, this idea that peers don't really have unique skill sets or, you know, well, they're not professionals. And so how can we trust them? And I think what the secretary had brought up was really interesting and important to note, which is that peers have a unique skill set because of their lived experience. And that experience allows them to connect with people in ways that a clinician may not be able to.

And so it is fundamentally important to ensure that peers are included in our workforce and that peers are represented in these spaces, and that peers have a working, livable wage, and that they also have career ladders in which they can advance within their careers. So it's not something that, well, you do for a couple of years, but maybe you have more responsibilities at a different age, and so you would have to find a new role. I think it's really important to recognize that peers play a larger role in this equation that we all accounted for originally, and it's time that they get the support behind them in order to do their jobs.

Vikki Wachino [01:20:13] Thank you. Now let's go to the audience. We have someone with a microphone who will, who will ask questions. Let's start right here.

Howard Goldman [01:20:25] Thanks, Vikki. My name is Karl Polzer. I'm an advocate and an analyst. Also, my family member, I have personal experience of, has serious mental illness and has been through the system, mental hospitals, hospitals, etc. So I want to put in a plug based on experience. For more information is something HHS can do more data and actually targeted studies on the very seriously mentally ill settings like hospitals and acute care hospitals, is I think we're headed back from you know, we got them all off the street, got them all out of the institutions, back on

to the streets. And now you have New York, California and even like Virginia kind of bubbling, just taking people off the streets by force and putting them back in institutions.

And from the ok, personal experience, I'm going to take about another 35 seconds. My son was one of the ten Virginia mental hospitals during COVID, couldn't visit, so he had paralysis because he was given an old medication. So I worked with two hospitals, and I worked with the legislature to get family visiting by Zoom past, and I couldn't get any information hardly from NCSL and even from the associations, they just don't, and then I went to the HHS survey of mental health settings. There's a good mish mash of information on there. But, you know, you can see that private institutions give a lot more up to date drugs than public ones, which was an issue for my son. It doesn't tell you much about forensic folks like the fact that you can't bring in Virginia, you can't bring in your own doctor to check their body out. And they're relying on whatever doctor they get there. And which wasn't bad, wasn't bad care. But we need to know a lot more about those settings, I think in advance, hit them off at the pass because I feel like we're going to fill those places up again. So thanks for listening to all that and I'm happy to talk more after.

Vikki Wachino [01:22:24] Any reactions from the panelists or shall we go to our next question. Conrad, there's a gentleman here in the second row, thank you.

Audience Member [01:22:34] Thank you. As they get up slowly, you can see I'm wearing bifocals. And I give you an analogy about my bifocals and all the lens that we see the world. How many veterans do we have in here? Veterans. Service-disabled veterans, two veterans. I'm Wali, service-disabled veterans, that's one lens I look at the world. I happen to be a Truman scholar. That's another lens that I look through in public service in the world. I'm a certified peer specialist for over a decade. My life calling is this work that this distinguished panel has shared, because for 52 years, 54 years, I've been living with trauma as a marine. I've been able to work with certified community health centers in Montana. I'm working there now, currently as a contractor certified to do work with HHS. But the system hasn't awarded me a contract yet. Black boys, my dear sister, Black girls, we coexist. Not one time did I hear that individual. And yet we know the stats they are, all of you know the number one according to the American Journal of Medicine, suicide among teenagers is Native Americans in nine tribes in Montana.

Because of the logistics, I want to get a chance to provide evidence-based services. Since 1997, there's been out here. SAMHSA recognized the work that we do, but I have to wait until April to

work with Native Americans in Montana. What I did never thought I would not hear was grassroots, state, federal, local. But that's not grassroots. I go, we work with one individual or one family, if we want to really resolve, we're talking about solutions, from my lens, the workforce shortage in health care is to make evidence-based practices in every household. That's my dream. That's what I'm living for. I have a model that shows that in the state of Montana, only one third of providers are available. One third of all the youth in Montana. That was my motivation to leave Maryland and go to Montana. So the two thirds, they don't matter. No one is listening to them. So I'm here to walk the talk by asking for your cards, because the real work for me is after we leave here. I need you. And I believe you need those of us who are working with all of those segments. Thank you so much and God bless you.

Vikki Wachino [01:26:00] Thank you for that perspective and certainly a number of fairly important populations that you that you described there. Do you have a question for the panel or—.

Audience Member [01:26:10] I just want to be polite [inaudible]

Vikki Wachino [01:26:16] I think we can arrange this right after the—.

Jameta Barlow [01:26:18] Can I can I jump in? I just want to jump in on both points. One on your point. I am a community psychologist. My whole field came about because of the deinstitutionalization process in the 1950s and sixties. So we have a major problem because we, the unhoused is an issue, but they are fragments in the system. We have to build the system much better so that we're not doing what we did before. And I think that's a major issue. And I'm so glad that you brought it up. I also, I mentioned inherently Black when I said Black youth. So just wanted to mention that because to me, the fact that we have 5- to 12-year-olds who are completing suicide, if that's not alarming to anyone and we've known about it for since 2019. To me, that is the biggest issue, because what is going on in a child's life, that that is the solution that they're making. And if that doesn't concern anyone and I maintain that investing in community groups that are doing the work, they don't get the supports. And it's been like that for the last 100 years. So we have an opportunity to create change. That's how we make behavioral policy work.

Vikki Wachino [01:27:31] Thank you. Sandra, do you want to jump in.

Sandra Wilkniss [01:27:33] Yeah. Just real quick with some specific examples that I think might touch on both issues, too, in terms of what we're seeing across some states to address the gap, to get more grassroots, to get more community based workforce in which we, we still need some good data to show us what kind of workforce we need that matches current team based, evidence based

models. And so I put that to the feds. But in in Alaska, you might be interested in the behavioral of aids approach, a behavioral aid approach, which is village-based counselors who are there to serve their own tribes. So that's a really interesting model that might interest you.

And of course, there's a lot of work happening to knit together, together peer supports and community health worker approaches that really are, of course, by definition from the communities they're from, with, with a real nod towards getting those career ladders in place. I think that's a really important focus area for, I think, over 30 states who we collect with, who we convene around community health workers. And then I would say the last thing is there are other really interesting models like in Utah has developed a certified crisis worker approach model. So there are these these little pockets of innovation that, if we could bring it all together, might actually really help fill the gap.

Vikki Wachino [01:28:42] Thank you. I think we have time for a few more questions in the, towards the back.

Audience Member [01:28:51] Thanks, everyone. My name is Sanjay Arora with Substep Technologies. I have a question around technology, so being the cause of a lot of distress for young people, but what are you seeing on the solutions side outside of telemedicine delivery or back-end data integration?

Vikki Wachino [01:29:08] Great question. Any positive developments on the tech side that aren't necessarily telehealth related? Andrea.

Andrea Palm [01:29:13] I'm sorry, say, the backend data integration.

Audience Member [01:29:19] Yeah. Besides that.

Andrea Palm [01:29:21] Yeah.

Audience Member [01:29:22] There's a lot going on.

Andrea Palm [01:29:23] Well, there we go. Thanks.

Vikki Wachino [01:29:28] Anyone else on the panel seen promising tech solutions in a way that makes tech not just the driver of some of the problems, but the solutions, if I understood the question.

Jameta Barlow [01:29:38] But beyond telehealth is what you're saying. Because that was my answer. Telehealth and the integration of systems. But I'm not a tech person, but I do want to, I do want to point to the point of evidence. Right. I think sometimes this concept that we say evidence can be a barrier to a lot of organizations because they say that their evidence doesn't count. And to your

point is that a lot of times the argument is like, what is the evidence for this technology? So then it becomes what came first, the chicken or the egg?

So I think right now, for at least what I'm seeing, a lot of the solutions are, let's create this app that connects people. Right. But there probably are more solutions that I'm not aware of. But I do think that this concept of evidence can be a barrier for community organizations. Because who's evidence? Because there's a lot of anecdotal evidence. There's qualitative evidence. But the evidence that's required at the federal, state and local levels is different.

Andrea Palm [01:30:40] I think the other thing that that we're looking at from a technology perspective that we, that we really want to drive as it relates to integration is, you know, when we did the High Tech Act early in the Obama administration, there were incentives for health care providers to adopt EHR's electronic health records and technologies to allow the flow of information among health care providers. What got completely left out of that equation was the whole behavioral health part of the health care system. And so how we think about access to care, integration of services, no wrong door requires us to think about how we really are putting people at the center of their care. And no matter sort of what that is, it's all available to the patient and to the providers who they wish to share with information about the full spectrum of their health care needs and services.

And so how we as a department think about our levers to drive adoption of technologies that help facilitate behavioral health providers. And that integration, I think, is a place where we see an opportunity for us as a department and where we have some levers and some opportunities, again, to think about how we break down silos and work to drive the use of technology in a way that benefits and puts people at the center of their care. So that would be another example that I would, that I would highlight.

Vikki Wachino [01:32:04] Great. We're just about done time. I think we could squeeze in one more question. How about right here? The young man in that greenish jacket with a hood.

Audience Member [01:32:14] Thank you. Well, my main question for the panelists is, which organizations besides your own are you excitedly watching in this space? Which organizations should we be watching that are doing particularly good work?

Jameta Barlow [01:32:26] Well, I have a list.

Andrea Palm [01:32:32] Did you know this question was coming?

Jameta Barlow [01:32:34] No, but I always love resource questions. Okay. Maybe it's the scholar in me. So Dr. Alfiee Breland-Noble, the Acoma project, that's one. The Black Emotional and Mental Health Collective, that's another, it's a collective of mental health professionals. Black Mental Health Alliance out of Baltimore, I've done work with them. Therapy for Black Girls is a podcast it's also a resource. Therapy for Black Men. Black Women's Health Imperative, Council on Black Health. Association of Black Psychologists. The American Psychological Association. Melanin and Mental Health Community Healing. The Community Healing Network, who does work on emotional emancipation circles that I'm also a part of. The National Queer and Trans Therapists of Color Network. The LGBTQ Therapists of Color, and that's all I got today.

Vikki Wachino [01:33:21] Anyone else have anything to add before we wrap up?

Howard Goldman [01:33:23] I'm breathless.

Sandra Wilkniss [01:33:24] You can't follow that.

Kenna Chic [01:33:27] I would quickly plug two things. I wanted to answer your question, but I'll answer your question first. So I will quickly plug the Unapologetically Black Unicorns podcast by Keris Myrick, who is a person with lived experience. I would also say that it's really also important to keep in line and understand behavioral health from the perspective of disability rights, and so it might also be important to really understand what disability rights organizations are doing in this space.

And then very quickly, to answer your questions there, I would say that what's really interesting about technology as a solution is that a lot of times, because we are aware of the harrowing statistics around youth struggling because of social media and creating eating disorders and other types of comparisons, we're also not looking at the other side of the coin, which is social media and technology as a way to build connection. And so I think that is a really important area of interest that we can explore further.

And the other area I think that could be interesting to explore as well is also the adaptation of new technologies in the health space of things like VR technology would be really important to explore in this space. But I also understand that with the health systems, if we don't even have EHRs, you know, how are we going to get to VR therapy. And so I think there's a lot of important work to be done in that space in terms of exploration as well.

Vikki Wachino [01:34:47] Great. So I'll end by thanking the administration for putting out these policies that really brought us here together. So obviously a lot of interest there and on the Hill.

So hopefully more good policy to come. I think the panel has shown both that there's a lot of, lot of expertise and momentum and interest, but also that that as promising as these new policies are, we have a long way to go. You know, particularly with some important communities whose needs have been unaddressed. And I really appreciated the emphasis on getting to a more holistic understanding of the circumstances of people's lives.

So, Andrea, Jameta, Howard, Kenna and Sandra, thank you so much for being with us today and sharing your thoughts. Thank you, too, to this fabulous audience. And I hope that we can all find ways to continue this conversation and the important work going forward.