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TFAH-Congressional Briefing: Pain in the Nation: How High Rates of Suicide, Alcohol, and Overdose Deaths Require a Comprehensive Resiliency Strategy

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>> HOST: Good afternoon. Welcome to pain in the nation: How high rates of suicide, alcohol, and overdose deaths require a comprehensive resiliency strategy. My name is Tim Hughes, the outreach manager at TFAH. We would like to thank our speakers and audience for being with us today. For today's webinar, audio will be accessed through your computer speakers or headphones. Realtime captioning is provided today by Karla Ray from ACS Captioning. For captions, click on the multimedia viewer icon under the circle with three dots at the bottom of your screen. Next on the right side of your screen, locate the link in the captioning panel that says "show/hide header." If the captioning window ever disappears, click the multimedia viewer icon to bring it back.

We encourage you all to share your thoughts and questions about today's presentation by typing them in the Q&A box. We'll try to answer as many questions as we can as time permits. To open the Q&A box panel, click the circle with three dots at the bottom on your screen. From there, select all panelists in the drop-down menu so that your questions will get sent to the correct location and press enter.

Now it is my pleasure to introduce the moderator of this event, John Auerbach. John is President and CEO of TFAH and he oversees their work to make disease prevention a national priority. Over the course of a 30-year career, he has held senior public health positions at the federal, state, and local levels. Welcome, John.

>> JOHN AUERBACH: Thank you, Tim. And thank you to everyone for joining us

today for this congressional briefing on Pain in the Nation: How high rates of suicide, alcohol, and overdose deaths require a comprehensive resiliency strategy. I'd like to welcome members of Congress and their staff as well as everyone else who has joined this webinar. We have registrations that came from people in every single state. I want to thank our staff At Press For America's Health who organized today's activities as well as the preparation of our recent report with the Well-being Trust. Finally, let me thank our esteemed panelists for taking time out of their busy schedules to participate in this event.

Trust For America's Health is a nonprofit nonpartisan public health research and advocacy organization, and we promote optimal health for every person and community. The purpose of today's briefing is to highlight the most recent report in our pain In the Nation series and help our audience get a better understanding of the policies and the programs that impact our nation's mental health and substance use systems. We'll hear from an expert panelist speakers who have valuable insights and information on our nation's health and wellness. And after their presentations, we'll have time for discussion and questions from you. So next slide, Tim.

I'm going to begin by briefly sharing some of the most salient backs from our most recent Pain in the Nation report series that was funded by the Well-being Trust. The series has tracked the nation's deaths of despair since 2017. And the latest report includes newly released data showing that an astounding 156,000 Americans died due to alcohol, drugs, and suicide in 2019, which is the latest year for which we have complete data. This number was 52% higher than in 2009, just ten years earlier, and it represented the most deaths from these causes that were ever recorded in a single year. Here's some of the highlights.

Drug-induced deaths were up 5%. Alcohol-related deaths were up 4%. And suicide deaths were down slightly but still much higher than they had been in all other past years. We also note a demographic change this year. For many years the death rate for drug overdoses among lives was substantially higher than any other racial group. In 2019, that wasn't the case. For the first time since 2005, the 2009 death rates due to drugs was higher for Blacks than for whites. Furthermore, in 2019, drug-induced deaths among Latinos, American Indians, and Asian-American populations grew at a faster pace than among whites. Next slide.

There is real fear that these trends, these trends going upward almost every single year for the last 20 years, are likely to continue. And in addition to that, the COVID-19 pandemic has impacted Americans in almost inconceivable ways. The loss of life and serious illnesses, the impact on the economy, and the incomes of many American residents. And social isolation. They have resulted in increased stress and anxiety. And this was further exacerbated by the trauma that's associated with racism, social injustice, and related violence.

Data shows that Americans struggled to cope with these conditions and experiences in 2020. We don't have final data from 2020, but we have some preliminary data to share. In that year, so far, the data indicates that more Americans were in crisis. In 2020 there was a 900% increase -- 900% increase -- in calls to the mental health crisis hotline. As well as increases in emergency room visits for mental health conditions. The U.S. household Pulse survey found that one in three adults reported symptoms of anxiety disorder or depression, three times the 2019 rate, and

higher still among certain populations.

Surveys also showed increases in both drug and alcohol use. Preliminary CDC data showed a 27% increase for the period of time from October 2019 to September 2020 in drug overdoses. 27% increase in just one year. That increase is pretty staggering and a much larger annual increase than typical, for example, between 2018 and 2019, we saw a 5% increase in drug deaths. Next slide.

When we look into the data in 2019, we saw decreases in certain drug classes responsible for overdoses, including natural and semi-synthetic opioids such as prescription opioids like Oxycodone. This was likely an indication that the efforts to reduce inappropriate prescribing of opioids by doctors was working. But unfortunately we also saw large increases in deaths from overdoses into to what are known as synthetic opioids such as fentanyl, as well as from cocaine and from psychostimulants such as methamphetamines.

As previously mentioned, there was a large divergence in the increase in drug deaths by race and ethnicity, and while deaths among whites increased and remained at a very high level, all other races and ethnicities saw more rapid increases during 2019. Next slide.

Most Americans need support coping with the stresses created by the pandemic and racial injustice. In addition, some of them including those already struggling with addiction or an acute or chronic mental health issue, may need urgent attention. We know what policies and programs can work to prevent deaths of despair, and we now have to invest in those programs. Our report includes recommendations that fall into three priority areas: Investing in prevention by promoting resilience in children, families, and communities, and limiting access to lethal means of suicide. Secondly, addressing the worsening drug use and overdose crisis by continuing pandemic-related flexibilities for substance use treatment and implementing policies focusing on increasing psychostimulant use. And third, transforming the mental health and substance use prevention and treatment systems through improved data accuracy and increased community capacity.

Well, with these stark trends and disturbing data as well as hopefully timely and helpful recommendations in mind, I will introduce now our esteemed panel. Next slide, please. I am pleased to be joined by Dr. Deb Houry. Dr. Houry is the director of the National Center for Injury Prevention and Control at the Centers For Disease Control and Prevention where she leads innovative research and science-based programs to prevent injuries and violence and to reduce their consequences. Dr. Houry previously served as an associate professor at Emory University and an emergency room physician at Grady Memorial Hospital.

Next we'll hear from Dr. John A. Rich. Dr. Rich is a professor and former Chair of the Department of Health Management and Policy at Drexel University. He's the Co-director of the Drexel Center For Nonviolence and Justice and his work focuses on issues of urban violence, trauma, and health disparities, particularly as they affect the physical and mental health of men of color.

Next we will hear from Isha Weerasinghe. She is senior policy analyst at the Center For Law and Social Policy. She focuses on mental health and behavioral health impacts on communities living with low incomes, particularly for People of Color. She led the technical assistance work in mental health for youth and young adults and

mothers over the last few years.

And finally, we'll hear from Dr. Benjamin F. Miller. Dr. Miller is the Chief Strategy Officer for Well-being Trust, a national foundation committed to advancing the mental, social, and spiritual health of the nation. A clinical psychologist by training, Dr. Miller oversees the Foundation's portfolio, ensuring alignment across grantees, overall strategy and direction, and connection of the work to advance policy. And as I mentioned earlier, Well-being Trust supports our Pain In the Nation reports and this webinar.

Finally, we'll save questions for the end. We want to hear from you. So submit your questions in the question and answer panel, as Tim mentioned. Don't put it in the chat panel but in the question and answer panel, and we'll get to those questions at the end. So with that, let me welcome Dr. Houry.

>> DR. DEBRA HOURY: Well, good afternoon, y'all, and thank you all for the opportunity to discuss this very important and timely topic. While COVID-19 continues to dominate our national focus, we cannot lose sight of so many lives continuing to be impacted by the overdose epidemic and all the other issues that John just highlighted. And we know that many Americans are facing challenges such as financial hardship and job loss that can raise the worsening mental health conditions, suicide, violence, excessive alcohol abuse, and adverse childhood experiences. COVID-19 has also exposed long-standing inequities that have systematically undermined the physical, social, economic, and emotional health of racial and ethnic minority populations that are really bearing the disproportionate burden of COVID-19. This health crisis has really increased the need for us to come together, to help our families, our communities, and our country be even more resilient.

So I want to start this conversation by first recognizing the strong link between substance misuse, suicide, and adverse childhood experiences, or ACEs. Overdose suicide and ACEs are urgent and related public health challenges that have consequences for all of us and can lead to a cycle of risk across generations. And as the pandemic has shown us, not every population is affected equally. These ACEs are potentially traumatic events that occur in childhood such as experiencing violence, abuse or neglect or witnessing violence or substance abuse issues in the home or community. And the research shows that the challenges we are discussing today are related because these adverse childhood experiences increase the risk of overdose, suicide, and mental illness later in life. Unfortunately we know that elevated stress during the pandemic has raised this risk of suicide and substance abuse really continuing the cycle. At CDC we released a report in February that examined realtime emergency department data from December 2018 through October 2020 and this revealed higher visit rates for mental health conditions, suicide attempts, drug and opioid overdoses, violence and child abuse during the COVID-19 pandemic compared to the same period in 2019. But -- and I'm looking forward to hearing from the panelists -- these crises are preventable if we take a comprehensive public health approach and by building on community strengths and focusing not just on treatment but also on prevention, we can meet the immediate needs of those already affected today while preventing future risks and negative health outcomes tomorrow.

So now I'd like to take some time to focus on each of these problems individually and to share with you what CDC is doing. While overdose deaths were already

increasing in the months before COVID, the data, as John highlighted, do show an acceleration of overdose deaths during the pandemic and we reported increases primarily driven by synthetic opioids which is used primarily illicit manufactured fentanyl. The pandemic has added new challenges to the drug epidemic, particularly when you look at things like feelings of isolation while social distancing and heightened stress, how these can increase substance use. And social distancing can also increase the likelihood of using drugs alone.

Also heard of the change in illicit drug marketplace and the wider availability of illicitly manufactured fentanyl is increasing overdoses. We also know that the drug supply chain may also be disrupted, leading to withdrawal or contaminated drug products. Next slide.

As our most recent CDC data have shown, there were 87,000 drug overdose deaths in the most recent 12-month period. This is the largest number of drug overdoses for a 12-month period ever reported. So CDC's priority through the pandemic has been to continue and adapt our systematic response to the drug overdose epidemic through our program called Overdose to Action or OD2A. This is a cooperative agreement with 66 jurisdictions that focus on the complex and changing nature of the drug overdose epidemic through an interdisciplinary and comprehensive public health approach. These funds are supporting health departments in obtaining high-quality, comprehensive, and timelier data on morbidity and mortality and to use these data to inform prevention and response efforts. In light of the COVID-19 pandemic, we've worked to really combine more flexibilities to the grantees, and an example of this is in Delaware, the Department of Health adapted their in-person naloxone distribution activities to a drive-through model. And they also hosted small-scale distribution events in local hotels to reach homeless and transient populations. Our goal is to be nimble enough to address the drug overdose epidemic as it evolves over time.

I also want to just highlight the prevention of excessive alcohol use as excessive alcohol use is associated with more than 95,000 deaths each year. And we know that increased stress during the COVID pandemic can lead to increases in alcohol use, and drinking alcohol, in turn, may increase anxiety, depression, or other mental health concerns, and it can increase the risk for violence, injuries, and motor vehicle crashes as well as other chronic diseases. We need a comprehensive approach to prevent binge drinking, substance misuses, and overdoses to have these population-level strategies. Next slide.

So between 1999 and 2019, the U.S. saw that rates of suicide increased 33%. 2019 we began to see the first declines in rates in more than a decade, but we still lost more than 47,000 lives. The first six months of the pandemic in 2020 have not shown an increase in any age category for suicide deaths including in youth. And while overall this is encouraging, rate decreases over a single year do not indicate a trend and really need to be interpreted with caution. Next slide.

Last summer CDC found that 40% of U.S. adults reported considerably elevated adverse mental health conditions compared to 2019. And this includes 13% reported having started or increased substance use to cope and 11% reported having seriously considered suiciding in the preceding 30 days.

Preventing suicide and other adversities is particularly important now as we know

that risks for suicide may increase across the nation during stressful times like the current pandemic. We previously found that there are many factors that contribute to suicide, and more than half the people who died by suicide did not have a known mental health problem, and their deaths were often precipitated by economic losses, relationship issues, substance use, and housing stress. So this is not just a mental health problem. There's a significant role for public health and prevention. And just as there's no one cause of suicide, there is not a single solution to prevent suicide and why we need that comprehensive public health approach.

As the nation's public health agency, CDC's uniquely poised to prevent suicide among all populations including those most at risk. We focused on primary prevention or preventing suicide risk and the reduction of risk at the individual, family, and community level and our approach uses data to drive action. With a new dedicated funding line for suicide in fiscal year '20, we are now funding nine sites to implement and evaluate our comprehensive public health approach to suicide prevention with attention to populations at risk such as veterans, LGBTQ, tribal, and people experiencing homelessness.

For example, the Colorado Department of Health is developing and promoting youth and community peer support programs for those identified at risk. And Pittsburgh is training primary care providers to conduct brief interventions with follow-up care to patients. We had over 85 communities apply, really showing a great need for this type of work, and we greatly appreciate your continued support for this important work as there is great need and capacity for this. Next slide.

We know that heightened stress, school closures, and loss of income and social isolation during COVID may have increased the risk for children and youth to experience ACEs. Next slide. In 2019, CDC released our first-ever vital signs on adverse childhood experiences. This showed that nearly three-fifths of adults reported experiencing at least one ACE and approximately one in six reported experiencing four or more adverse childhood experiences. Adults who reported the highest level of ACE exposure had increased odds of chronic health conditions, substance use disorders, heavy drinking, suicide, depression, compared to individuals with no ACE. Next slide.

For example, men with six or more ACEs were found to be 46 more times nor like lie to inject drugs. We are meshing four recipients to track ACEs in their state. And through this funding participants will better understand the burden of ACEs in their communities and engage in strategies that can prevent ACEs from occurring. Michigan is developing a toolkit of ACE prevention strategies and educating home visiting staff on a two-generational approach to ACE prevention. And we're also supporting nine sites to implement the Building Community Resilience Model which engages communities in a data-driven process to identify and address the social and structural determinants of health that contribute to ACEs and also suicide and overdose. This is a systems level change that really allows for cross-cutting prevention in communities across the country.

Before we close, I would like to reiterate that these issues we have discussed today are urgent and related and have consequences for all of us. But these challenges are preventable if we adopt a coordinated and comprehensive approach that focuses on addressing today's crises while preventing tomorrow's. And all of our efforts, whether it be focused on suicide, overdose, ACEs, alcohol or other types of violence, we must recognize how these threats interrelate. With CDC's help, states and communities can

implement comprehensive evidence-based strategies, and we are committed to identifying the best evidence and partnering with other federal, state, and local agencies as well as external organizations to address these complex issues. Thank you again for the opportunity to join you today.

>> JOHN AUERBACH: Well, thank you very much, Dr. Houry. It's clear that CDC is doing a lot on this issue and the last few years under your leadership. Many new efforts have been undertaken to address these issues. So, you know, thank you very much for your leadership and for this really impressive work.

Now it's my pleasure to introduce Dr. John Rich. As mentioned earlier, he's the co-director of the center for gnaw violence and social justice and a Professor at Drexel University. Dr. Rich.

>> JOHN A. RICH: Thank you so much. I'd like to build on what Dr. Houry has said and speak to the complex intersection of substance abuse, behavioral health problems, violence, and trauma, all of which, as you've heard, have worsened during this time of pandemic. I'd also like to speak to a range of solutions along with my panelists, fellow panelists, and to think about how we address these interrelated public health challenges through a public health approach. Now, Dr. Houry has already spoken compellingly about the damaging impact of adverse childhood experiences on health. So I won't reiterate that. But I would add that there were a number of adversities -- are a number of adversities that are not routinely measured in the ACEs study such as discrimination, exposure to community violence, violence at the hands of the police, which disproportionately affect Black and Brown communities. And so on the next slide, you'll see in my city, home city of Philadelphia, the number of fatal shootings in Philadelphia so far this year -- and I cite this because of the 108 homicides that are mapped here, we've seen an increase -- a dramatic increase in the number of shootings and homicides. And these represent a source of trauma to people in communities, often people who are also living in poverty.

The next slide shows the total number of both fatal shootings and nonfatal shootings. Again, adding to the universal exposure virtually to trauma when violence is concentrated in these ways. And we're now seeing an increase, even a larger increase, in violence and shootings in Philadelphia. It is also true that when we look at police homicides, between the years 2013 and 2020, we see that these were concentrated largely in communities that had large populations of Black or Latinx people. And similarly, police shootings on the next slide. You will see also concentrated in communities of Color, thus adding to the trauma where people feel as though the police do not protect them and at times victimize them.

And so together, we would include these experiences under the category of racial trauma. And as the American Psychological Association talks about this on the next slide, racial trauma can result from major experiences of racism such as workplace discrimination, hate crimes, or these brutal acts of violence against Black people at the hands of law enforcement. But it can also be the accumulation of many small occurrences such as everyday discrimination and microaggressions.

And now so let me just for a moment walk you through an example of how these key issues can intersect and involve substance abuse, violence and trauma. We know from our research and that of others that if a young person has been a victim of violence, they will suffer physical wounds, but they will also often suffer the wounds of

posttraumatic stress. And so there's both a physical and psychological wound.

These young people may not, when they're in the health care setting, have this recognized if there's not strong integration of public, of physical and behavioral health and an appreciation of public health, and so these young people may not know what's going on in them, and they may not have access to primary care. Young person often turn to what is in their environment to treat their distress. Frequently that is turning to cannabis. And so when young people are self-treating their trauma with cannabis, it has other consequences such as if these young people seek even entry-level employment, often they are disqualified because they have the metabolites of cannabis in their urine. So we see how trauma and substance abuse and economic opportunity are intertwined.

In addition, we know from the events over the past decades that People of Color often hold mistrust for the police. And young people in particular who have found themselves victimized. And so many of these young people, when we talk with them, tell us that they turn to weapons in order to protect themselves because they believe that the law enforcement will not protect them. And that you'll see on the next slide, the proliferation of these firearms, which has increased in the time of COVID contributes to the downstream consequences of potentially incarceration or death, and we can also say contributes to the possibility, the likelihood that these firearms could be used in self-harm.

And so these complex issues require a broad and public health approach. And so some of the solutions you'll see before you I'd like to talk a little bit about. But we have to continue to think about integration of physical and behavioral health through a trauma-informed and culturally responsive behavioral health lens.

On the next slide, you'll see this as a high priority because what we are looking for is more than the co-location of these services, but true integration. And we know, for example, that emergency departments are critical points of entry for those who don't have primary care. And so we have to make sure that we expand access to Medicaid for those who qualify and to ensure that we have culturally responsive primary care services delivered by experts with the lived experience of trauma.

On the next slide you'll see an example of this. Hospital-based violence intervention programs seek to intervene at the moment of trauma among young people who have been victims. And this catches people at a critical moment where they may be turning to thinking about either retaliation or substance abuse. And across the country, there is growing support to invest in these programs so that there's a continuity from the acute care setting into the community.

These programs and in the example of healing and hurt people are also staffed by young people with a lived experience of trauma who have undergone training to become community health workers. And there's power in cross-training that allows these community health workers to be able to address the wounds of trauma while also addressing individuals who have opioid addiction. So we can add capacity to often busy providers to shore up the infrastructure of intervention. These programs have been documented, particularly healing hurt people, to decrease depression and improve sleep, which also is critical to preventing despair.

On the next slide you'll see how we can build the capacity of community health workers. We have, in Philadelphia, a community health worker peer training academy where young people, many of whom have been impacted by violence, have themselves

been impacted by substance use, are able to take that lived experience and develop it into a mission-driven passion and work. These young people engage in weeks of training, come away with certifications, that allow them to work within institutions that receive Medicaid reimbursement so that we have a sustainable stream. Supporting and investing in young people who have the lived experience of trauma is a way to create opportunity while also tapping into this often-untapped resource.

Research on these young people demonstrates that through the course of this education, they come away with improved well-being and a sense of possibility for the future. Critical to these endeavors is understanding and identifying and acknowledging racial trauma. On the next slide you'll see Dr. -- work by Dr. Kenneth Hardy who is an expert in trauma who has written about healing the hidden wounds of racial trauma. I would simply say that his work focuses on acknowledgment. And once we acknowledge racial trauma, when we're interacting with people at the community level or at the individual level, we create space for improving trust. By training providers, not only providers of color, but providers across the spectrum in racial trauma, we can begin also to think about how to close the gap in health disparities.

Part of this requires that we use a health equity lens. And that health equity lens, as you'll see on the next slide, is one that incorporates racism as one of the social determinants of health. So as we think about access to food or we think about environmental exposure, we also ask how it is that racism and other isms are contributing to the disparate health outcomes that we're seeing with regard to substance abuse treatment, depression, and other behavioral health challenges as well as trauma.

And then finally, I would point up the need to address stigma. The stigma of trauma, the stigma of the distress of substance use, and the stigma that goes with being a victim of violence. Social media can be a powerful approach. And we have pioneered in Philadelphia and has been replicated elsewhere, social media approaches including the one you'll see on the next slide, "Our Words Heal." Our Words Heal taps into people in communities to ask them how is it that you have been healing in a culturally responsive way as a community over the past centuries? Because we know that there are strengths in communities. So a strength-based approach to creating a larger dialogue and conversation with community can also help us to identify and connect young people, people who are suffering from behavioral health problems to resources. And finally, the next slide shows a website. Part of this social media campaign that affirms that communities heal not only from physical trauma and emotional trauma but racial trauma. And we need to continue to augment the range of resources and invest in resources and community that help create healing. I look forward to contributing to this conversation and building on the work of Pain In the Nation as we lay out a roadmap for healing for all communities.

>> JOHN AUERBACH: Thank you, Dr. Rich, for this presentation and for your groundbreaking work. Those of you who are interested in learning more about Dr. Rich and the work that he's involved in, there's an extended interview with Dr. Rich in the new Pain In the Nation report, and we'll remind you later where you're able to access that report.

I'm now pleased to turn to Isha Weerasinghe. She is the Senior Policy Analyst at the Center For Law and Social Policy. Welcome.

>> Dr. Weerasinghe: Thanks, John, and thanks to the TFAH team for inviting me

here today. So just for some context, I am a senior policy analyst on the youth team, and on the youth team we focus on young people ages 16 to 25. And I lead the mental health work across the organization. So I'm going to build in my presentation upon and echo Dr. Houry's presentation on the impacts of the pandemic on mental health and as well as Dr. Rich's presentation on the impacts of racism and discrimination on Black and Brown people's well-being.

I'm going to be talking about two initiatives today that we embarked in this year focusing on reframing and reimagining policies and systems because of our need to act now. Next slide, please.

So a little background about CLASP. We're a national, nonpartisan, anti-poverty nonprofit. We focus on policy solutions for people living in low-income households. We've been around 50 years and we focus on local, state, and federal policy solutions. And a lot of our focus is on Communities of Color and the barriers that they experience. Next slide, please.

So over the past few years, we've been building our work in mental and behavioral health, and I have pictures of a couple of our reports that we've released that are really informing and built our foundation of our work informed by youth voice and voices of lived experience. A lot of these reports have been through -- we've gathered data from focus groups, in key informant interviews, and gotten a lot of guidance from our mental health advisory board, which is advisory board of 18 members with various experience but particularly in young adult mental health and maternal mental health and who have a great deal of racial equity experience. And we realized we needed to capture how we frame mental and behavioral health for partners and policymakers, so we decided to release these core principles to reframe mental and behavioral health policy. And that was really because of the exacerbated mental health rates through the pandemic and even the high rates pre-pandemic, but also really focusing on the country's racial reckoning, as Dr. Rich was talking about as well. We know that now is the time to act. Next slide, please.

So here is a schematic of our six principles that we have decided to -- that we have decided to focus on. And I'm going to give you an overview of the six principles, but I really encourage you to look at the entire document that really goes into more detail. So the first principle is redefining mental health. As Dr. Rich was also saying, that we really need to focus on wellness and prevention. This won't be a surprise to many of you who are listening, that mental and behavioral health needs to be asset-based, not deficit-based and not diagnosis-based. And it really needs to be community-informed. Drawing from what works in communities, what communities have felt needed to work and what they've made work for them, and that often means not looking at evidence-based practices because of the research and implications behind that.

The second principle is to expand access to care. When we're talking about access to care, of course, at CLASP, of course we're talking about parity enforcement to equitably cover physical and mental and behavioral health. And then also looking at mental and behavioral health holistically. So as Dr. Rich was also mentioning, thinking about the integration of care through thinking about the mind and body connection and also thinking about co-located models, and thinking about payment structures that help to allow that to happen.

We believe that mental health is at the core of a person's livelihood and that interventions and supports need to be supported in places beyond the traditional physical health visit. So that means looking at community centers, job centers, places of worship, places where mental health supports are already happening, but funding for these supports is often lacking because they don't directly relate to health.

The third principle is focusing on mental and behavioral health as culturally responsive. So we know that mental health has been criminalized for centuries, and we know that there's reinforced stigma in certain communities due to cultural norms, racism, discrimination, due to other barriers that communities are facing. And that plus discrimination and racism in the health system has resulted in discomfort and distrust for many Communities of Color to seek mental health services. So services and solutions need to draw from the solutions that communities have created, and listening to what people need to make sure services are culturally responsive and linguistically concordant.

The fourth principle is to focus on social needs. So when we talk at CLASP, talk about social needs, of course we're talking about the social determinants of health. But also Dr. Rich had been saying we also think about a broader definition to include racism and discrimination and the other isms, and also thinking about job quality, not only job security, but also job quality. And in order for us to move forward, we have to address these root causes along with the other social determinants of health like community safety, food insecurity, housing, and we must focus on the cultural and intergenerational trauma that has existed in communities and the cultural trauma that we have all experienced in the pandemic. And if we do not look at those factors, people with low incomes and particularly People of Color will continue to experience negative mental health outcomes.

The fifth principle is focusing on quality care and quality infrastructure in all areas. Again, defined by communities, not by policymakers, and making sure there's comprehensive data. Culturally responsive mental health care really needs an infrastructure that is able to be open to show gaps in services for communities and is innovative to reduce and close those gaps and includes a comprehensive data system that meets communities where they are, that looks at community-driven data collection processes, and focuses on things like provider training to help meet the needs.

And then finally, the sixth principle is meeting the mental and behavioral health needs of communities with an enhanced workforce. So when we're talking about a diverse and robust workforce, we're talking about increasing and diversifying the range of current and future mental health providers by looking at diversity not only by race and ethnicity but other identities like gender identity, sexual orientation, disability, languages spoken, meaning, making sure that people reflect the communities that are served.

And then expanding the definition of who is qualified by looking at scope of practice laws within states to be broader to match community needs, so including community health workers, including peer support specialists, including doulas in the broader spectrum of who can meet the needs and making sure they are reimbursed for those services. Next slide, please.

So I'm going to switch gears and talk about some of our latest work in -- with young people and an initiative that we are launching. And so this started by focusing on a data portrait for young adults in three areas, healing and well-being, economic justice,

and safe communities. And like some of the other speakers, this data was drawn from Pulse survey data. And this will be of no surprise, but during the pandemic, nearly two out of three young people expressed that they were feeling down, depressed, and hopeless. We saw high rates in Asian-Americans, particularly. And even before the pandemic, there were growing numbers of young people living in poverty who needed mental health services, but they weren't able to receive them. Next slide, please.

And similar to what was found in the Pain in the Nation report, there have been, even before the pandemic and then exacerbated through the pandemic, young women's rates of nonfatal self-harm increased more than 7%. And deaths in suicide increased for Black and Hispanic young men as well. Next slide, please.

So on top of that, uninsured rates for young adults have increased -- had increased, and in 2020, they were 22.8% for young people. So next slide, please. What we really realized was that we're, as I said earlier, are experiencing a cultural trauma that happens once in a century, and if we don't intervene now, we're going to feel these impacts for a long time. And the pandemic has made clear which populations policymakers are paying attention to and who they aren't. And young people are often left out of the equation. So we partnered together with a number of young people to create a New Deal For Youth, which is a call for leaders in public and private sectors to support youth-led policy solutions to address the economic and social injustices that face young people today.

And so we are partnering with 38 young adult changemakers -- they call themselves changemakers -- and next slide, please. And they've defined a number of areas, issue areas, to work on. They defined these areas. We did not. But we help to support them in these areas. Healing and well-being is one of those areas. But we are also -- they were also really interested in focusing on other barriers including economic justice and opportunity, justice and safe communities, environmental justice, democracy and civic engagement, and immigration justice. And, of course, there is synergy in these different areas of focus, and we are working together to figure that out. And next slide, please.

I can't give you details about their demands because we are having a public launch where they are going to talk about their vision and their demands next Wednesday, May 26th, from 4:00 to 6:00 P.M. Eastern, and we really invite you to join us to hear their demands and what they want out of the new deal. And next slide, please. I also wanted to share some videos that two of our fellow changemakers had produced, but because of buffering issues, I wasn't able to. So I encourage you to look at the links that are in the chat. So with that, I'll pass it back to John. Thank you so much.

>> JOHN AUERBACH: Thank you so much. Such fascinating and important work and ways of tapping young people to come up with solutions. Really impressive and I think inspiring to a number of our listeners. Now it is my pleasure to turn things over to Dr. Ben Miller. As I mentioned earlier, Dr. Miller is the Chief Strategy Officer for Well Being Trust. Dr. Miller, we're eager to hear your presentation.

>> DR. BENJAMIN MILLER: Thank you so much. You know, I've spent the last 24 hours talking to people all over the country about this report. What it means, what they can do about it. I'm a clinician by training. I know how to compartmentalize. But when you consider the impact of even one lost life on you, your family, your community, it gets

real fast. You start to feel that true impact, the true loss of life. You see beyond the numbers. You see the names. You see the faces. So when the recordings were off, I heard stories. I saw vulnerability. I felt fear. People want hope. They want answers. We lost too many in 2019. Too many last year. Too many this year. And likely too many next year. I tire of saying the most ever seen. Our trends are disturbing, and it is on us to do something about it.

This is not a moment for timidity but of courage. To stand up for a new way of thinking about mental health and addiction, to stop chasing money for the moment, and to develop an actual strategy for our structures. Mental health is all our responsibility, and it's hard to see how more money into the current system and structures does anything to change these outcomes. I don't think we should pretend that it does. It's our moment to pursue something radical, something that understands the solution to our problems are not more of the same. So today I want to outline some of those solutions. Next slide, please.

Survey after survey showed the impact of COVID on our mental health. My colleagues have spoken about this eloquently today. While the trust together with Kaiser family foundation has shown data like how 7 in 10 young people say the COVID-19 pandemic has negatively impacted their mental health, 70% surveyed. Or how in July of 2020 about half of adults in the country reported the worry of the pandemic-related stress had negatively impacted their mental health. And even with shots in arms, 47% of adults continue to report negative mental health impact. And to add insult to injury, about a third of this group reported unmet needs for mental health care.

I highlight these data again to show that mental health is literally something that everyone is having to come face to face with during COVID. While not all the same, at the same level, and not all will turn into illnesses or feelings of illness. It's a true moment to begin to talk about today's topic. A moment that may not come again for a while. A moment that allows us to come together and to look for change, a change that could be more readily addressed when we look at people's needs and whatever they might be. Next slide, please.

As my co-panelists pointed out, our problems were daunting before COVID-19. And COVID has gone through gas and already burning fire. When we see numbers that continue to rise, it doesn't scream let's keep doing what we were doing before and hope something is going to get better. No. The status quo wasn't working. 156,244 lives. 162,000 is one too many. We see the need to address America's mental health crisis as the public health crisis that it really is, truly is, a crisis that's consistently killed one-fifth of COVID-19 and more importantly, we need to immediately respond by investing in prevention and conditions that promote health, promote well-being. Addressing the worsening drug use and overdose crisis and transforming the mental health and substance use prevention system should be a top priority. We need to make mental health all our responsibility, not just the responsibility of a select few. Next slide, please.

So what can we learn from this moment of reflection? A few things that I think should be front and center in our policy deliberations on what we do next. First, people like it when care comes to them. Before 2020, 1% or fewer of all mental health visits were conducted virtually. However, in May through June of last year, as much as 75% of mental health visits among the commercially insured population were done by

telemedicine. And up to about half for Medicare beneficiaries in April through July. We already knew the trends about other locations like primary care in prisons and we were seeing the importance of bringing care to where people are. Referrals oftentimes perpetuate fragmentation and in some cases even stigma. Let's embrace that no wrong idea that we've been talking about for decades. Second, while some people were able to still take advantage of services like telehealth and in-person visits, many went without. I kill will never forget the pictures I saw of the kids outside fast food restaurants looking for that elusive Wi-Fi signal to go to school while their caregiver was at work on the inside. And then there's those moments where we needed to turn to each other because we had no one else. Where we looked to each other for help and the need to have those in our lives who could help us was made more with challenging with social distancing as important as they were. That being said, time after time we saw from the data, and you all likely heard from your friends, as I, stress was up, symptoms of depression, anxiety, threefold increase, and alcohol consumption up. We were not coping well without having one of the most powerful tools to help us cope, each other.

And finally, how can we not say something about the intergenerational impact? The 40,000-plus kids who lost a parent from COVID, from the increase in suicidal ideation from the stress and uncertainty about when they could go back to school, when it would be okay to hug Grammy and Grandpa again. Or as Dr. Houry said, data from the CDC around the visits in the emergency department, how they are constantly up. We need to think about bringing care to people, being there for one another and focusing on the next generation. Next slide, please.

So people often say they can't wait to get back to normal again. That way it was before COVID, I have to say, wasn't working for most people in the United States, especially for mental health and addiction. I can show you data point after data point, and many of you probably know this yourselves. Most people who have needs don't get help. There remains a gap between the needs we have and the care we receive. Half of folks with mental health needs don't get help and one in nine with those with substance use disorder problem, it wasn't working. So if you hear nothing else for the next few minutes in my brief remarks, hear this: Our current siloing of mental health and addiction at every level has not worked in service to advancing our nation's health. And in fact, some cases it's worked against it. Next slide, please.

Studies show the cost and lack of health insurance are barriers for people seeking mental health care, even if they have health insurance. As we know, it's not always guaranteed that their mental health and/or addiction needs will be covered. In the often cited study that found that people seeking mental health care are often forced to turn to out of network providers six times more often for mental health and for other types of health care. We must continue to look at ways to enforcement of health parity that's been on the books over 11 years now. There's also that access issue. I get calls and emails literally today from someone looking to find help for their loved one. While I'm always happy to help, it shouldn't rely on who we know to get our loved ones help. What would you do if yourself or loved one needed mental health care? For many the answer is still visiting the emergency department. And with tremendous respect to our emergency departments, that's not necessarily the best place to go when you're in an acute mental health crisis. But it's the only place people could think to go when the wait times can go from over a week to 25 days to much longer. Next slide, please.

In 1967, there was a report that came out called the Fulsome Report. It's probably very familiar to some of you. And it was developed by the Private National Commission on community service services and sponsored by the national health council. It had a series of recommendations that still matter today. The report highlighted how action on health cannot and should not be an effort imposed solely from the outside and foreign to the people. Rather it must be a response of the community to the problems that the people in that community perceive, carried out in a way that is acceptable to them and properly supported by an adequate infrastructure. The Fulsome report recognized the complex administrative structures often hinder our communities' attempts to solve problems by creating barriers to communication and compromise. If the community cannot lead in its own solutions, progress may not be as robust as we want. Which brings us to today again.

Another report highlighting the problems our nation faces. But yet another opportunity in the face of crisis. A national strategy is needed. A national mental health rescue plan, have you, a comprehensive push for something bigger that addresses upstream and downstream simultaneously and all of this led by with and for community. Next slide, please.

So what should be in that plan? Three things which I'll go over briefly. You can see all the recommendations which we have in the report online. Or if you're looking for the specific policies, you can find those online as well. But there are three things I want to discuss. First of all the importance of prioritizing prevention. Second, reexamining all our structures that we built. And third, tackling head on health disparities through novel, tailored strategies that meet people where they are. Next slide, please.

So how do we begin to prioritize prevention? Which was said brilliantly by my colleague youth. I can talk for hours like many of you about the myriad of ways with he can do more for prevention, but I want to talk about where our youth are for a second, the places they often spend more time than they do us, their parents, and their schools. Schools may be some of the most fertile ground to start to help address these crises before they become problematic. As many of you know mental health services and schools go hand in hand. One analysis found 13% of adolescents received some sort of mental health services from a school setting in the past 12 months, which is roughly over 3 million adolescents. Another analysis found that among all adolescents who used any mental health services in the year, 57% received some school-based mental health service. So let's go deeper here around prevention.

While we work to reduce traumatic experiences that have long-term impacts on our kids' mental health, let's also expand those critically important programs in schools that focus on substance use prevention, mental health, and resiliency. We need a comprehensive school mental health strategy that prioritizes early identification treatment, training partnerships and so much more. We need to be very thoughtful about how to better move into the space and push for programs that have a long-term impact. But we also need to see the limitations of these services alone and know that without equipping our youth with skills that they can use to help each other, even on-site programs will only get us so far. According to youth, they were more likely to listen and to benefit from their peers, helping them with their mental health than they are their parents. So we must aggressively move to let youth lead and to have their shared experience and in some cases shared trauma be seen as an asset that we can build off

of to help each other. Not pathologizing, not judging. Their voice becomes a foundation for our prevention efforts. Next slide.

We also have to reassess and reevaluate our assumptions about mental health. We know that some of the most important drivers of our mental health are some part social, some part economic, and some part health. And we also know that most of our response to mental health needs are to send people to a clinic, to refer them on. And while we work to bring together public health, primary care, and mental health, let's also begin to consider how to empower communities to do something about these crises. As I've already mentioned most people don't get the care they need. So what happens if we begin to equip our communities with skills to tackle mental health and addiction? If they became the first response to a crisis but did so in a way that can change that person's trajectory. It seems too simple to say but we really need to learn how to be there for each other beyond just saying that we are. So that mental health is not just left to clinicians to manage. All of us should be better prepared to help friends, family, neighbors, and any others that we see struggling. Simply saying go there for that or call 911 or July of next year, 988, it's not likely to change these horrific trends we're seeing. We need to invest in widespread health training for individuals in communities, implement pathways for referrals to additional mental health services when needed. This is disruptive and it's a hard change at its core, but other countries have pursued these models, and they are shown to be highly effective.

We cannot even begin to have a conversation about our crisis response in our initiatives like this if we're not conscious of the full continuum of care that oftentimes begins with you and I doing something different. Next slide, please. And finally, we have to address our profound disparities. I get many questions -- I got many questions this week about what surprised me about the Pain in the Nation report. A lot of things did. John highlighted some of those. But the profound increase in drug overdose deaths in our communities of color stands out. When we saw a 2% increase for whites but a 15% increase for Blacks, that tells me our efforts are not working in the ways that we necessarily intended. That one size does not fit all. And when we see the profound increases in deaths, synthetic opioids and meth and cocaine, it also tells me that we have approached our nation's addiction problem as if it was only about opioids. We can learn through that and we can course correct.

The framework that you see here is one of the well-being trust alongside many others have been use to address mental health. Let's start with the community and address the disparities, the structures, and let's look to ways to provide more affordable coverage and bring care to where people are. From barber shops like our friends at The Confess Project all the way up to the schools and to our clinics. Next slide, please.

So in closing, without seamlessly integrating health across communities and our health systems, we are failing people, families and their communities. We must pursue policies that reinforce this approach to care. It's time for mental health and addiction to be on the agenda of every administrator, every elected official, every stakeholder. The rallying cry for the next generation will be integration. It will be about ways that we can move from one thing to intervene with our friends and family to actually being an interventionist. Where he must begin to do more what's right for us now, to avoid seeing these trends continue and going the wrong direction. We must be courageous, bold, and push way for envisioning mental health care. Thank you.

>> JOHN AUERBACH: Thank you, Dr. Miller, for that comprehensive and really thoughtful presentation and highlighting where we need to concentrate our efforts. Just all of you, really wonderful presentations. Thanks to each of you.

And now let me turn to those of you who are participating in the webinar and remind you to submit questions. Again, you do that by opening the Q&A panel and typing your questions to all panelists. I'm happy to say that I'm being joined now by my colleague At Trust For America's Health, Jonah Cunningham. Jonah is the Government Relations Manager for our behavioral health portfolio. And Jonah's going to help moderate the Q&A by looking at the questions that you're submitting and putting them in an order for the panel to consider.

But before I up things to Jonah, I'm going to ask the following question to our panelists. This is going to be a really hard question. Good luck, panelists, in trying to answer it briefly. But I would ask each of you to take just one minute each to say what you would ask a member of Congress to do, what one step would you ask a member of Congress to do to address the suicide, alcohol, and drug crisis? This is a congressional briefing, and so being able to deliver that one message in a concise way is part of all of our challenge. So maybe I'll just ask each of you in whatever order you like to answer that question. And then we'll turn things over to the questions that Jonah's fielding from the participants.

>> DR. DEBRA HOURY: I can jump in. Can you hear me, John?

>> JOHN AUERBACH: Yes, we can hear you well.

>> DR. DEBRA HOURY: I always say we want to stop the bleeding. If we can stop the people from coming to my ER, that would save a lot of money and resources. So I think focusing on preventing all these issues from happening in the first place, like our panelists all talked about, about coordinating, aligning policies that have greater impact on these issues together than focusing on individual issues.

>> JOHN AUERBACH: Great. Thank you. Thanks, Dr. Houry. Dr. Rich, would you like to go next?

>> JOHN A. RICH: Yes. Thank you. I would second Dr. Houry. I would also say building community capacity to address these key issues takes a long view. And it takes a step towards rebuilding the public health infrastructure by tapping into the strengths of communities. So I know that's a broad area, but investing in communities to take full opportunity of that -- those strengths to really invest in communities themselves in their own healing.

>> JOHN AUERBACH: Great. Thanks, Dr. Rich. Ms. Weerasinghe?

>> ISHA WEERASINGHE: Yeah, I would echo what Dr. Houry and Dr. Rich had said. In the immediate also to focus, like we've said multiple times in the past hour, to hear directly from young people. So these ideas that I've been talking about in terms of wellness and asset-based framing, we've been pushing text-based therapies, all those solutions came from young people. So if there's a way to partner with young people and hear from them and partner with them meaningfully, that is the, I think, solution that needs to happen.

>> JOHN AUERBACH: That's great. And Dr. Miller.

>> DR. BENJAMIN MILLER: All of the above. And I think that we have an opportunity right now to tee off of what I said there at the end. It's a moment for us to have our federal partners create a new workforce that's in community, by community, for

community. We haven't had this before. There's lots of examples of federal programs that train folks to work in communities. But what would happen if we had an entire program focused on mental health and addiction, that we lifted up these voices that had lived experience, lifted up voices of folks that were on the front lines of community? To me that would be one of the most important and impactful and consequential things that we could do.

>> JOHN AUERBACH: Great. And thank you all for doing the near impossible, which is saying all of that in very concise but very clear ways. Jonah, I know questions have been coming in. So what's the first question you'd like to share with the panel?

>> JONAH CUNNINGHAM: So we have a number of questions. And, again, this is to all panelists. What shifts in current investments or new investments might be necessary to address these trends?

>> JOHN AUERBACH: So this is particularly about the budget issues, the investments I'm assuming the questioner was asking about that, in terms of budget focus, what would you shift or what would you emphasize?

>> I can start. We've been trying to push for direct funding for mental health for our young people. We've been thinking about that in terms of appropriations and even thinking about set-asides in different agencies to make sure that they go towards young people. And another way that I think funding needs to be reimagined is trying to get rid of the middle man and get direct funding from community-based organizations and trying to figure out how to do that.

>> DR. BENJAMIN MILLER: I'll add one, John. It's a great question. Currently we're seeing legislation pop up all over the country to try and create telecom fees specifically to support the 988 infrastructure, and this is something that a lot of mental health community you're talking about. For those not familiar, 988's going to be the new number for the suicide prevention hotline, and it will go live in July of next year. The problem is that each state is pursuing their own legislation, which is a good thing. But there is no current federal mechanism to provide consistent funding for these suicide prevention hotlines, that at the level that they need to support the community type of services that are going to be necessary to have a full continuum of care. So in a perfect world if we're looking at budgets, it would be wonderful to have resources that were allocated to support these communities as they build out a more thoughtful approach to crisis response.

>> JOHN AUERBACH: Great. Thanks.

>> DR. DEBRA HOURY: And I would just add, I think with, like, our adverse childhood experiences and our suicide program, we've seen overwhelming interest in these programs. And I think being able to make them national would be huge and not just at the state level, but as my panelist said really at the local level and engaging with the communities is so important. And certainly, John, I would say your report, I think really, you know, hit on it with a lot of the recommendations on how do we address these issues today. So I hope people who are watching this read the report, particularly the recommendations at the end.

>> JOHN AUERBACH: Thanks very much for that. Jonah? Next question?

>> JONAH CUNNINGHAM: On a similar note of recommendations, what are immediate steps that can be taken to increase behavioral health -- treat the behavioral health treatment workforce to address these needs? And my guess would be Ben

Miller, perhaps, or John?

>> DR. BENJAMIN MILLER: Yeah. Happy to take that on. I mean, first of all -- and I had a slide on this. I didn't speak as much to it because I got carried away in the moment -- you know, we need to really look at the distribution of our current workforce to make sure that they are in the places that people show up. And a part of moving our workforce is that they need to have competencies to work in these new settings. You can't just take a mental health clinician that's been trained in mental health and expect that they're going to understand the culture of primary care or even the culture of working in a jail or prison or school. And so I think we actually have an opportunity to reevaluate who's out there doing what for whom, where and how. And when we reconsider that and look at the distribution of our workforce, it does create different pathways for people to get instantly more accessible access to care. It's redundant, but you get it. So I think that would be number one is looking at the distribution and the training of the current workforce.

>> JOHN A. RICH: I would add to that that we have to create environments that are trauma informed for those behavioral health practitioners. So we have to invest in both training, support, and the infrastructure to make sure that burnout is minimized in these circumstances, because we know from what we've heard about the adverse childhood experiences study, that many of us have experienced some of those. And it puts us at risk for these adverse consequences.

So investing in making those pathways more accessible, so relief from student loan debt, incentives for providers to enter settings where they're not forced to work in a way that can be detrimental to their own health, we can't underpay people who are doing this critical healing work because we then have turnover in these. And we see this certainly on the front line, so we have to have some resources for organizations to transform their organizational culture, and I would add, again, that addressing issues of racial trauma, addressing sort of anti-racist practices within these, given that we have to make sure that all organizations are able to provide this quality care, that's really about professional development and funding the infrastructure to make sure that that's available.

>> JOHN AUERBACH: Great. Thank you. Jonah, next question.

>> JONAH CUNNINGHAM: What role or potential do you see health providers and other related professionals having in schools? And what recommendations do you have in terms of family outreach, educational priorities, and interdisciplinary community work?

>> JOHN AUERBACH: Isha, would you like to take a stab at that? Your focus is on strongly on youth.

>> ISHA WEERASINGHE: Yeah, sure. When we think about youth, we tend to think about young people who aren't in school or who haven't had the opportunities through school. We have been trying to push the Department of Education to really think about mental health guidance through the American Rescue Plan and the importance of making sure that there's a comprehensive set of mental health providers that are there for our young people when they need them, and not only thinking about the school environment but also thinking about the after-school environment, too, and partnering with community-based organizations, youth development organizations that already have the strong relationships with young people to make sure there is that continuity of support for young people, too, in their mental health.

>> JOHN AUERBACH: Maybe I'd jump in and just mention as well, we're seeing more and more communities that are training teachers and school administrators in trauma-informed approaches to education where, you know, we're hearing of the teachers who say, you know, in past years, I would look at a child and say the child's acting out, and that's disruptive and, you know, what can we do to control that, that disruption? And the change with the trauma-informed approach is to say, what has happened in that child's life, and what is happening now? Can we work with the family to try to identify if there are traumatic situations, and can we help the child and the family through having ready access to services? Some schools, for example, have in-house health services that are available or nearby referrals and relations with federally qualified community health centers and others. And what we certainly heard from those schools that have adopted those approaches is they found that not only is it helpful in terms of improving the -- eliminating the disruptions I was referring to earlier, or the ways that kids can sometimes be acting out, but it also has resulted in improvements in overall academic performance within the schools. So there's something special, I think, about trauma-informed approaches within schools.

>> DR. DEBRA HOURY: And John, I would just say to be broad. We always talk about looking at the one student that we might be concerned about, but really trauma-informed approaches should be across the board because I think, you know, destigmatized, minimize bias, and really it's the right thing to do for everyone. You know, it lifts everybody up.

>> JOHN AUERBACH: So true. Thanks, Deb. Jonah, next question.

>> JONAH CUNNINGHAM: So this question's for Dr. Houry, but we can open it up to the larger panel as well. How do you view the role of CDC in the public health field and the larger mental health and substance use prevention, treatment, and recovery landscape? And are there opportunities for cross-sector collaboration?

>> DR. DEBRA HOURY: So there's definitely opportunities for cross-sector collaboration. We work closely with public safety and justice, you know, with our treatment and recovery colleagues, education. Because, you know, there's really -- when you have to look at how comprehensive an approach has to be -- and I think, you know, my panelists have really spoken to that, if I just focus on my lane, we're only going to move things a little bit, so it has to be all the sectors to have that comprehensive approach. And for CDC we're very much focused on primary prevention, community-level interventions, and there's been a lot of focus on treatment, which is so needed. But if we aren't preventing it, we're going to continue to grow a population that needs treatment and response. I would say continuing to invest in our suicide prevention work, our adverse childhood experiences work, all of our overdose work, and know that at CDC, those are our three priorities, and we realize that they intersect. So where we can, we're looking for shared risk and protective factors and interventions that address them.

>> JOHN AUERBACH: Thanks, Dr. Houry. Jonah?

>> JONAH CUNNINGHAM: This one's for Dr. Rich. How can policymakers support programs that promote healing from trauma?

>> JOHN A. RICH: I think that's an important question. I think it begins with a fundamental understanding that, as John Auerbach pointed out, it's asking a different set of questions. It's not what's wrong with this person, but it's what's happens with this

person, and I would say and family and/or community. And so one way to support that is to begin to look not only at health and public health but to look at these cross-sectors. So when we think about substance abuse treatment, when we think about the justice system, how do we ensure that we take a trauma-informed lens? Because these systems intersect, and people move between multiple systems all the time. So what we might ask, how is it that we, in our housing policy, make sure that we are trauma informed, that we understand the challenges that people are facing in housing? How is it that in our justice system, we understand that trauma often drives cycles of involvement with illicit activities or violence. So while we are holding people accountable, we have to also bring the resources for them to heal.

Now, it's a mindset and a framework, but I believe that it will allow us to identify specific investments that would improve cross-sector collaboration. So how do we think about collaboration within the justice system and public health, given that we care about the ways in which substance abuse, trauma play out in populations for which these experiences are connected. And so I think new ways of bringing people together, forming coalitions at the community level that include supporting that work, which is often not simply in the day-to-day activities of organizations, but support for the kind of collaboration that will bring together leaders from various different sectors to identify how trauma is -- addressing trauma could improve the effectiveness, measurable effectiveness, of their systems.

>> JOHN AUERBACH: So we've got just about 6 minutes left. And I'd like to ask one last question and maybe ask each of you to, if possible, just to spend a minute or two on this. You know, I think that the sense is we've gone through this traumatic experience of a pandemic, you know, an intensified period of recognition of the importance of racial justice. Many people, I think, think, well, we're going to -- next year things will being back to normal. We'll go back to normal. We'll get beyond this. And I guess I wonder, what do you worry about when the pandemic is over? What will be -- will there be a lasting impact in terms of the issues we're talking about, and do you have a suggestion -- maybe just one suggestion about what might be a way of tackling that area that maybe keeps you up at night or you worry about post-pandemic? And Deb, why don't you start with you?

>> DR. DEBRA HOURY: So I always learn the sleep at night rule where I always try to think about what do we need to do so that we can sleep at night. I think for me, flipping and trying to be positive, my hope is that during this pandemic, we learn to build resilience and that, you know, we've developed a lot more of the safe, stable, nurturing relationships with our families during this period. I've certainly had more family time than I had anticipated, you know, being at home more. But I think looking at what are the lessons learned. So things like more telehealth, more virtual connectedness, things that I hope really post-pandemic persist. And my hope is that we take these lessons. And, you no, really the innovations versus worrying concern. And the things we've learned that are new best practices and elevate those.

>> JOHN AUERBACH: That's a great flipping of the question. Let's flip that question, then, to what lessons do you hope we have learned that will be helpful in dealing with the post-pandemic continuing issues that we'll be facing? Dr. Rich?

>> JOHN A. RICH: Yes. I hope that we don't forget that inequity and inequality hurts us all in very specific ways. And so what COVID has pointed out is that when we don't

have -- when we've dismantled our public health infrastructure so that poor people and front-line workers have -- are exposed at these very high levels and don't have paid time off, aren't able to stay in when they're ill, when they're subject to greater complications, that that -- we see that. That affects all of us in negative ways. I'm sorry that we have to get to that kind of understanding from COVID, but there is a sense that inequality hurts us all, and that these health issues are related. We can't parse them out. So when we build a prevention infrastructure, we will really begin to see improvements across the board. This is issue by issue and I think Pain in the Nation points out those real pain points, but making these same investments, we'll see improvements in other challenges, I believe cardiovascular disease, ability of people to get screening for cancer and for our ability to prevent and protect young people from adversities that we know affect their health. So we can't forget that inequality really matters.

>> JOHN AUERBACH: Thank you. Thanks so much for that. Ms. Weerasinghe.

>> ISHA WEERASINGHE: I'm trying to be hopeful, but it is a really scary moment. And I think one thing that I do want to acknowledge and I think we've been talking about it is that everyone's talking about mental health now. That wasn't the case a year ago. And we are having more clear discussions about racial justice in a way that we weren't having a year ago. So we need to move with the openness that, you know, the dialogues that we're having and think about what Black and Brown communities really need, and that is, like I said, you know, thinking about text-based therapy. Thinking about expanding locations and look outside the traditional medical model to acknowledge racism that exist within the medical system and work to innovate. And that is from not only health practices but even through payment models. It's across the board. And support solutions like we are also pushing for mobile crisis and the implementation of the 988 system and thinking about nonco-responder models, making sure that law enforcement is not involved in mental health care. So we have to take advantage of this moment.

>> JOHN AUERBACH: Thank you so much for those thoughts. And Dr. Miller, closing comments.

>> DR. BENJAMIN MILLER: I've worried about this erosion of empathy the last several years, and I feel like COVID has given us this moment to almost reflect on what it means to truly be connected to each other. The power of presence. When you can no longer -- and I said there -- when you can no longer access the friends, the family, the community that really supports you in whatever it is you might need, there's something that we can learn from that. And I don't want to go away from it. I think that that erosion has led to some pretty nasty things in our communities, where we've not fought for each other in ways that we should have. We've not stood up for issues of justice in ways that we should have. And I'm hopeful that on the other side of this, while we won't slide back into complacency and status quo 101, that I hope that we continue to look out for each other in ways that maybe we didn't before COVID.

>> JOHN AUERBACH: Wow. Terrific panelists, terrific thoughts. Very, very helpful. Thanks to all of you. In closing, I want to say to those of you who have participated, particularly the congressional members and your staff, please do look at the report, the Pain in the Nation report. It is available on the website, tfah.org. That's Trust For America's Health.org, or PITN for Pain in the Nation, pitn.org. Please take a look at the report. In addition to that, the video for this panel, for this webinar, will be available on

The Trust For America's Health website within a few days. We expect it by Friday, but Monday at the latest. So if you'd like to share the panel with others, the words -- the thoughts of the panelists with others, that should be available soon.

So in closing, again, just thanks to all of you. We're really glad you joined us and engaged in this thoughtful conversation. Good afternoon.