

>> Good afternoon, everyone.

We're going to get started for the concurrent session on Facing Substance Use and Mental Health, Challenges with Facts and Moral Courage.

We have two presenters for today, Ms. Roslyn Holliday-Moore, who's the senior public health analyst in the Office of Behavioral Health Equity, Substance Abuse and Mental Health Services Administration, and joining us at the table is Dr. Marcia Riggs who is at the J. Erskine Love Professor of Christian Ethics at the Columbia Theological Seminary.

They will both be presenting.

I'm Julio Dicient Taillepierre in the Office of Minority Health and Health Equity and I'll be keeping time as well as taking some minimal notes and then helping with facilitating the discussion after the presentations. So we'll start with Miss Moore.

Take it away.

>> Thank you all for joining us.

Looking forward to the conversation that we've planned.

I think it will be a little bit easier if we can be tighter but I don't like to ask people to move if you're settled in at the moment.

So I get and it's really a privilege to be able to engage as many people at a distance as we are with this afternoon's conversation.

So I know it's not just limited to those in the room and I'm glad about that.

So my focus will be on substance use and mental health issues but I'm going to start the conversation with a question that I'd like everyone to focus on for a moment and it's looking at the what if.

What if behavioral health equity was the starting point for decision-making and innovation?

Sometimes we get to the place of equity at the end but if we flip the switch and we have that as the driver of how we think, I want to use that question in framing the way you look at the next set of slides that will give you a snapshot,

a snapshot of how we are understanding binge and heavy alcohol use among people age 12 and older.

And as you look at the slide, I'd like you to just pay attention to the tan bar for a moment.

It's showing you a focus on binge drinking that creates a different vulnerability than regular alcohol misuse.

And I also want you to look at the age range, starting at 12.

So imagine if you would someone you know in that age category who might be vulnerable to binge drinking and at the same time, still with that question around behavioral health equity in your mind, thinking about the use of illicit drugs.

And as we look at the bars here, we also see an alarming number of young people engaging in the use of illicit drugs and the tan bar showing a larger number of those 18 to 25.

And so for those in our virtual space as well as those in the room, I want you to focus on this morning's panel and to think about the brilliance that we heard

and the age in which young people are more vulnerable to alcohol and substance misuse.

And as we know our national narrative on opioid misuse is rampant and growing, again looking at the prevalence for those 12 to 17 as well as 18 to 25.

And at this place, the data not only shows illicit drug use ages 12 to 17 but it highlights something different, those with major depressive episodes within a year.

And as you look at that and listening to this morning's discussion, it underscores the need for better understanding how we can move in front of conditions that are rooted in mental health and substance use issues. Unaddressed mental health needs very often create pathways to alcohol misuse and illicit drug misuse.

That's what this slide is pointing to.

And earlier today I talked about, it was the group that before this, that these data slides very often are not the point that people want to focus on.

They're not interesting.

They're not trendy.

They're not colorful.

They're informative and they're important.

But this is too often what we see, social media, mainstream media, our public leaders speaking to both the crises, the needs but also solution.

But if you're in the average public domain, it all starts to sound the same.

So for 17 seconds, I'm using 17 intentionally, I want you as an individual and for those in the virtual space, you have the opportunity to share with us using the chat feature or Twitter, some of what you are seeing here and through the previous slides as most significant, what is standing out for you that may not have been in the forefront of your mind at the beginning of this conversation.

And so there will be 17 minutes of silence,

seconds. Thank you.

Seconds.

Thank you for taking time to reflect.

And while we're not going to take moments at this point to ask you what bubbled up, I am going to ask you to save that thought because I want you to put it in the place of moving forward now, thinking what's significant can be better aligned with what's actionable.

What are we doing?

How are we thinking about the cultural frames in which people are experiencing some of these conditions?

What are the cultural frames that are underpinning the occurrences that are reflected in the data?

And how do we understand culture as a pivotal point, one of the pillars of how we move forward?

How do we think about culture as a strength and not always as a second thought, as an aside?
What are the drivers here that allow us to break through points of isolation that help us identify new people to work with, strategies for building awareness, new ways of thinking about expression?
Sometimes it's leveraging the way it used to be said.
Sometimes it's the new way of doing it.
Culture is very often the driver that sets the stage for how we create partnerships and how we frame partnering.
So I decided that today would be a good opportunity for us to think about not just the partners but also the partnering.
How do we take action?
How do we create those steps on the bridge that was mentioned in the opening remarks?
And so I've identified three different resources here that are all in the public domain but all reflecting new ways of partnering with different industries, with federal agencies, and with ways in which the voices of young people are rising to the top.

In addition to that, you see through these sites a way in which we combine health education material with interactive options so that there're live chats.
And so when we think about the infusion of social media in our everyday experiences, is there a new way of thinking about the way we communicate with each other and that that communication can also be brought to the forefront of how we can think about prevention and the effectiveness of prevention.

So from my home base, the Substance Abuse and Mental Health Services Administration, we also manage a network that I'd like to invite everyone to join.
It's a network established for communities who are prioritizing and focused upon the support of diverse populations in addressing mental health and substance use needs.
So here we have the National Network to Eliminate Disparities in Behavioral Health.
We affectionately call it the NED.
But it's a way in which you and your community can join other partners around the nation in thinking forward about strategies.
Some of them are emerging directly from community.
Some of them are developed and designed, implemented by young people.
Others reflect partnerships that are new and innovative.
But all of them, all of them are being focused on promoting health and equity across every community.
And we start with seeds.
There's a repository of best practices that we invite you to submit ideas around and today I heard a number of them that would be more than eligible to fit into this space.
It's also a way that you can connect with other partners in different parts of either your state or across states

that may have similar challenges which are looking for solutions.
And so here we have a way that not only can you provide a voice
but you can hear what other people are sharing.
And while we have a number of resources, I've brought some
to share with everyone here.
So in the back of the room, there's a table with resources.
I encourage you to take
and to definitely use once you return home but I want
to focus attention on the last resource that's on this slide
which is National Prevention Week.
It's May 12 through the 18 of this year.
And you'll see here we are asking everyone
to take action for prevention.
And so there's a wristband and the wristband has a number
of tools and resources that you can use when you go home
but also a brochure that can help guide some of the actions
that you might want to initiate.
And for those of you who are in the virtual space,
these resources are available on SAMHSA's website.
They are downloadable aside from the wristband,
but you can order them and everyone
in your community can have access to these tools.
The idea here is that we are creating champions,
creating champions where they already exist
and where they don't exist to establish new platforms
for those voices to be heard.
And so with this, I am asking everyone here not only
to reflect but to move forward so that we have a chance
to think about equity versus equality, that we have a chance
to take action to promote equity and that as partners,
this will be our time to make the difference
that everyone knows to be most important.
Thank you very much.

[Applause]

>> And now we'll follow with Dr. Riggs.

>> Since the presenter this morning did
such an excellent job of talking about ethics and ethical theory,
I decided I would shift my presentation a little
because what I want to do is talk to you
about what ethicists do
and we have three tasks that we normally do.
One is descriptive, one is analytical
and the other is normative.
But what I think is most important is the way
in which we describe the context in which we live in order
to think about, you know, the challenges
of doing public health
around substance abuse and mental health.
And one of the ways to describe our context is
that there is the omnipresence of violence.
And

so I want you to look at the diagram and take this
as a visual representative of the way I want you to think
about how the context looks.

So if you think about the context as one in which there is an omnipresence of violence and by that I don't simply mean episodic events of violence but that we live in a context in which harm is often done in a variety of ways to different groups of people and that is where I can begin to talk about describing the dynamics of the context of seeking to address substance abuse and mental health challenges. If we think about for example the omnipresence of violence around drug and alcohol abuse in terms of the way that the media and pop culture for example represent that behavior as somewhat acceptable or even romanticize it such that youth and young adults may think that it's a way to be grown up to engage in such behavior or if adolescents and youth live in communities where life is hard economically for example, some adults they know may engage in substance abuse and alcohol abuse as means to survive, to escape to harshness of the context in which they live. So at that point, adolescents and youth are kind of caught in a kind of tension between seeing behavior that has been told to them by some people as destructive but represented in the culture as acceptable or finding that the only way some of the adults in their lives can make it in their harsh context is to engage in substance and alcohol abuse. Likewise, mental health disorders are constantly today used to explain or even demonize individuals who commit acts of mass violence. Well if that's the case, why wouldn't an adolescent think,

"Wow, I don't want to admit that I have a mental health issue because I might get demonized" or in some of their racial ethnic communities and religious communities, they hear that mental health disorders are not signs

of illness that are treatable but instead they are described as perhaps lacking in character or faith. So once again, you have adolescents caught in a tension between real physical, mental and psychic distress that may result in substance abuse and/or coincide with mental health struggles and they find themselves without parents or other adults with whom they can speak about the struggle. So when we live in this context of the omnipresence of violence, it becomes important to think about what are the tensions that drive us when we begin to think about making ethical choices or practicing our professions even in ethical ways. Well one of the ways I view that is to ask people to think about living into tensions. And living into tensions means that you recognize that the context is filled with the omnipresence of violence but it's also a context where there's the omnipresence of justice. And so in micro context, we're all living out our lives struggling between what are the values of a culture

of deception and what are the values
of a cultural moral courage and how do we live
in neither one totally because we can't but how do we live
in that overlap and begin constructing ethical ways
of being and practicing that will allow us
to find creative constructive ways to engage these issues.
So one of the ways that I would want you to think about it
from a public health ethics perspective is to think about,
you know, perhaps there are principles
that guide the way public health ethics operates and some
of those might be nonmaleficence
or a principle about doing no harm.
Beneficence, a principle about how do we do good
for individuals and collective good or health maximization.
You know, how can interventions actually do the most good
for the most people or how can we provide our services in ways
that efficient, so a principle of efficiency.
How do we have respect for the autonomy of individuals
at the same time we have to think
about what's the public good.
How do we think about justice.
You know, is it about discrimination against one group
that has a historical basis which would mean we need
to think both about reparational acts as part
of how we do public health at practice.
We might have to also think about how one moves
to compensate within a policy for past bad acts
and then you think about the future.
You know, how are we going to redistribute
that which has not been equally shared so we can get
to what the first presenter said so we can get to equity.
So the tensions that we are seeking to live into
and practice moral courage look something
like this, I think, today.
There's a tension between how can what the interventions are,
how they can be effective in tension with cost benefits.
You know, how can it be effective
but also how can we pay for it.
Secondly, the tension
of discerning what we owe each other, you know,
that's what justice is really about.
What we owe each other and how what we owe each other may lead
us into questions of how do we differently serve different
groups in the society and it still be just.
We also are weighing individual freedom, which is autonomy,
the right to make choices, with wider social goods and we want
to think then about individual responsibility as well as rights
of people within the context and communities and, therefore,
you know, what's our social contract with each other
and how do we maintain it.
So private goods versus public interest.
So ultimately what I want to suggest to you is
that an ethical fame for public health ethics practice
and the way you think about it theoretically should be one
that pushes us to think about how we live into the tensions
of doing what I call countercultural and justice work
because both of those have to happen when we do really,

really good public health work.

So how do we get so that we can live in that overlap and become creative partners in designing interventions and policies that actually live into the tensions, don't resolve them necessarily but don't ignore them for sure, and use them to creatively construct new responses. We understand that we live in a context that's dynamic, so the answers we may come up, the ethical responses for now may not be the same later on and we have to come back together, be willing to come back to the table and grapple.

So fundamentally, in a context where the omnipresence of violence is the pervasive way in which we live out our lives, I think we have to ask ourselves, "Can we or are we willing to be morally courageous in ways that are countercultural and about the business of justice?" Thank you.

[Applause]

>> So now we have an opportunity to open up the microphones and to invite our online viewers for questions or comments. Just before we get started, I want to summarize a little bit on what were the themes of the two presentations. So the first presentation by Ms. Moore really posited a,

not a conundrum, I would say, but definitely a problem in terms of how public health and public health data is understood and digested. She posited that we should consider looking at data in ways that help to provide an indication of a larger narrative, that the data may not appropriately describe but that hints at, right, that the data is a reflection of a larger narrative of people that that data represents.

And Dr. Riggs presented what for me is a major conundrum and is this issue of, you know, as public health practitioners, how do we manage an environment of tension between, you know, understanding that we are surrounded by all of these different sources of violence in our lives regardless of who we are, how old we are, or what our position is and then what is our particular role within that environment of violence if we're committed to doing social justice work and that as we figure that out, it might require that we take a countercultural approach.

But the question here is, countercultural to what.

Right? So that environment which permeates everything that we do in our lives when we watch TV, when we play video games, when we go to see a movie, when we're interacting with people in the supermarket, there are all kinds of macro and microaggressions that we're managing or that we've grown accustomed to, right.

So, you know, how do we manage that and, from a principle of ethics, what do we do as agents of change in public health to really ensure that we're moving as agents of change and social justice.

Some really interesting questions for us to consider.

One other thing that I want to point out again is

that Ms. Moore pointed out that there are a whole host of resources that given that she represents HHS and a major agency within HHS SAMHSA, that there are major sources of resources that SAMHSA has made available to support a national partnership network of organizations and individuals who are committed to this kind of change in communities. There are things that people can do. This is not simply a theoretical exercise. There are opportunities to engage and be engaged by other partners. And so she gave resources that are at the table, on the corner, by the microphone to everyone's right. And so we encourage people to take the materials, go online, get connected, because part of what prevents us from becoming agents of change is being isolated and there's no reason to be isolated in moving forward. So now I'm going to open up the microphones for any comments or questions for the two presenters.

And you also have the microphones at the table. If you want to ask a question, you can just press one of the mikes on the table or you can come up to the mikes in the room.

Thoughts, questions, comments?

>> Hi. My name is Kauun Mohammed [phonetic]. I'm getting my master's in clinical psychology right now.
>> Can you speak a little closer to the mike?
I'm having a hard time hearing you.
>> My name is Katun Mohammed and I'm getting my master's in clinical psychology right now. One of my concerns as a young adult right now, what would be on your part, what would be some resources that I could take to be more aware of the public health and mental health combination?

>> I want to start with congratulating you on your choice. It's a great professional endeavor and I think there are a number of practical ways. So in part by sharing resources that allow you to take action from wherever you are is so that you can start that practical application of the theory. There are also a number of internships and fellowships that I would encourage you to take advantage of and we can offline definitely connect you to some of those directly. But I do think applying theory as early as possible is one of the best ways to anchor the learning in making sure that we are able to take advantage of your educational experience.

>> Good afternoon.
So Dr. Riggs, does this model only presuppose a religious way

of, a religious response, a religious way of dealing with the culture of deception and conflict and so on?

>> Well, what's important about it is religious is not referring to particular doctrinal or denominational or traditional, you know, ways of being religious. Religious has to be understood here in this framework as whatever is used by an individual or a group to define what is of ultimate concern to them. That's what religious stands for here. So what's religious for you or me may be connected with some particular tradition but what's religious to someone else may not be defined by membership in some religious tradition or church or synagogue or whatever but instead has to do with what gives their lives ultimate meaning.

>> So someone grounding themselves in this dynamic is a resource for overcoming substance abuse. Is it also a resource for dealing with mental health issues?

>> Someone grounded in this perspective, and I was really thinking about the practitioners of public health, someone grounded in this perspective is willing to grapple with individuals and communities about what substance abuse and mental health is first and the ways in which they respond to it in their communities and then begin to grapple together for answers in terms of what kinds of interventions would make sense, what kinds of solutions might make sense for now. It's really a framework that also -- I guess the other way I could've talked about describing our context, it's to invite anybody who's willing to be countercultural in the sense of not buying into the kind of culture of absolutism and polarization that we live in today.

>> I'm sorry.

Can you define culture of absolutism and polarization for the, you know --

>> Well, I'm defining absolutism as a culture in which people hold their positions and their commitments as positions of certainty, of absolute truth and, therefore, they don't see a need to engage someone who has a different position. And consequently, we end up with partisan polarization, people standing on each side and maintaining that side at whatever cost. People who are willing to work in this religious ethical frame are willing to say, "Hey, I can stand here and invite the polarities, the people in their polarization, to grapple for new meaning together," rather than staying in a culture of absolutism and certainty where all we do is make claims

and counterclaims against each other.
>> Can I just add one piece to that
because I think you raise an interesting point.
I just had the opportunity to meet Dr. Riggs.
It's been a real interesting alignment
of experience and perspective.
But it reminds me also of one of the closing remarks
from this morning that looked at principles of equity
and health equity in particular, where we were trying
to address issues that are avoidable,
systematic and unfair.
And with that thinking and in the space that you've defined,
I imagine work that's related to policy
and practice that's more inclusive in the dialogue
than not inclusive and that
where the paradigm can be more applicable and relevant.
And in that relevance, I think we have opportunity
for being accepted and effective in ways that we have yet to see.
>> The posture of a person practicing religious ethical
mediation and the policies you would come
up with would be adaptive and responsive.
Yeah.

>> Hi. Thank you for this very interesting stuff.
I'm feeling stuck in a model and I'm feeling that there's a lot
of really fascinating theory here but I'm thinking about some
of the discussions that we have.
I'm from CDC and I think a lot
about how health departments can do things differently
but I'm thinking about children versus adults.
And when we talk about people who are in the system
of substance abuse or people who use substances, we often think
about adults and yet children are in this environment.
And I wonder if you take this model and think about children
who are exposed to these kinds of situations, the omnipresence
of violence for sure would be a place where children are found,
how do we, how can we think about this more practically,
I guess, thinking about those kinds of age groups?
That make sense?
>> Yes, I think so.
You can tell me if I don't answer your question.
Okay? That will mean I didn't understand.
But one of the things about this model is it invites folks
to think about who are the partners in the conversation.
So if you're dealing with children,
your practices are not going to be conventional, necessarily.
Dialogue happens differently.
I mean, art therapy is one of the things that folks use art
with kids for example.
So you begin to think about what are the ways kids communicate,
you know.
The model does not preclude them as partners engaging
in the dialogical kind of encounter
that this is calling for.
It does require us to think outside our boxes.

Does that make sense?

>> One of the things that comes to mind in this discussion are conversations that we often have in the office where when we talk about advancing health equity in practice, we've talked about how we want to convey that often it doesn't mean that our actions in public health need to change so much as our understanding of why we're taking the action. And both of you, for me, in your presentations, spoke to that and how we look at data and what we think data is telling us and what may be missing in that data that we need to do further investigation around so that we're not blindsided or coddled by our confidence in that data and then also how we're engaging our partners and what do we think is feasible or actionable, right. If we're only staying within the lane or within the model, there are a whole host of practices or techniques or methodologies that we're not going to even consider because they're not normative. And so we have to be creative in not necessarily having to construct new models or new strategies but taking the models that we've used in other settings and in other contexts and using them in new ways or with new audiences. So it's a highly iterative and creative process. Who said public health is boring? I don't think public health is boring. I never say public health is boring. But I want to take this time to see if there are any questions online. Do we know if there are any questions that came online? Okay. Alright. So at this time then I want to thank our two presenters and please give our presenters a round of applause. [Applause] And so I want to take the last few minutes to present the certificate of appreciation to both of our presenters. This is to Roslyn Holliday-Moore in recognition and appreciation for your participation in the CDC Office of Minority Health and Health Equity 2019 Public Health Ethics Forum at CDC on April 26, 2019. Please come up.

[Applause]
And this certification of appreciation is for Marcia Riggs in recognition and appreciation for your participation in our 2019 Public Health Ethics Forum.
Thank you, Dr. Riggs.

[Applause]
So now this concludes this session.
Thank you.
[Applause]

[Applause]