



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

ESSENTIAL SCIENCE CONVERSATIONS:

APA – NIMH BREAKFAST TOWN HALL: CELEBRATING 75 YEARS OF THE NATIONAL INSTITUTE OF MENTAL HEALTH (AUGUST 4, 2023)

TRANSCRIPT

Dr. Jermaine Jones: Hi, everyone. I think we're going to go ahead and get started.

[background noise]

Does everyone have a seat? Oh, it looks like it's standing and rolling. I think we'll go ahead and get started. I just wanted to welcome everyone to today's town hall. I'm Jermaine Jones. I'm an experimental psychologist with the Division on Substance Use Disorders at Columbia University Medical Center. However, I'm here representing the Board of Scientific Affairs of the American Psychological Association. I'm also here on behalf of APA science director, the host of today's event. As you know, APA is the nation's largest organization devoted to the study and practice of psychology.

NIH is one of the largest funders of psychological science. Among its 27 institutes and centers, NIMH is one of the largest funders of behavioral and social research. NIMH is turning 75 this year, which gives us the opportunity to reflect on the mental health challenges we've faced in the past, and also look towards solutions for the problems that we face currently and will face in the future. Part of what we wanted to do today was honor the ongoing collaboration between our two organizations, but before we hear from the Deputy Director of NIMH, we're going to have two individuals speak to the ongoing work that's being done between APA and NIMH.

First, we'll hear from Julianne Baron, the Executive Director of the Federation of Associations in Behavioral and Brain Sciences. Also, we'll hear from Pat Kobor, the leader of APA's science directorate. Finally, this is a town hall, so at the end of all of the presentations, there will be time for Q&A. Feel free to start thinking of some questions now that you have a representative of NIMH here in front of you. With that, I will turn it over to Julianne.

Julianne Baron: Thank you, Jermaine. I'm very impressed that you got the name of my organization right. It's been a long time. As Jermaine said, it's the Federation of Associations in Behavioral and Brain Sciences or FABBS. FABBS is a coalition of 29 scientific societies and 60 academic departments. We come together to advance our disciplines, to advance the rigor, the impact, the equity, the accessibility of our disciplines. We have a presence here in Washington, DC. APA is a very cherished leader and member of our coalition. We have the opportunity to partner on all sorts of things, which I think is part of why I got to be invited here today.

One of the examples of the things that we have partnered on is creating a coalition called the Friends of NIMH. Here in Washington, DC, it's very common to have coalitions around individual federal agencies or individual institutes that NIH as the case may be. There's an expression that if you're not at the table, you're what's for dinner. These coalitions come together to make sure that they don't send each other down the river. They have the stakeholders of a particular institute will come together and they'll all agree on advocating for a top-line number for that institute or the federal agency. APA and FABBS are members of many of these different types of coalitions.

In 2020, we realized there wasn't one for NIMH. APA and FABBS got together, and we looked at the stakeholder community for NIMH and we thought, oh, this could be really valuable. These coalitions, in addition to having a united voice for a top-line number, they really work to educate their members, to make them better advocates, and tell good stories. We hope that provides efficiency for NIMH instead of our 35 friends each asking for an update. We do that once a year for all of them at the same time. We submit testimony on the hill in favor of NIMH. We can do things that NIMH can't. We can have congressional briefings and talk about the funding in ways that they can't.

The Friends of NIMH, I guess we launched-- I remember very well our first meeting because it was our last meeting before the pandemic, so we launched in the beginning of 2021. Since then, we have grown to about 35 members. Each year we have two congressional briefings, two educational briefings for our members, like I said, to keep them abreast of all the good work that's happening at NIMH, and we have one discourse with the director. That just tells you a little bit about the Friends of NIMH. Another perk has been it's been delightful to get to know our colleagues at NIMH and really feel engaged with what they're doing.

Then the second thing I just wanted to say was that we have a script for psychology too. There's a lot of stakeholders, there's patient groups, there's practitioners, and researchers. There wasn't a place really to bring them all together, all in support of NIMH. To be able to have a seat at the table has just been really valuable. We can always be like, oh, we have a good speaker idea for you, or we can help give ideas for the topic. We really value that in terms of our work of advocating for psychology. It's been a really great partnership and we're looking forward to continuing to grow and continuing to do these types of activities. Thank you.

[applause]

Pat Kobor: Good morning, everybody, and thank those of you in the back for standing. I know that maybe we can do something about that in a few minutes. Thank you all for being here. I'm Pat Kobor. I'm the Deputy Chief for Scientific Affairs Advocacy at APA. I work on science advocacy issues. I'm located in the advocacy office, which is integrated. We have a big office that works on science, practice, education issues, and public interest issues. It's a real pleasure to be able to collaborate with the science directorate and to work on behalf of APA scientists.

The team that I head, four of us work on trying to get more funding for research, trying to get better regulations for science. I wanted to tell you a couple of things that APA's doing on behalf of science, and particularly on behalf of NIMH. NIMH from time to time issues requests for information, or they're asking the scientific community to weigh in on particular issues. Maybe it's the strategic plan, maybe it's something that they're going to put out the funding announcement about, and they want to know the lay of the land research-wise. We try to keep on top of that, and we come to you, the scientists, and say send us your references.

Help us put together this response so that NIMH has the benefit of psychological science thinking. I hope that when you see emails like that, often from Mitch, you'll respond, because usually there's a short turnaround. We really need your help with those in order to showcase the best of psychological science. Another thing we've begun doing just recently is that APA is meeting with a group of staff at NIMH- people from practice, from advocacy, from science- just to talk about issues that they're dealing with, issues that we're dealing with, what's hitting the wall for practicing psychologists, what does NIMH know about it, what are they struggling with?

This is a really good way too to keep the lines open. We're really happy to keep those conversations going. Sometimes we may need additional voices in those conversations. We know where you are and we might need to call on you. I wanted to tell you a nice piece of good news. We've been working on some legislation that would authorize additional funds for research. One of APA's advocacy priorities, as you know, is to promote and increase funding for research.

We want to do that in a way that's useful to the agencies too. We're not going to tell NIMH that they need to fund research for purple animals when they don't have any purple animals. We put together a bill on increasing funding for mental health disparities. NIMH was asked by Congress to resolve the problem of mental health disparities in youth by the year 2031. We thought that seems like a big job.

[laughter]

It seems like they should have more money to do this work. We drafted a bill and shopped it, shopped it, shopped it around. I'm really proud to tell you that we have Senate, Democrat and Republican. Senator Amy Klobuchar of Minnesota's going to introduce the bill along with Senator Katie Britt of Alabama. You look surprised.

[laughter]

Okay, yes. Way to go, all right? She's interested in youth mental health. In the House, Congresswoman Bonnie Watson Coleman, who's been such a champion for youth mental health, minority youth mental health in particular is leading on this. Man, she's a house on fire. She's ready to push this and make it happen. Congressman Brian Fitzpatrick is the Republican. We're really proud to have him. He's very active in mental health and substance use space, and we're delighted to have the chance to work with him. This bill's going to be introduced in September.

When it is, you're going to hear all about it because I'm going to be sending letters saying, call your congressmen, write your congressmen, ask them to co-sponsor this. If they get a lot of co-sponsors, then they'll mark the bill up if there's support for it. We've got people well placed in committees who are interested in this bill. We need to do it; I'll tell you just a little bit more about the bill. It would authorize \$100 million a year for five years to improve youth mental health disparities. The money would go to NIMH, but NIMH in partnership with NICHD and NIMHD.

That's a powerhouse combination. They're already working together on this issue, but of course, they don't have extra money. If this bill authorizes extra money if it goes through, we'll still have to get the funds appropriated for it. Having seen that Congress is supporting a big initiative to solve a big problem like the youth mental health crisis, this is huge for us, and so we're really excited. I wanted to tell you because you're going to hear from us, pens at the ready, or computers, whatever you'd like to use.

[laughter]

Thanks very much. I guess I'll turn it back to Jermaine so he can introduce our guest of honor.

[applause]

Dr. Jermaine Jones: Thanks, Julianne and Pat. I'm here to introduce Dr. Avenevoli. Dr. Avenevoli received her PhD in developmental psychology from Temple University, and later completed a postdoctoral fellowship at Yale School of Medicine. She's currently the Deputy Director of the

National Institute of Mental Health, the lead federal agency for research on mental illnesses. NIMH seeks to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

Dr. Avenevoli joined NIMH as a staff scientist in 2001, and in 2005 she moved to the extramural division. In 2008, Dr. Avenevoli became the branch chief of Developmental Trajectories of Mental Health Disorders branch. She's been heavily involved in a number of key NIMH efforts. Among them, the revision of NIMH's strategic plan, redefining the institute's approach to supporting research in neurodevelopment and bipolar disorder, and she has served as a liaison to other agencies for special initiatives. Everyone, please help me in welcoming Dr. Avenevoli.

[applause].

Dr. Shelli Avenevoli: Thanks so much, Jermaine. Hello. It's really my pleasure to be here. The first thing you might notice is that I'm not Joshua Gordon, the director of NIMH. He wanted you to know that he sent his deepest regrets and sincerest apologies. He came down with COVID last week, recovered over the weekend, and has rebounded. He has every intention to be here and was really looking forward to this discussion with you. I'm sorry you got me, but I have to say, what is Josh's loss is really my opportunity. As you heard, I am a developmental psychologist by training.

My training in developmental psychology has really shaped my work for 22 years at the National Institute of Mental Health. This feels a little bit like coming home for me. Thanks for having me. I'm really excited also to be here because it's a special event. It's a special time. It's our 75th anniversary. Wow, that's amazing. It's really a great time, as Jermaine said, to reflect on where we've been, how far we've come, what we've accomplished, but also a little bit on where we might be going in the future. I'm going to talk about each of those things just briefly because I want to save a lot of time for your questions.

First, I wanted to give you a little bit of information on our 75th anniversary. To celebrate 75 years of transforming our understanding, standing, and treatment of mental illness, we planned a number of events over the course of a year. It officially launches in September, although this is really the first time we've actually been speaking formally about the event, so, congratulations, you are our inaugural event. Starting in September, we're going to launch a series of scientific symposia that will really celebrate our progress and look to the future.

The first one is on September 13th. I really hope that you can join us where you can join us in person, you can join us virtually, both are options. Take a look on our website, all of the information is there, and we love to have you. The first event really focuses on scientific advances over the past 75 years. Then future ones will focus on areas of inclusion and areas of looking to the future, future activities that are planned. The other things that we're planning are videos, inspiration, and fun things on our website. Which we'll really talk about accomplishments and fun ways, and be interactive.

We really invite you to join our email list and participate in those things, and follow along in social media, if you will. I just want to give a shout out to my colleague, Phyllis Ampofo, sitting there in the lovely orange and white sweater. She's really helped to lead our efforts on the 75th anniversary. You'll enjoy a lot of this because Phyllis is an excellent leader. Now just to step back a little, Josh and I, I'm using some notes because we prepared some things that we wanted to talk about with you.

Obviously, there are a lot of accomplishments that NIMH has made in collaboration with the scientists that we fund, but we thought we would focus on four areas that are particularly germane to this group and that many people in this room and many others of your colleagues have contributed to over the decades. The first one we wanted to mention is NIMH-supported research in the '60s that led to the development of cognitive behavioral therapy. NIMH continues to support CBT in many various forms.

Some of my own personal memories, I was a program officer before I was deputy director and we supported the treatment for adolescents with depression study, the TAD study, which was the first to show that a combination of CBT and fluoxetine was the most effective treatment for adolescents with depression. That was groundbreaking and critically important. We supported a number of trials since then that have showed similar results.

Josh also wanted to highlight that we've used and supported CBT in treatments with ketamine to show that while ketamine is fast-acting and can take care of people with treatment-resistant depression or suicidal thoughts, or bipolar disorder, CBT is really essential for carrying over those long-term effects in-between ketamine treatments. It's not just important in its own regard with efficacy and effectiveness, but it's important in partnering with other therapies that we have available to treat the widest swath of individuals who are challenged by mental illness.

We continue to support CBT research, as I mentioned. Now I would say we're really focusing on enhancing the accessibility of CBT for a larger part of our population, as well as using different platforms to do it. Imagine mobile platforms and applications, and things like that, and different healthcare settings like college campuses, allowing people who normally might not have access to these opportunities to have this access. Another area we wanted to highlight was that in the '90s, NIMH-supported research led to the development of dialectical behavior therapy, including versions optimized for borderline personality disorder.

Since then, we've supported research to minimize suicidal behavior in adolescents using DBT. Right now, again, with CBT, we've been supporting research that's really focused on improving treatment access for DBT. It's an intensive therapy, and we want to make that available for a wider variety of people. Another area we wanted to highlight was in our digital health interventions. We've come a long way here and we've supported a great deal of research that has shown that digital interventions can be effective for a wide variety of people and for a wide variety of disorders.

We are really investing a significant amount in this space, and that's really important right now, we're facing a growing mental health crisis and a shortage of caretakers to care for people. We really have made an investment in this space and are continuing to support not just the testing of interventions, but the development of technologies and training for people to be able to learn how to administer these potential therapies. We've supported really interesting creative approaches to this, and we can talk about it a little later in the questions if you want, with things like chat box that encourage people to--

If you write something about an eating disorder, it's a chat bot that encourages you to get help. Things like that. Our ALACRITY Centers, we've really stepped up centers that are focused on treatments and interventions for both adults and children. We've made a significant investment in those in the past few years particularly. Many of those have, at least, a component that supports digital health interventions as well. Let's see. The last thing, it's not the only other thing to mention, but the last thing I thought I would mention today was emphasizing the role of NIMH and many of

you in establishing the collaborative care model as an evidence-based approach to mental health in primary care settings.

Collaborative care, as you know, has been shown to improve access to care, improve quality of care. It's associated also with reducing mental health disparities, which is critically important and a very challenging issue. Right now, in this space, we're supporting at least four large trials through the HEAL Initiative. That's the Helping to End Addiction Long-term. We're looking in individuals who have both an opioid use disorder as well as a mental health condition, including suicidal behavior. We continue to support collaborative care, and it's something that we talk about a lot with Congress about what we have.

What are some of the models and therapies we have available and have really pushed that point? I talked about four of our broad accomplishments. There are so many more. I just encourage you to join our other events because you'll hear about a lot more things and see them on our social media as well. Let's talk a little bit about where we're going in the future. There has been, this is refreshing and wonderful, a lot of White House and Congressional interests on mental health. It's for a bad reason in the sense that we have a growing mental health crisis, as I mentioned, and particularly among our youth.

The pandemic just served to exacerbate that, but it did bring a lot of attention to the issue. There seems to be a lot of serious attention right now. We've had a lot of these conversations and we've been challenged in many ways to address some specific issues. I'm going to mention a few of those. There are just a few because there are many more that we'll be tackling. One of those in youth mental health is focused on the impact of social media screens, generally, but particularly the impact of social media on children and adolescents.

We are beginning. We had a few applications. Most of those applications were very correlational. It was like if you use the more screen time you have, the worse your mental health symptoms are. Now, we're really challenging. We already had an RFA on the street to really challenge people to look at the bi-directional influences of the impact of social media. We know that kids' involvement online has benefits to some children too. The issue is, what are the boundaries? What are the challenges? What is the content they're exposed to? What's the context in which they're doing these things?

It's very complicated and it really demands sophisticated methods and analytic approaches. This is what we're trying to challenge in our most recent RFA. We do plan to continue to build a portfolio in that space. We think this is just the beginning. We're not alone. We'll be working with sister organizations like NICHD as well on this issue. The other area is in mental health disparities, which thank you, Pat, for introducing that for us. As Pat mentioned, most recently, we posted on our website a strategic framework for addressing youth mental health disparities.

This was in response to a request from Congress, but it was also something we had been working on our own. It really lays out our plans and priorities for the next 10 years at the time, until 2030, of what we can do through research- remember, we're a research organization- to try to learn more about how we can minimize health inequities and disparities, and things like access to care. That's not the only area in which we'll focus. Finally, the last area is in what we're calling precision psychiatry. As we know, treating people with mental illness is challenging, and it's mostly trial and error at this point.

Someone comes to see any kind of caretaker and it's trial and error of what's going to work best for them. That delays treatment and prolongs suffering. The idea with this, this initiative is really to

speed that up and figure out how we can best connect people with the right care that's going to be the most effective for them. Within this precision psychiatry initiative, we already have some RFAs out there.

One focusing on biomarker development that looks for biomarkers for existing treatments for depression. The other is called impact. Here, this is more of a precision diagnostics effort, which uses data-driven approaches to find more specific and less biased clinical phenotypes for identifying people, predicting their outcomes, and optimizing their treatment. I'm just going to stop abruptly there with some of those ideas on where we're going, and mostly just to save a lot of time for your questions. Thanks again for your attention, and, again, great to be here.

[applause]

Want to stay here, or here?

Dr. Jermaine Jones: Yes. Any questions?

Dr. Bill Haley: Hi, I'm Bill Haley. I'm at the University of South Florida. I work in geriatric mental health and dementia care. Models like collaborative care, as best I know, have not really penetrated the healthcare system very far. One thing that's going on in National Institute on Aging, which is very exciting, is they're working toward having pragmatic trials, which are actually implemented in healthcare systems because it's so hard to translate our interventions into real-world setting. I'm interested in whether you think NIMH is looking at that type of approach because, as we heard from Dr. Eisler when he retired, we're not making the dent in the system that we need to.

Dr. Shelli Avenevoli: It's a good point. We actually do collaborate with NIA in a lot of these efforts, so that's one thing. It's much more powerful, especially with large scale trials, when we can collaborate together on those things. I think I would also add, we can continue to do trials, but we also have enough of an evidence base that some of these things are ready to move into practice.

We feel like there is, but they don't, absolutely. I think that's where we need partners to help us bridge the gap between what the evidence base is and how to move it into practice. We absolutely, if there are things that people say, "This is the piece of the evidence base that are missing," there are things that we feel that we should build, but we also feel that we really need partners to help us bridge that gap.

Dr. Bill Haley: Just a follow-up.

Dr. Shelli Avenevoli: Absolutely.

Dr. Bill Haley: The pragmatic trials actually work in with partners that are delivering healthcare on larger scale, so I really urge you guys, if you're not looking at that model, it's a way we can really show systems of care.

Dr. Shelli Avenevoli: Absolutely. We do, do it in other spaces. We're not doing it right now in geriatric medicine but thank you. Excellent point.

Speaker: Hello. I'm from Division 10, Psychology of Aesthetics, Creativity, and the Arts. Also, I'm part of NYU's International Creative Arts Therapies Research Consortium. I wanted to know if you are welcoming arts space or creativity-based intervention that we found that are very helpful. Especially with populations that don't have access to words, and elderly as well, older adults and

children, this is a spectrum of many different settings. I know we are behind in terms of the federal research. Music therapy is more, but arts therapy is not just music, so drama, drawing, movement. There's great evidence with dementia. We're collaborating with the WHO, so I think it's time to explore other possibilities too.

Dr. Shelli Avenevoli: Absolutely. We actually do support. We don't have a large portfolio in that space, but we do, and we have in the past and continue to support research on music therapy, art therapy, other kinds of interactions with animals, horses, dogs as well. We also have a sister institute that supports a lot of that work. Sometimes it's hard to know whether it comes to us or them, but I really encourage you to just reach out to us and have a conversation with one of our program officers.

Many of you in the room know that we did begin to frame our clinical trials, particularly in intervention development around an experimental therapeutics approach. We did that because we have limited resources and we're trying to hone in on what we think could be the most promising therapy. The idea there is that we want you to come in with a target and test that target before we jump into a large-scale trial. Again, that's something that a program officer can talk through with you and find the best fit for you. Absolutely, we do support that work.

Dr. Jim Cohen: Hi, my name is Jim Cohen. I'm from the University of Virginia. Historically, the NIMH has funded a lot of clinical research, basic research, and intervention research that's very focused on treating an individual. You mentioned in passing the pandemic as a possible determinant of the increase in mental health problems that we're seeing. I'm just wondering if there are barriers in funding at NIMH to original research on the social economic policy determinants of mental health and intervention. If we're talking about access, if we're talking about treating elderly, these are often policy and social level kinds of things that we really need better research on. I'm wondering if you could comment on the role of NIMH there.

Dr. Shelli Avenevoli: Absolutely. We have portfolios in our division of translational research that include work like you just explained. We've had a history of sometimes being more open to that research and sometimes not. We are in a position of being more open to that research. We do support it right now. I think that we don't get a lot of applications that focus on the policy level. We get a lot about other social determinants of health or other contextual variables, but we just don't get a lot. Then I would admit that sometimes those things have challenges in review.

They're things we've also worked through with some of our applicants to have successful grants in that space. I think this is an ongoing conversation. There's a lot of attention across NIH right now on social determinants of health. We're all trying to work together with community-based organizations to really figure out how best to measure and integrate these things in our research and do a better job methodologically at unpacking some of these issues. I think there's absolute interest, and we're still working through some of the challenges.

Dr. Bethany Teachman: Thank you. Thanks so much for being here. I'm Bethany Teachman. I wonder if you can talk a little bit more about the ways that you're hoping NIMH moving forward can do more to have us be a more inclusive and diverse field. I'd love to hear more about how successful, for example, have diversity supplements been. I think there are concerns about people not necessarily even knowing about them or using them as much as they ought to be and would like to be, and all of those kinds of things.

I wonder if you can talk about innovations that are planned in that space to increase our ability to have a more inclusive and diverse field. Because I think if we want to address health disparities, that's a step to doing that that really can't be divorced from research trials and things like that.

Dr. Shelli Avenevoli: That's right. All of the institutes made a decision that this was a topic, broadly speaking. When we're talking about enhancing diversity and inclusion in the broader scientific community, that we needed to tackle at the NIH level, that no institute alone could probably do that. That doesn't mean we don't have NIMH-specific RFAs, but funding opportunities for that purpose. Through the UNITE Committee, there's been a whole host of initiatives that have come out which support institutions, organizations, and individuals at all different levels.

I think the older model was support individuals by providing them with more time, more mentoring, extended leave for maternity leave, childcare, paternity leave, et cetera, diversity supplements. I think we continue to do those and improve upon them based on feedback. We've had some RFIs, we request for information where we've gotten some good feedback, and we've revamped a lot of our traditional training and support programs. We've gone a step further at NIH to really support institutions.

We have a number of things that support people's time to engage in DEIA efforts within their institutions to support the training of individuals in that space. There are really countless, and I don't have them all at the top of my head, but if you go to the UNITE webpage, they're listed there. I'm happy to follow up with you, Bethany, and send you some links to some of those activities. I think it's an area where we're doing exceptionally well. We continue to drive out and learn from some of these programs that we've initiated.

Dr. Karen Osilla: Hi, good morning. My name is Karen Osilla from Stanford. I work with Kate Watkins on one of the collaborative care projects that you mentioned. When we got that funding, we were thrilled that NIMH was involved because historically you hadn't focused on co-occurring disorders. I wondered if you could speak to whether that's going to continue, and I hope you will.

[laughter]

Dr. Shelli Avenevoli: Yes. Things are cyclical. Different leaders have different emphasis. In our current state, we recognize that these things never occur in a vacuum. At the most obvious level, to treat individuals, you can't just treat substance abuse without taking care of the mental health issues and vice versa. Also understanding the pathways to illness, really having to understand both of them in tandem. We really have stepped up our collaboration with other institutes.

Many of you may know about the Adolescent Brain and Cognitive Development Study. We are major supporters and drivers of that study, financially supporters, but also we're involved in the development of that and continue to be involved. We don't say no. I do agree that because different institutes have buckets, sometimes it's difficult to know when something fits in NIMH or NIDA or NIAAA, but I think we're much better at trying to work through that than we were, say, 10 years ago.

Dr. Karen Osilla: Thank you.

Dr. Leslie Hammer: Hi, I'm Leslie Hammer with Oregon Health & Science University. I'm an industrial organizational psychologist, so I study the workplace. I've spent the past 32 years studying how the workplace is structured, and the systems and the conditions within work impact psychological health and well-being of workers. I know you're part of an RFA on work as a social

determinant of health. I am wondering how open NIMH is to other workplace research, because that's one specific RFA and I haven't heard or seen very much at all, even though we know that the workplace really is a source of risk and protective factors for mental health, and specifically that the workplace is where so many people spend a majority of their time.

Dr. Shelli Avenevoli: I want to say that just because we don't have a funding opportunity announcement out doesn't mean we're not interested in something. We have programs within both our translational divisions, so that's where things about how the workplace might contribute to risk for mental illness would sit, but we also have our intervention division where we are focusing on intervention development within the workplace. I wouldn't say we have a large portfolio, but it's not because we're not interested, it's because we're not getting sometimes the application.

Just a reminder, almost, I think it's about 90%, don't quote me on the number, of what we pay for is investigator-initiated. It's not through RFAs. The RFAs, notice the funding opportunities are a very small part of our investment in science. Again, I'm a broken record because I was a program officer, but I always encourage people, if you have an idea, write a paragraph or a page and contact a program officer to ask if this is a good fit.

Dr. Leslie Hammer: Thank you.

Dr. Maria Felix-Ortiz: Thanks. my name is Maria, I'm from SUNY New Paltz now. I just left Texas where I was there for 15 years at a Hispanic-serving institution, also faith-based. Before that, I was in Los Angeles, also in a Hispanic-serving institution. We know that our Latinos are struggling a lot with mental health. One in five of mine had a history of suicide, and it's usually with the substance use problem. I think 30% of my sample was already drinking heavily in college as future health professionals.

These are young people who will have access to prescription drugs in the future and they're already heavily drinking. Having said that, what are the projects or plans for doing more support of selected prevention in college because they are there already. They're captive audience. I can see where a model of regional centers where NIMH informs the local college counseling centers and the health professionals at the local colleges can be as successful as the educational regional centers are for public education, or do you all have plans or anything on the horizon around those issues?

Dr. Shelli Avenevoli: That's a great idea that I think you should turn into a grant application.

[laughter]

That's a very specific area and I think that we are broadly trying to move our intervention work into communities, having community engagement on those issues. We're very interested in that, and we have several general notices of funding opportunities on those topics. They're not specific in the setting or the population that you're talking about, but that fits completely under the umbrella of the areas in which we're engaging.

There's also the ComPASS program, which is an NIH common fund. I think you should look that up on the NIH website. It's ComPASS, C-O-M-P-A-S-S, I believe. It is an NIH common fund initiative focused on developing interventions to reduce health disparities, particularly through community-based work. It involves the community. It's a large-scale initiative. Josh is actually--our director is actually the advisory board for that initiative.

Dr. Terry Keane: Hi. Thanks very much for coming today. My name is Terry Keane. I'm from VA, Boston and Boston University and I'm a very grateful recipient of, I think we're at year 27 of 1832 program. Thank you very much for this. I raise a couple of questions that have actually caused some consternation in our group, and that is that, one I learned a few weeks ago from sitting on the board of our CTSA, Clinical Translational Science, that everybody's having trouble recruiting postdoctoral fellows, especially in the city of Boston, largely because the competition is stiff with the corporate world in Boston, let alone the academic world.

Then secondly, in May I think, I received an email from our office of Postdoctoral affairs at Boston University, saying that as of January 1st it'll be compulsory for us to pay all postdoctoral fellows- those of you who are postdoctoral fellows, please keep your ears closed- \$65,000 when, of course the stipend is considerably less than that, and that's because of the the uproar of unlivable wages that training in science requires. I'm curious, I've talked with Mark Chavez and we know, and he didn't have much information, so I'm hoping in the last couple of months there might have been some progress here about what we're to do.

When I spoke with Boston University about this compulsory requirement, they said, you can pull it from philanthropy or clinical dollars, Terry. Of course being at the VA, we don't have philanthropy or clinical dollars to support. I'm curious, one, are you all working on it? What can you provide us? Do you have any recommendations that I could possibly implement to meet the mandate that I'm confronted with? Thanks very much.

Dr. Shelli Avenevoli: Thank you. I'm not going to be completely helpful. I know there are NIH discussions on this topic. I think my understanding was, moving forward, that those would be built into the cost, but you're stuck in a position where you already have the grant and there's a mandate. Let's talk again to Mark. I'm happy to join you in that conversation. I don't have a specific answer for you. Mark attends the meetings that would tell us most recently what's going on and I don't have an update in that space. Sorry about that.

Dr. Don Grant: Hi. Thank you so much for coming in. I wish Joshua a speedy and full recovery. My name is Don Grant. I am the current past president of Division 46, Media Psychology and Technology. I also am the National Advisor of Healthy Device Management for Newport Healthcare, and I was recently asked to join the Youth Services Committee of the National Association of Behavioral Healthcare. I don't think anyone is going to have to buy a vowel to solve the puzzle about what my question's going to be.

You talked about screens. I know we've gained some gray traction. I'm very excited and I'm really looking at maybe something's going to happen. We have a Congress right now that if one side says the sky is blue, the other will say there is no sky. The one thing that they really agree on at this moment in time is children and screens. I feel like we really started to make a little traction and now everyone's, oh my god, AI, and I'm getting a little nervous.

I'm wondering, you talked a little bit about what you have in plan. Can you talk a little more about any action steps that may or may not be in place to try to-- those of us who are really trying to get some guidelines, guardrails and now we're feeling like we have to leave it to the parents or some governors who are putting legislation through. Can you talk about are we really focused on this and what action steps that your organization has or partnerships to move forward with this. Because we're getting nervous, those of us who do what I do.

Dr. Shelli Avenevoli: We're a research organization. Our role is to try to fill gaps in the understanding, provide the knowledge base for the questions that people have. What are the right

ages, what are the context, what's the content that's problematic, et cetera. I can say that aside from the funding opportunities that we're doing, they're fairly broadly burdened right now because there's so much we don't know. Our partner, NICHD, is also doing a lot of large scale. They've developed centers that are focused on this topic, that A, B, C, D study that I mentioned is one of the areas that they're studying as well.

We're collecting data, but we're also just starting studies. That's only one piece is the research piece. What I hear from you is you're interested in how that's penetrating through other areas. I do think there's a lot of focus aside from the office of the Surgeon General. The Surgeon General released two reports that really highlighted the concern around the role of social media on the youth mental health crisis. There are a lot of discussions in work groups and task forces going on behind the scenes that I know of because we have NIMH members who are part of them.

Some of them are around guidelines for parents. How can we help parents or try to understand how these platforms should be regulated. We're at the table because we're trying to figure out what are the gaps we need to fill. Other people are at the table because maybe they have more leeway to move the dial a bit. I agree with you and I do think there's a lot of attention. It's always hard to know where things are going, but there's a lot of interest, a lot of energy, and a lot of attention in this space right now.

Dr. Don Grant: Thanks.

Dr. Mitch Prinstein: I'm also just happy to say that in addition to the amazing work that NIMH is doing and really helping more research, the KOSA Act has just unanimously made it out of committee and it's moving to the floor in large part thanks to the APA advocacy staff who were there every step of the way to make sure it's getting there. After the APA health advisory, we also have met with top brass at both Google and Apple, who literally have annotated the APA health advisory and sent it to all of their staff to create this year's goals for how they're going to work on these platforms.

Some of these things don't appear in the news, but there's actually a lot happening based on the research and the work that NIH has done, that APA has done on this. AI is a new shiny object everyone's looking at, but no one is forgetting what we need to be doing with screens too.

Dr. Don Grant: Thanks for reminding me

Dr. Shelli Avenevoli: Wonderful. Thanks, Mitch.

Dr. Erin Hambrick: Hello, I'm Erin Hambrick. I'm a clinical child psychologist and I study disaster trauma and other forms of trauma. With really the increase in both man-made and natural disasters and catastrophes, it's going to be increasingly a driver of health disparities. If we know there are significant and long-lasting mental health impacts, it's extremely hard to study our early interventions. I'm curious about mechanisms just in time funding, how NIMH is thinking about how in disaster strikes we can start to research early.

Dr. Shelli Avenevoli: Typically, in these situations, we've implemented urgent awards, which allow us to more quickly receive applications. We typically review them in-house and then can release the award. It's super cumbersome and that's why we can't do it for all things. In the case of a natural disaster, we've done that. In COVID, the pandemic was our most recent natural disaster, which we've funded a lot of work, and we found a whole variety of research, but we were also

trying within those contexts to move a little bit beyond what are the negative effects, because we know what--

You just summarized what we know. They have short-term effects on people. Some of those eventually go away for others, other people have prolonged, but there are vast social inequities and disparities in these situations, vast. It just exacerbates problems that we already have. We're really, and with the COVID money, really try to have the investigations focus on the intervention component. What can we do? What have we learned from past disasters? How can we test those now in these contexts?

I think that's probably where we're still going to be going because we're doing the work around the COVID pandemic right now. As you pointed out, there are going to be more natural disasters, and unfortunately more opportunities to try to identify that work. I think you're right; it's not just about figuring out what are the best interventions, but how can you do them in these contexts?

Dr. Erin Hambrick: How can you get them out there so quickly?

Dr. Shelli Avenevoli: Absolutely. We have a couple of good examples and even some good examples in our HIV/AIDS portfolio of how people continued HIV/AIDS care during the pandemic. There are models that we can use for all types of care. Thank you.

Dr. Mitch Prinstein: I've got a question for you. Thinking about your whole portfolio, what do you wish great applications fell from the sky to study? You're ready, you've got funding, it is a high priority for your office, and why aren't more people sending in applications? What would be your wish list?

Dr. Shelli Avenevoli: I think we're starting to tackle some of those. Mitch, you know my passion is in youth mental health. I wish we had more resources to do more of the studies that would help us unpack the crisis and really understand it. That would involve youth in the conversation. In social media, we actually require advisory boards of youth to be engaged in those applications because we're 40 or 50-year older, and what do we know about what's really impacting youth? That's my passion. If I had endless amounts of money, I would design a portfolio that really tries to unpack at a societal level why there's such a major increase in symptoms and disorders among youth.

I think we are moving forward in a few other areas. I do think that social media, I'm really glad, I know it takes sometimes money to influence people to come in, and we are able to do that in some spaces, but I would also really like to see an influx of applications in the youth intervention space that through scalable approaches, that can be tested at a large-scale level. Things that we know work, but we haven't quite been able to test at a large scale.

Gosh, there are so many, but I think through some of the additional money we've received over the past few years, which has been fantastic, we've been able to step up things like the precision psychiatry, whether you label it that or not. It's really not just limited to medications. It's really about how can we intervene and treat people most effectively faster and minimize their suffering? I think that's another critically important area. I could go on, but I'll stop there. Thanks, Mitch.

Dr. Jermaine Jones: People were allowed to submit questions beforehand, so I'll read one of those questions now. Can you reflect on ways NIMH has and has not been effective at increasing the diversity of the pipeline of clinical scientists and how NIMH hopes to further advance this goal moving forward?

Dr. Shelli Avenevoli: Again, we've had a lot of discussions at the NIH level, so this is not just NIMH, but I think we're all recognizing, and I alluded to this earlier, that a lot of what we were doing in the training space to try to enhance diversity was patchwork in a way to provide things that we thought people couldn't access, but instead realizing that these are systemic issues, that they're structural issues, and that we need to help change structures, and we need to do that on a large scale.

I think, as I mentioned, some of the UNITE initiatives really focus on addressing issues at a institutional or structural level. I think that's the major advance we're making. I also know that we're still learning and we're still open to feedback and suggestions, and we'll continue to engage with the community to learn how these things are working, but more importantly, what we're still missing and not engaging in.

Dr. Melissa Santos: Hi. Thank you so much. I'm Melissa Santos. I'm the President of Division 54, the Society of Pediatric Psychology. One of the concerns that many of our researchers within our division have is that much of their work is in the space of sexual and gender minorities, particularly around trans youth. How much do they have to worry about their research funding pipeline drying up, given the political climate?

Dr. Shelli Avenevoli: No one can read tea leaves but we continue to fund research. We have a robust portfolio in many areas, and particularly in the area of suicide research. We continue to operate as if there are no issues until we're mandated otherwise. We're not concerned right now and we continue to fund this important science.

Speaker: Thank you. Can you talk a little bit about how you would reflect on the impact of RDoC over the past little while and what you see about its future?

Dr. Shelli Avenevoli: That's great. I do wish Josh was here for this one.

[laughter]

Speaker: Sorry.

Dr. Shelli Avenevoli: No, I didn't mean that for political reasons. I meant mostly because when Josh came to us, it was one of his top three priorities. Remember when he came, he had three priorities, and one of them was an RDoC-like construct, but to make it-- an RDoC-like theme or initiative. The idea was to drive the current state of RDoC into more of a computational or data-driven approach. That is essentially what IMPACT is doing. IMPACT was one of the initiatives that I mentioned earlier, which is meant to take these constructs, test them in large populations of people, and take data-driven approaches to see what phenotypes are yielded in that sense.

I think we all understand that there are some aspects of clinical phenotypes based only on symptomatology that's not relating as closely as to the biology in getting us to the targets that we need to create new treatments. At the same time, we're trying to advance the notion of the original RDoC in new ways. That's where we are right now, is in more data-driven approaches in large populations. We're actually collaborating with the All of Us Study. Are you familiar? All of Us is the 1 million cohort that's supported by NIH broadly. It's a study of 1 million people in the US.

It takes health records and collects regular kinds of questionnaire-type data from individuals over time. We're actually integrating behavioral and cognitive tasks into that battery. We're testing that now. Actually, some of them have already been tested. The idea is to use the health records

combined with some of these behavioral and cognitive tests towards that effort to understand these underlying constructs that might get us closer to essentially optimizing treatments for individuals. I only wish Josh would be here because he's very passionate about this, so it would've been--

Dr. Jermaine Jones: Another pre-submitted question. Could you comment on the importance of animal research for NIMH's mission and what NIMH is doing to combat disinformation campaigns from opponents to animal research?

Dr. Shelli Avenevoli: Thank you for that loaded question.

[laughter]

It's been challenging. NIMH has supported animal research and continues to support animal research and feels that it is critically important to our mission. We do try not to support research in animals that is not necessary or that could be done in humans, and we've also not paid grants when something is purported in animals that is ready to be tested in humans. That said, we wouldn't make advances in particularly developing interventions if we weren't doing this research.

It's more challenging on how we try to communicate the importance of animal research. Josh has spoken on this issue numerous times, numerous roundtable discussions, trying to learn and understand both points of view. It's very difficult for us to-- We're not a political organization to have a-- I think we can speak to why it's important for science but it's not that we can do a lot more than that.

Dr. John Pachankis: Thank you. My name is John Pachankis. I'm at the Yale School of Public Health. Our country often seems to do a better job on studying mental illness than providing care to people who need it. The average person according to Tom Insel's book, once he left his directorship at the NIMH, said that the average person with mental illness in the US is either homeless or imprisoned. He also made cases of the world over, countries that do a much better job of caring for mental illness and have lower rates of remission, et cetera, or countries that provide a sense of meaning, purpose, and dignity, and housing to people, who suffer from mental illness.

I ask all this as a very grateful recipient of NIMH funds, but also on behalf of my students and family members, et cetera, who I think would like to be reassured that the funding priorities of NIMH, or at least at NIMH, also in its role of being the most aghast research institution for mental health in the world in a society that has not always gotten it right. Have people reflected on the former director's, "tell of them more" of this data of mental health research in the US vis-a-vis the reality that our country lives in but with mental health challenges?

Dr. Shelli Avenevoli: Thanks. I think that our view is that we think there are critical things that research can address, while at the same time recognizing and completely acknowledging that we can't force the evidence base into practice. As a government agency, we're siloed a bit. We do our part, we reach across the aisle to our other sister agencies to try to implement this evidence base. Sometimes it takes an act of Congress to get something moving, for example. That's where some of the advocacy comes in with this. I think that we completely acknowledge this guided piece.

I think what we're trying to do is change our research so that it's more ready to be deployed and put out there. Your colleague mentioned these pragmatic trials earlier. We have, in our clinical trial funding opportunities, we ask people on the services and interventions side to explain how it can fit within certain settings, and how it can be deployed at a larger level, and we require those elements

in that kind of research. We're trying to move all of the research in a direction so that it's as ready as it can possibly be. I would say, years ago, we weren't doing that quite as much.

We were much more focused on the traditional trial that's very clean, no method, make it as clean methodologically as possible. Now we're trying to say let's make this as practical as possible. I think that's the part that we're trying to do, is to help bridge that gap, but I also admit, and we fully acknowledge that we need partners. We do work very hard with many of our sister agencies. We have a great relationship with SAMHSA right now, trying to move some of these along. How can we do this? What will it take? Et cetera.

Dr. Raquel Rose: Hi, I'm Raquel Rose. I'm at NYU's Counseling Psychology PhD program, but also at Yale's TCC Center for Internship, and about to go on postdoc. I want to combine the retention of diverse scholars and the looking at structural contributions to mental health disparities. One of the things, I work with system impacted, crossover youth, and just recognizing that it's a very hard-to-reach population partially because of just how the juvenile justice system in the US is just a hot mess.

I'm wondering, for a postdoctoral scholar who really wants to use liberation approaches within psychology to not just focus on the symptoms like recidivism and a few other things, but to really tackle that through interventions. We're not even at the point of scalable interventions yet. A lot of the milestones I've seen from juvenile justice-related projects, it's like, how many kids have you enrolled? Are you following up? Kids move a lot. They get lost in the system.

As a postdoc scholar, I'm afraid to go propose my own research as a postdoc because if you have two years, that's going to be a hard project to implement. I'm wondering, what is the understanding of NIMH of these structural barriers to, especially a postdoc of color trying to do this work, but it's a needed intervention because we have so many black and brown youth still within the system who need this support, but the system itself doesn't support interventions for these youth? We're not even at the point of scalability right now. We're still at what works.

Dr. Shelli Avenevoli: We have a number of initiatives. I'm losing track of time with the pandemic. A few years ago, I would say, focus on the juvenile justice system. We had specific money set aside and we were trying to grow the portfolio in that space. We do have program staff in our intervention and services division with expertise in this space. I would encourage you to reach out because I think they're going to know better than I do, what the specific challenges are.

You can convey those challenges and they can provide guidance on what other investigators have faced and how they may have tackled some of those hurdles. Then also by your talking to them, informs us about what are the specific barriers, so that as we plan research going forward, we can try to plan around them or provide structure to be able to do some of those things.

Dr. Susan Collins: Thank you. I'm Susan Collins. I am the president-elect of Division 50. Addiction psychology and mostly our funding has come from the sister agencies. One thing that we're noticing, and I'm so glad everyone's bringing up the structural issues that are impacting people who are marginalized and minoritized. We work a lot with people experiencing homelessness and chronic homelessness especially in Seattle and on the West Coast, and I think everyone's seeing the media exposure on these issues, remembering, as I think many of my colleagues in this room have, those are our family, those are our community members, our neighbors who are slipping away from us and to this vast chasm.

One thing that we're a little frustrated with is that, as psychologists, we're trained to work with people individually versus structures. We've expanded through community-based participatory research methods to start doing community-level interventions. We're noticing that's also a band-aid. We need to go further as psychologists and really work structurally, and I think everyone's pointing that out.

I guess you mentioned you have great models that maybe you could point us to, as we as psychologists are trying to expand our efforts to work more structurally on the structural level versus on the individual or community level even. Are there good models you can point us to so we're not just doing these trials again and again where we enroll person by person or school by school, but that we're really tackling the issue on the larger level?

Dr. Shelli Avenevoli: It's an excellent question and a big problem. It's essentially the reason why the COMPASS program that I mentioned was developed before. To address something at a structural level, we need a lot of funding and a lot of participation. One institute alone is often not able to do this, and this is why it's an NIH-wide to try to address some of these issues. I urge you again, sorry, to refer you always to the website, but I think that is a great study that exemplifies what you're doing. I think that we're learning a lot and planning the different components of the COMPASS initiative, and we're going to continue to learn as it rolls out.

Dr. Jermaine Jones: Another question from another pre-submitted question. We understand that you have a role in coordinating NIH's research on climate change. Can you tell us more about NIH's interest in this topic and say more about how NIH's interest may help shape research on climate change and health?

Dr. Shelli Avenevoli: Sure. There is a climate change initiative hosted by one of our other institutes, but it is a collaboration across several NIH institutes. NIMH is one of them. It's not something we're tackling alone. Admittedly, we don't have a lot of in-house expertise in this space. It's not something that we've had a big part on. We're really working collaboratively across NIH to try to identify the important things. One of the issues that's important to NIMH is what your colleague just mentioned, is natural disasters.

This is an obvious result of climate change and something we're going to be tackling, and it's just going to exacerbate our own problems at home in terms of mental health. That's a major focus area there. I would say that's probably our primary focus and we're still developing the programs in that space, so there will be more to come. There have been initiatives out there, but you'll start seeing more together in collaboration with our other institutes and centers.

Dr. Jermaine Jones: Anyone else?

Dr. Donte Bernard: This is part of the room. Good morning. My name is Donte Bernard. I'm an assistant professor at the University of Missouri. I have a question about the 2031 goal to eliminate health disparities. I think it's an admirable goal. I'm also wondering what objective markers is NIMH putting in place to say, "Yes, we've reduced that"? Particularly thinking about my research, I look at racism and health, as we know about the legacy of racism that's persisted in our country for years. Thinking about ending health disparities in 10 years, how is that happening? What's happening at NIMH, and how are we going to do it? Then what happens after 2031 to continue the reduction or elimination of health disparities?

Dr. Shelli Avenevoli: Excellent questions. NIMH is not going to reach that goal alone. That was a goal that was put towards us, but again, we're only going to be able to fill the gaps in the literature

about how we might approach some of those issues. If you take a look at the framework that I told you about online, it really does list our research. What we see right now is our research priorities.

We're going to have to refine those research priorities over time as we learn more. We're going to have to also be part of conversations that are much broader than that around things we've already been talking about, about implementing some of the evidence base in ways that can move the dial. Again, it's not going to be something that we can do alone. I think I missed a part of your question. Did I?

Dr. Donte Bernard: It's a multi-parter, right?

Dr. Shelli Avenevoli: Yes.

Dr. Donte Bernard: I think what is happening, I'm familiar with the framework that's there-

Dr. Shelli Avenevoli: Good.

Dr. Donte Bernard: -and I've seen that. I think my question is how do we know when those things have been accomplished?

Dr. Shelli Avenevoli: Milestones.

Dr. Donte Bernard: Milestones that are there given many of the priorities listed in the framework.

Dr. Shelli Avenevoli: Admittedly we're not quite there yet. The idea was to get the priorities out there. The next step is going to be developing an implementation plan for how we're going to roll these things out over time and how we're going to set milestones, evaluate ourselves, and really hold ourselves accountable on top of that. We're not quite to that phase yet, but it's an excellent point and something we are getting to.

Dr. Ben Handen: Hi. I'm Ben Handen from University of Pittsburgh. One thing that I've seen changing is the desire to have stakeholders involved in projects, even in the conceptualization stage. I'd like to hear more about what NIMH is looking from those of us submitting grants, thinking about grants in terms of involving stakeholders, clients, et cetera, throughout the process.

Dr. Shelli Avenevoli: Absolutely. Right now, we have focused that effort in specific areas where we know it would be most beneficial to gain traction. We haven't made a blanket statement per se, that everyone should always engage stakeholders. We focused on efforts around interventions and community-based health and health disparities, and youth mental health issues, particularly the social media.

Things that in many levels we should have all known these things a long time ago and should have been more actively doing them but we've come collectively, I think as a scientific community too, to recognize that this is a critical element that's likely to bring us to change. Again, not a blanket statement, but we're really focused in very specific areas to gain traction right now. That doesn't mean you shouldn't consider that in your own research if you think that's important.

Dr. Jermaine Jones: Related to that, one of the pre-submitted questions was, is there an area of NIMH's portfolio where you feel like there isn't enough interest or there aren't enough applications being received from psychologists?

Dr. Shelli Avenevoli: Oh gosh. Every program officer, I think would have a different story, because I think it depends on how deep you go. When you get into the details, a specific program officer managing a portfolio or a topical area is going to say, oh, if we need this, why can't we get it? If we had endless amounts of money, we would probably have 100 notice of funding opportunity announcements out at a time. We recognize these gaps and try to fill them. We also try, within our strategic plan, we have those strategic research priorities, the more fine-grained several levels down.

Those are things that we use to try to articulate what we think are the gaps. A lot of times it's not just the gaps in the science, but it's the kind of research. I mentioned, like with social media, we are getting some of that, but now we are trying to challenge people to take more fine-grained approaches and put it in a context, the social media use in context and really consider a wider host of factors and elements, and use new methodologies implied. It's not always a whole gap area, but it's often the kind of science that we need to push the field forward just a little bit. We do that when we can with funding opportunity announcements, but we don't have the resources to do it in every area every year.

[silence]

Dr. Micky Koffarnus: I'm Micky Koffarnus, University of Kentucky. You mentioned earlier that certain of the priority areas for grants sometimes require more outside-the-box thinking, and these approaches don't necessarily always review well at study section. Can you talk a little bit more about that, and strategies at an individual level to overcome this economy, and maybe strategies on a more institute level to marry some of these research priorities and the outside-of-the-box, or the more complicated research methods that might not fare so well at review?

Dr. Shelli Avenevoli: I think there are two main strategies. One is what you all know is typical. If we have a notice of funding opportunity announcement with money attached, we can create a peer review group that's focused on that particular notice. You can then seek out people who have that broad thinking for reviews. I think a more general approach that we're trying to take both at NIMH and NIH, which speaks to the structural issues we've been talking about, is to just diversify our reviewer pool.

We've been working so hard through a variety of methods within NIH as well to diversify our pool. Diversify in all ways so that we get people from all sorts of different backgrounds and perspectives, and expertise, and training, and institutions, and locations in the country to be able to contribute to that. I think that's the slow-moving way of doing it, but I think it's the critical way because we always want to have that broad and diverse perspective within all of our reviews, not just for these more innovative ideas.

Dr. Terry Keane: Again, Terry Keane. Thank you again. This has been so informative. This is in the vein of a public service announcement. I did want to just emphasize that among my various roles in life, is that I serve as the President of the American Psychological Foundation, which is a pretty remarkable little entity in that it provides small grants to people who have incredible potential but struggle to get their first NIH or NIMH grant. These grants, we give out more than 100. There are 90 different programs. We have a website, please go. Many people here and Gill Beck is a board of trustee member as well. This is an amazing opportunity.

We have so many examples of publications and subsequent first grants from the NIMH. Even remarkable awards going to these young people. It is competitive. I must tell people that it is competitive, but please encourage your students to look. For those of you in a position, please

encourage yourself to contribute and donate. Because this is philanthropy. This is money that people give at a very hard-earned dollars and can serve in so many useful ways for launching people's careers. I do want to encourage people. The goal has been, for now 20 years, 20-plus years to help people. That 44-year first NIH grant is to try to help people get the pilot data needed. It's early career-focused, although graduate students are also quite eligible. Thanks for that.

Dr. Jermaine Jones: Anyone else?

Dr. Kim Boller: Hi, Kim Boller, APA. What is your take on the big science movement, and as an input to open science as well? What is NIH doing to make this happen? Things like the Many Babies Project global work.

Dr. Shelli Avenevoli: I haven't really thought about it as my personal opinion of it. I do think that NIH broadly recognizes that to accomplish some of our goals, we need these large efforts. All of it is as a great example. That's about precision medicine overall. You can't accomplish that-- There are just questions you cannot answer on a small scale. I think we're supportive of that. The real question or challenge, I think, across NIH is very much about how do you balance the portfolio towards those kinds of efforts, and then the investigator-initiated efforts as well. I do think we support that notion in general. There are often a lot of common fund initiatives also that I think reflect that perspective as well.

Dr. Mary Dozier: Mary Dozier, Mississippi State University, which I would say I'm somebody who got an APS grant and then was able to get NIH.

Dr. Shelli Avenevoli: Great. Congratulations.

[applause]

Speaker: You did. I did too.

Dr. Mary Dozier: I absolutely would not have gotten NIH grant without that pilot funding. I just, based off of the last question, finished my first NIH data archive submission, which was awful. I was wondering if y'all have any thoughts about how it'll be better going forward?

Dr. Shelli Avenevoli: I think we would appreciate, not here, but in another venue, your precise feedback on what was awful about it, what was challenging. I think we are aware of some of the challenges and trying to address them, but we also might not be aware of all of the challenges.

Dr. Mary Dozier: I know my statistician has sent me an email to the help desk.

Dr. Shelli Avenevoli: It's a great question. I'm actually going to ask the person who runs that, how many of those help questions things we get. That information. Either way, feel free to send that information. I don't want to invite it all coming to me, but if you don't have another person to send it to, send it to me because I think we really need to know what is challenging and what's not, and in order to make sure we're fully addressing the problems. Thank you for your comment. I'm really sorry for the challenges, and I can tell you we're trying to work on some of the things behind the scenes.

Dr. Jermaine Jones: I think with that, we can end a bit early. I just wanted to thank Dr. Avenevoli for coming here to represent NIMH, and all the other individuals who help organize this event; Pat, Julianne, Mitch, and the science directorate. You've been amazing as well. You all for showing up

and making this a really lively and interesting discussion. With that, we'll give you a few more minutes to get back to you and enjoy some APA fun.

[applause]

Dr. Shelli Avenevoli: Please join us in our anniversary celebration. Really encourage you and I hope that you become part of that. Listen in, comment, and participate. Thanks.