

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
Center for Substance Abuse Prevention

Open Session Minutes of the
Center for Substance Abuse Prevention National Advisory Council Meeting

August 14, 2013

Rockville, Maryland 20857

OPEN SESSION MINUTES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention National Advisory Council
1 Choke Cherry Road/Rockville, Maryland 20857
Seneca Conference Room

August 14, 2013
(9:30 a.m. – 3:45 p.m.)

Attendees

Council Members Present: John Clapp, Ph.D.; Michael Compton, M.D.; Eugenia Conolly, M.Ed.; Michael Couty, M.A.; Steven Green, L.C.S.W.; Michael Montgomery, M.Ed.; and Patricia Whitefoot, M.Ed. (by telephone).

Ex Officio Council Members Present: Fran Harding, Pamela S. Hyde, J.D.

Designated Federal Officer: Matthew J. Aumen

Call to Order

Mr. Matthew J. Aumen, Designated Federal Officer, called the meeting to order on August 14, 2013, at 9:30 a.m.

Welcome and Opening Remarks

Ms. Frances M. Harding, CSAP Director, welcomed participants, noted that SAMHSA Administrator Pam Hyde would join the meeting shortly, and introduced Suzanne Fields, Senior Advisor to the SAMHSA Administrator for healthcare financing, as a guest speaker.

Prevention in the Context of Health Reform

Ms. Harding noted that the Affordable Care Act focuses on wellness rather than looking at disease only. This aligns nicely with the Institute of Medicine levels of prevention. Beginning in 2014, the Affordable Care Act will mainly, at least at the start, look at services to be covered by Medicaid and by insurance companies. CSAP has formed a workgroup which includes staff members from the Center for Mental Health Services (CMHS) to talk about primary prevention's place within health reform moving forward. This is a pressing issue because most of the states that will be implementing health reform in 2014 are looking at coverage.

The CSAP workgroup's priorities are to emphasize healthcare benefits under the Affordable Care Act that are preventive in nature and to connect healthcare providers to prevention resources in communities.

The workgroup is engaged with Ms. Fields to develop informational briefs and material that states and communities will be able to use to give them ideas. A key question is whether it is more important to be funded or to understand where behavioral health fits within the overall health of the country moving forward.

Ms. Fields stated that she works with various federal partners related to the Affordable Care Act to ensure the inclusion of mental health and substance abuse. Prevention has the most opportunity to connect the current emphasis on the healthcare benefit of prevention services to broader prevention issues, including environmental or community-based initiatives, and a broader services- integration strategy.

The Surgeon General's National Prevention Strategy includes investments in workforce, community demonstrations, and an emphasis on educational campaigns related to health and other prevention efforts. A 20-agency National Prevention Council provides a focus on a federal strategy related to prevention. The Affordable Care Act puts a heavy emphasis on healthcare prevention benefits and related changes in the healthcare industry. The prevention field has shown added value in health outcomes and cost effectiveness.

Discussion. Ms. Hyde responded to a question from Mr. Michael Montgomery about the impact of sequestration on SAMHSA. The impact has been mainly in constraining grant awards, repurposing funds to undertake new activities, and engaging in belt-tightening and efficiency measures. Uncertainty remains regarding the 2015 budget as 62 million people will have more coverage for behavioral health through the Affordable Care Act, yet some things will not be covered. Meanwhile, SAMHSA is asked about moving some of its block grant dollars to other purposes.

Referring to his work as a court administrator trying to collaborate with child welfare, Mr. Michael Couty asked how collaboration can be encouraged from the federal level to the state, and how the use of assessment tools and instruments can be expanded.

Ms. Hyde replied that SAMHSA has partnered and collaborated at the federal level in the juvenile justice area, including Larke Huang's work with the Department of Justice (DOJ) and the Administration for Children and Families (ACF). She pointed to a 10-year history in developing models and ways of approaching child trauma. Partnering with ACF has included technical assistance, data gathering, and providing SAMHSA's models to ACF's grantees. SAMHSA, ACF, and the Centers for Medicare & Medicaid Services (CMS) have sent a three-way letter regarding child trauma to all the states and authorities in the three agency purviews.

Larke Huang is doing a lot of work with staff in the juvenile justice area. Along with the MacArthur Foundation, SAMSHA recently conducted a juvenile justice policy academy with several states. Another policy academy with tribes, in cooperation with the Bureau of Indian Affairs and DOJ, focused on how to address youth without using a facility-based approach.

Mr. Couty said there should be feedback to SAMHSA from the behavioral health entities on how collaboration is being done at the state level. Ms. Hyde replied that SAMHSA has required in its requests for applications that states have a partner at the county or coalition level, and that coalitions show how they are fitting in with the states' directions. SAMHSA has received some feedback in this area. SAMHSA also is making efforts to facilitate links between state mental health and substance abuse authorities and insurance commissioners and Medicaid authorities.

Ms. Harding observed that SAMHSA is learning from states about collaboration on three levels: connecting prevention programs at a community and a state level in order to meet the medical community

as one behavioral health system; behavioral health becoming part of primary care; and becoming part of and recognized by clinical health.

The informational, or info, briefs mentioned by Ms. Fields will highlight difficulties and successes from states and communities. The briefs will help states and communities as well as primary care and clinical partners to understand issues such as evidence-based programs and how behavioral health ties into treatment of diseases such as cancer. The info briefs are also going to be very useful to help people understand preventative medicine and programming versus prevention programming. Ms. Harding added that the central focus of prevention is that which is funded under the block grant. However, some preventative services like the assessments Mr. Couty referred to and other interventions like SBIRT, can be funded with discretionary dollars.

Mr. Couty raised the issue of non-violent drug offenders and how they are being sentenced, a topic that Attorney General Holder talked about recently. It was noted that prisons continue to experience overcrowding. As a result, there will be an increased need for prevention and working with the families. Many tools exist but they don't get to the community. Ms. Hyde replied that serving these individuals requires a coordinated effort between all healthcare discipline workforces.

Ms. Hyde returned to budget issues noting that the block grants are 60 percent of SAMHSA's budget followed by the high-priority HIV-AIDS and children's mental health portfolios. As a result, budget impacts will fall on smaller programs.

Ms. Fields returned to the issue of collaboration. She pointed to the opportunity to think about how we collaborate differently with purchasers of healthcare such as Medicaid directors and state insurance commissioners. These parties are making important decisions about what to buy and what to cover in health benefits. The inclusion of community-based initiatives and a focus on whole individuals should be included. The planned info briefs will focus on those state purchasers who may be thinking narrowly about the healthcare benefit.

Ms. Hyde observed that the Affordable Care Act has brought about a National Prevention Strategy. Substance abuse and mental health issues are integrated within roughly about half of the strategy including tobacco-free living,; alcohol, underage drinking, mental and emotional well-being, reproductive and sexual health, and injury- and violence-free living.

Ms. Harding asked Dr. John Clapp for questions or input on prevention issues in higher education. She mentioned SAMHSA's heightened focus on this setting and referred to the continuing challenges of underage drinking, a focus on prescription drug misuse, and the growing issue of marijuana.

Dr. Clapp concurred on these challenges and said there is a gap in the translation of science to practice and in the support and training that colleges and universities and professional staff need in implementing programs that work, especially in the current environment of fiscal retrenchment in academia. While campuses are required to use evidence-based approaches, their ability to implement them has declined over the last five years.

Ms. Hyde added that finding the best way to get information out is challenging, given the different emphases and audiences of federal agencies. As it continues to develop its website, SAMHSA is working to have its name just as well-known as the Centers for Disease Control and Prevention (CDC) regarding

health promotion and prevention. She asked if it would be more helpful to have different resources such as CDC, the National Institute on Alcohol Abuse and Alcoholism, and SAMHSA, or to have a central federal source.

Dr. Clapp said people are looking for a single “go-to” place for reasons of ease and consistency of message. However, whatever approach is taken, identifying best practices and how to implement them is vital. Moreover, evidence-based practices are often too expensive to implement; campuses need ways to be effective on a shoestring budget.

Ms. Hyde replied that this is a topic for added work on informational briefs. Ms. Harding added that bringing mental health and substance abuse services together is a more intense challenge on a college campus. SAMHSA has not done much work with higher education. It was in bailiwick of the Department of Education but there is a void to be filled.

Ms. Harding returned the discussion to the broader topic of health reform and its implementation, asking council members for guidance on issues or matters to address related to behavioral health.

Mr. Steven Green asked Ms. Hyde about the Institutions for Mental Disease (IMD) exclusionary rule and whether it will be addressed through mental health parity. She replied that it will not be addressed in mental health parity because Medicaid and Medicare are not subject to parity. An IMD demonstration is underway to test it out in a very narrow situation that was put into the Affordable Care Act. Discussions involving the Secretary at the Department of Health and Human Services (DHHS) have touched on the lack of both enough beds and enough crisis intervention services.

Ms. Fields said SAMHSA is preparing an info brief related to the financing of mental health and substance use crisis- oriented services. The aim is to determine how to best target the state purchasers who are making decisions about such an important service.

Mr. Green suggested that as capacity and availability are discussed, to look at some of the needs of Indian Country when it comes to IMD exclusionary rules. Ms. Hyde mentioned a recent policy academy with tribes on how to provide community-based services to avoid inpatient services that cannot be paid for. The recently created SAMHSA American Indian Alaska Native Team (SAIANT) is another venue to look at such issues.

Ms. Fields returned to the subject of prevention opportunities under the Affordable Care Act, specifically how the agency operationally supports states regarding decisions and implementation involving the medical community, the mental health and substance use provider community, and the broader community. She reiterated a call for input on the priority of what information to direct to state purchasers about the broader prevention realm as it relates to the healthcare benefit. Recommendations on other levers to capitalize on the opportunities within the Affordable Care Act are also needed.

Ms. Harding asked for input on combined behavioral health, observing that some states are way ahead and have embraced it seamlessly as a second language while others are struggling. Likewise, colleges appear to be struggling most.

Ms. Harding announced Mirtha Beadle as the Center for Substance Abuse Prevention’s new Deputy Director, effective August 26. She is currently working in the Office of the Administrator.

The SAMHSA of the Future

Ms. Harding said that SAMHSA is looking at the possibility of reauthorization for 2014. She also stated that SAMHSA is planning to reduce the strategic initiatives to five in 2014; some of the goals set out for the last four years have been met, and some of the current strategic initiatives will be consolidated into others. Further discussion of the strategic initiatives and the corresponding Leading Change document would ensue in the afternoon.

Discussion. Mr. Montgomery asked about the political strategy on reauthorization. Ms. Harding said that because the treatment systems and other activities SAMHSA is responsible for will be affected so directly by health reform, SAMHSA will need to look at how the agency is authorized and see if improvements can be made. For example, SAMHSA is looking at behavioral health overall, despite the budget being split between mental health and substance abuse.

Ms. Harding referred the Council to a set of questions about SAMHSA's future with the results of the discussion to be reported out at the joint advisory council meeting the following day. Given the current behavioral health climate, members were asked to consider mental health disorders along with substance abuse.

Question 1: If you as a SAMHSA National Advisory Council member could help design a federal public health agency that advances the behavioral health of the nation, what would that agency look like to you?

Mr. Montgomery said there is not one lead agency that oversees substance abuse policies nationally, which may not be the most productive way to promote substance abuse prevention. Mr. Green concurred with the idea of a lead agency, noting lack of coordination regarding Indian health services. Ms. Eugenia Conolly agreed that SAMHSA should be the behavioral health entity for the nation while continuing efforts to integrate its Centers.

Dr. Clapp said merging behavioral health and prevention requires a coherent conceptual framework and leadership. The key to integration under an umbrella is a coordinating body to harmonize key components including programming; policy development and analysis; and research, evaluation and dissemination. He added his opinion that SAMHSA may have to be reorganized because of mental health programming that focuses on mental illness rather than early intervention and identification that includes substance abuse.

Question 2: Review the SAMHSA draft proposed FY 2015-2018 Strategic Initiatives. What comments, recommendations, and priorities do you have?

Ms. Harding identified five proposed Strategic Initiatives: prevention of substance abuse and mental illness; health systems integration and financing; trauma and justice; recovery support; and health information technology. No specific comments or objections were raised.

Question 3: What changes in statute do you think are needed to shape SAMHSA to be the behavioral health leader in a post-Affordable Care Act world?

Mr. Montgomery suggested having language and statutes that give SAMHSA the ability to be involved in the decisions that are made in other agencies that have SAMHSA related activities. Ms. Harding noted the

difference between statutes and Dr. Clapp's earlier comment about guidance or policy; she asked members to think about it.

Question 4: Given the short mid-term prognosis is for the same or less federal funding, should the structure and balance of the SAMHSA budget change? For example, the current split in funding is generally 70% substance abuse and 30% mental health. Should this split continue in the foreseeable future? If not, how would you change it?

Mr. Couty said there should be set percentages of funds for substance abuse and mental health to ensure attention to certain issues.

Ms. Conolly favored separating out prevention and said its profile needs to be raised. Funding percentages could change as prevention becomes reimbursed more through health reform. Prevention also could get a higher percentage of funds set aside for services not covered by health reform. Prevention funds could be separated out within substance abuse and within mental health based on clarification of promotion and resiliency.

Ms. Patricia Whitefoot (by telephone) said data should be used to decide funding percentages.

Question 5: SAMHSA acts on its mission and vision by: a) providing leadership and voice for and about behavioral health, b) conducting surveillance and reporting data, c) improving practice, d) setting standards and regulating programs, e) providing information to the public and the field, and, f) providing funding to states, tribes, territories and communities. Of these roles, SAMHSA is generally best known as a grant making organization. Which of SAMHSA's other roles would you emphasize most in the future?

Mr. Couty stated that SAMHSA should be setting the standard of care on how dollars are being spent on mental health and substance abuse issues wherever those dollars are being spent. Such a role would be consistent and permanent.

Ms. Whitefoot agreed that regulatory oversight is critical but also wanted a strong emphasis on inter-agency collaboration and partnership. Ms. Conolly supported a regulatory oversight for SAMHSA but also wanted a strong technical assistance role to support evidence-based practices and programs.

Question 6: To ensure that SAMHSA's greater emphasis on future roles is effectively implemented, how should SAMHSA optimize use of limited staff and what type of staff development would be necessary?

Ms. Whitefoot said there is a need for greater training and attention to what government to government relationships mean with respect to treaties and agreements tribes and territories have with the federal government. This information should be integrated in communication with states and the local tribal level.

Question 7: As SAMHSA looks towards the future, recognizing limitations on expenditures for meetings and other funding limitations, how should SAMHSA optimize its relationships with its stakeholders and how can it best use its National Advisory Council members?

Ms. Whitefoot supported more teleconferencing to facilitate participation in meetings. Dr. Clapp said that, working as a leader with federal partners, SAMHSA could look to coordinate resources. Multi-agency sponsored meetings of advisory councils could be cost effective and improve collaboration.

Question 8: The healthcare fiscal and research landscapes are always changing. These contextual issues and future drivers have implications for SAMHSA. What do you see as drivers in the next three years that SAMHSA should be positioned for?

Ms. Whitefoot said that research coming from diverse ethnic communities should be brought to the federal level and reflected in the regulatory function.

Dr. Clapp said that much research is waiting to be translated into practice and that SAMHSA could take a leadership role in getting this knowledge out in the field.

Mr. Montgomery asked what SAMHSA's role is in making sure that the evolving needs of special populations are met. For example, what is being done to address prescription drug and alcohol abuse as the older adult population grows, how will Medicare address those issues, and how can SAMHSA inform agencies?

Ms. Harding noted that coordinating primary care and general medicine with the work that is done in behavioral health prevention will need to be more thought out. Special populations are in all of SAMHSA's grants and contracts but this conversation indicates that it should be more widely articulated.

Ms. Whitefoot asked whether there is a person or group at SAMHSA focusing on school-related work and special education needs. She observed that prevention research does not cross over to the social work side of special needs populations especially in communities with high rates of substance abuse.

Ms. Harding asked the Council members to think about what issues in the eight questions are most important for the NAC to report out during the joint council meeting. It was agreed that discussion points from questions one, four, five, and seven would be appropriate to provide to the joint council.

It was agreed that one priority is for SAMHSA to position itself to be the lead federal agency on behavioral health which is to include mental health and substance abuse across a continuum of care. That role would involve policy research, coordination, and standard setting. Dr. Clapp noted that it will be important to maintain a focus on individuals and special populations along with a larger scope of prevention that includes environmental strategies.

Ms. Harding noted that discussion of Question four brought out the importance of primary prevention- be it universal, selective, or indicated- as money shifts and coverage changes. This emphasis brought agreement that this item would be the second priority for the report out.

Approve Minutes from April 10, 2013 Meeting

The minutes were approved as moved by Dr. Clapp and seconded by Ms. Conolly.

Strategic Initiatives on Prevention: 2015 and Beyond

Ms. Harding led the discussion on the topic of SAMHSA's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness. Subtopics included major accomplishments through FY 2013, select metrics, sample tasks for FY 2014, and proposed next steps for FY 2015-2018.

Key points elaborated from Ms. Harding's presentation included: moving away from the term, preventing mental illness, and toward using 'build emotional health;' working with CDC to address adult problem

drinking; the approval of SAMHSA's Drug Testing Advisory Board recommendations to expand the use of a drug testing panel; Prescription Drug Monitoring Programs as a multi-agency effort; expanding state policy academies to all states and tribes in cooperation with CMHS; and conducting a pilot project for the evidence-based, Strengthening Families II Program.

Discussion. Mr. Montgomery suggested a more strategic focus on marijuana such as concentrating on abuse rather than use and on juvenile use. Ms. Harding replied that the Office of National Drug Control Policy has the lead on such directions but marijuana is being included as a focus within CSAP grants.

Ms. Conolly said that training for healthcare professionals and practitioners should be complemented by training for people in communities. Ms. Harding replied that there will be a policy academy on workforce development in September and that SAMHSA works with the Health Resources and Services Administration (HRSA) on workforce issues. She asked whether the Council should reconsider including workforce in the report out.

Dr. Clapp noted that there is not much technical assistance on what works, regarding college drinking. He suggested disentangling the K through 12 and college programs from the Department of Education, and using an approach congruent with the Strategic Prevention Framework in a grant program to inform implementers what to do.

Prevention Implications—Hot Topics (Substance Abuse Block Grant and DTAB)

Dr. Clarese Holden, Acting Director of CSAP's Division of State Programs, reviewed improvements for the two-year 2014-2015 state block grant application. SAMHSA's mental health and substance abuse block grants are being combined into one application process to lessen the burden of completing separate applications for each. The 2014 block grant application is due on September 1, followed by a report due December 1 (April 1 in 2015). In 2015, the application will include a form to describe the applicant's goals and the plan for that year. States are asked to set-aside at least three percent of each block grant to increase the capacity of mental health and substance abuse service providers to bill public and private insurance, and to support enrollment into health insurance. States are asked to use at least five percent of their mental health block grant funds to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention, and early intervention. Changes have been made to streamline the application process, clarify primary prevention activities, and answer states' questions.

Discussion. Ms. Conolly praised the new five percent provision for mental health promotion and prevention noting the obstacle of not having a prevention set-aside in mental health. Ms. Harding replied that funds cannot be mixed for substance abuse- and mental health-specific activities but there is a small circle of overlap.

Ron Flegel, Director of CSAP's Division of Workplace Programs (DWP), provided the council with a presentation on the Drug Testing Advisory Board (DTAB). Topics covered included the history of oral fluid in the federal drug testing program; DTAB's process for evaluating the scientific supportability of the oral fluid specimen for federal workplace drug testing; proposed revisions to the Mandatory Guidelines for Federal Workplace Drug Testing Programs (Mandatory Guidelines); and studies in support of SAMHSA's initiatives.

Mr. Flegel elaborated on several points. The DWP oversees the regulated guidelines for all federally regulated testing including the National Laboratory Certification Program and oversees all Drug Free Workplace programs within the federal government. The DTAB is an advisory committee chartered by the SAMHSA Administrator. Mr. Flegel noted that technology has moved very quickly over the last 11 years, especially concerning the ability to test oral fluid and hair for illegal substances. What is detectable in oral fluid is not necessarily what can be detected in urine. Dosing studies help avoid positive test results for legitimate use of prescriptions, consumer products, or passive exposure. In 2011, DWP began working on a number of recommendations, such as including oral fluid in drug testing, as well as including oxycodone, hydrocodone, oxymorphone, and hydromorphone (synthetic opioids) in the Mandatory Guidelines.

Discussion. Ms. Harding said she had been asked about DPW's placement within CSAP but it has become clear that this is a prevention program.

Public Comment Period

Jane Goble-Clark, Executive Director of the Center for Prevention Services in Charlotte, NC, asked if training of trainers could be put in place across the nation at the state level as well as for local levels so that people there can do outreach on prevention and health reform. She also asked whether a percentage of the mental health and substance abuse budget be set aside for integration of the two as elements of behavioral health. Lastly, she noted that without designated money, it is difficult for state and local agencies to implement integration.

Adjourn

Ms. Harding recognized four NAC members who are retiring from the Council: Michael Couty, Eugenia Conolly, Kwesi Harris, and Patricia Mrazek.

The next meeting is scheduled for April 2, 2014. The council reconvened at 4:00pm for a closed-session grant review.

I certify that to the best of my knowledge, the foregoing minutes are accurate and complete.

/s/

Date

Frances M. Harding
Chair
CSAP National Advisory Council