

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

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

August 24, 2016

Rockville, MD 20857

**Meeting of the
Center for Substance Abuse Prevention (CSAP) National Advisory Council (NAC)**

Substance Abuse and Mental Health Services Administration (SAMHSA)
CSAP
NAC
5600 Fishers Lane

August 24, 2016
(9:30 a.m.–4:30 p.m.)

Chair: Frances M. Harding

Designated Federal Officer Present: Matthew J. Aumen

Council Members Present: Anton Bizzell, M. Dolores Cimini, Pamela Drake, Scott Gagnon, Dianne Harnad, Stefano “Steve” Keel, Michael Lindsey, Valerie Mariano, Craig PoVey, Kathleen Reynolds

Council Members via Telephone: Ruth Satterfield

In-Person SAMHSA Staff: Jennifer Fan, Ron Flegel, Gregory Goldstein, Clarese Holden, Jorielle Houston, Jewel Marsh, Charles Reynolds

Call to Order

Frances M. Harding called the meeting to order at 9:30 a.m.

Welcome, Introduction, and Opening Remarks

Ms. Harding thanked NAC members for their attendance and participation, provided an overview of the meeting agenda, and recapped Tuesday’s discussions, stating that the landscape and workforce conversations were rewarding and helpful for setting up today’s discussion. She noted that it is a pivotal time for prevention and for determining how SAMHSA can move forward with its agenda. She addressed the ongoing crises of drinking among young people and fentanyl misuse.

Minutes Approval

Mr. Aumen requested a motion for approval of the February 24, 2016, minutes. As moved and seconded, the meeting minutes were approved without dissension.

CSAP Updates

Division Directors, CSAP

The SAMHSA Center for Substance Abuse Prevention (CSAP) Division Directors provided NAC members with an update on activities within their departments. Jewel Marsh, Director of the Office of Program Analysis and Coordination (OPAC), presented first. Ms. Marsh reported that the division actively supports human resources functions, NACs, budgets, contracts, and grants. Ms. Harding noted that OPAC is involved in every CSAP activity.

OPAC supports CSAP’s implementation of programs and policies through

- Administration, analysis, planning, and coordination of CSAP's programs;
- Representation in the agency's policy, planning, budget formulation and execution, program development and clearance, and internal and external requests; and
- Coordination of staff development activities and analysis of the impact of proposed legislation and rule-making.

Charles Reynolds next presented on the Division of Community Programs. Mr. Reynolds has served as Division Director for 6 years. His division's main programs are Substance Use and HIV Prevention, the Drug-Free Communities (DFC) Support Program, and the Sober Truth on Preventing Underage Drinking (STOP) Act grant program. The DFC Support Program has provided funding to more than 2,000 coalitions, mobilized more than 9,000 volunteers, and provides funding to community-based coalitions to organize and prevent youth substance abuse. It is overseen by the Office of National Drug Control Policy (ONDCP) and is managed by CSAP. It is governed by the idea that local problems are best solved locally. The program's goals are to

- Establish and strengthen collaboration among communities, public and private nonprofit agencies, as well as federal, state, local, and tribal governments to support the efforts of community coalitions working to prevent and reduce substance use among youths; and
- Reduce substance use among youths and, over time, reduce substance abuse among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance misuse.

Grants awarded through the DFC Support Program are intended to support established community-based coalitions capable of effecting community-level change. DFC coalitions must target multiple drugs: alcohol, tobacco, prescription drugs, and marijuana. Coalitions can ask for up to \$125,000 per year and must provide at least a one-to-one match (cash, in-kind, donations, but not federal funds except for certain tribal governments).

The STOP Act was created in 2005. Its three main pillars are as follows:

- The Interagency Coordinating Committee on the Prevention of Underage Drinking;
- Underage Drinking Prevention National Media Campaign; and
- Community-Based Coalition Enhancement Grants to Prevent Underage Drinking.

STOP Act grants are intended to strengthen collaboration among various sectors of a community to reduce alcohol misuse among youths. They work to enhance the ability of established community organizations to create sustainable community-level change regarding underage drinking. Funding is provided for up to 4 years, at a maximum of \$50,000 per year, with no match required from the grantee. There are currently 97 funded grantees. New fiscal year funding will include up to 80 new grantees.

The Minority AIDS Initiative (MAI) was created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. The MAI's principal goals are to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and to reduce HIV-related health disparities. The program now also addresses hepatitis in the same communities.

The MAI program's goals are to

- To support an array of activities to assist recipients in building a solid foundation for delivering and sustaining quality and accessible state-of-the-science substance use and HIV and hepatitis prevention services; and
- To engage community-level domestic public and private nonprofit entities, tribes, and tribal organizations to prevent and reduce the onset of substance use and transmission of HIV/AIDS among at-risk populations, including racial/ethnic minority youths and young adults.

Mr. Reynolds discussed the HIV Capacity-Building Initiative (HIV-CBI), a capacity-building initiative for substance abuse and HIV prevention services for at-risk racial/ethnic minority youths and young adults (ages 13 to 24 years old) through cooperative agreements.

Mr. Reynolds then discussed minority-serving institutions (MSIs) in partnership with community-based organizations. MSIs have the greatest likelihood of achieving success because they have ready access to minority students needed to provide them with routine HIV/hepatitis C virus (HCV) screening, testing, and prevention education and information on substance abuse, HIV, and HCV. MSIs also have experience in working collaboratively with minority community-based organizations in surrounding communities to achieve prevention goals.

In reviewing the Tribal Applicant Workshop effort, Mr. Reynolds reported that the Obama Administration is taking action to strengthen Native American communities through education, support, and economic development. These initiatives build on the significant progress the President has already made in partnering with tribes on a nation-to-nation basis to promote prosperous and resilient tribal nations.

A NAC member noted that the HIV grant program included capacity-building, which he saw as extremely important. He referred to a study on programs in Africa that shows that just providing funding and other resources are not as effective as genuinely working with the community in increasing beneficial outcomes via capacity building. Mr. Reynolds stated that a paper on sustainability of these programs is in development with Northwestern University. In response to a question regarding funding requirements for DFC, Mr. Reynolds noted that STOP has a mentoring program in place that is designed to help grantees move from DFC to STOP as a step forward.

A NAC member said she was very impressed by the DFC numbers, and asked if national reduction experts reviewed the data to determine the reasons for the reduction. Mr. Reynolds stated that ONDCP did the evaluation and that its review indicated the elements that led to the reductions. Ms. Harding noted that CADCA also evaluates the DFC data, reviewing the strategies and promising practices. Mr. Reynolds will provide NAC with the information from the CADCA review. He then explained that the DFC program is funded by ONDCP, administered by SAMHSA, and training is provided by CADCA.

A NAC member asked about DFC and marijuana, especially regarding ongoing legislative activity in states where it has become legalized. Mr. Reynolds stated that SAMHSA's role is to educate, not impact legislation. Ms. Harding commented that SAMHSA provides no policy or legislation/regulation input, but rather, meets the public need for information on marijuana through resources for parents and students. She noted that a marijuana toolkit is in final review before release.

In response to a NAC member's question on measuring success in the MSI HIV/HCV effort, Mr. Reynolds reported that it has been most successful in terms of allowing people to know their status. People have encouraged their peers to get tested. The program has not really touched prescription drug use and misuse yet, but there are plans to reach out. Ms. Harding noted that this program is a huge success within SAMHSA for using prevention strategies to address substance use disorders.

Clarese Holden, Director of the Division of State Programs, next discussed her responsibilities, including the administration of the Substance Abuse Prevention and Treatment Block Grant (SABG) prevention 20 percent set-aside, the Partnerships for Success grant program, and the Strategic Prevention Framework (SPF) State Incentive Grant program. She addressed the requirements for use of the 20 percent set-aside (e.g., funding for certain types of prevention strategies and programs). She stated that, for 2016, 33 states¹ plan to spend more than 20 percent of their grant money on primary prevention. Data are collected through self-reports and site visits. Money is documented for the 20 percent this way. Many times, additional dollars are devoted to prevention activities the states are already conducting. Ms. Harding noted that some states only have prevention dollars through the Block Grant. A NAC member noted that the Affordable Care Act may allow even more money to be moved to prevention. Ms. Harding agreed that it would be good to see the data from states.

Dr. Holden next provided information on the Strategic Prevention Framework Partnerships for Success (SPF-PFS) 2016 activities. The purpose of the SPF-PFS grant program is to provide funding to eligible states, territories, and tribal entities to address two of the nation's top substance abuse prevention priorities: (1) underage drinking among persons ages 12 to 20 years old; and (2) prescription drug misuse and abuse among persons ages 12 to 25 years old.

CSAP accepted applications for the fiscal year (FY) 2016 Strategic Prevention Framework for Prescription Drugs (SPF-Rx) grant program. SPF-Rx is designed to assist grantees in developing capacity and expertise in the use of data from state-run prescription drug monitoring programs. SAMHSA received 28 applications, and CSAP funded 25 FY 2016 SPF-Rx grant applications (awards were announced 08/15/2016).

Dr. Holden provided information on grants to prevent prescription drug/opioid overdose-related deaths (PDO). The purpose of this program is to reduce the number of opioid-related overdose deaths and adverse events among individuals 18 years of age and older through the use of SAMHSA's Opioid Overdose Prevention Toolkit. The program will educate key community sectors and implement secondary prevention strategies, such as the distribution of naloxone. SAMHSA received 32 applications for the PDO program, and CSAP funded 12 FY 2016 PDO grant applications on 08/15/2016. PDO evaluations will be conducted in collaboration with the Centers for Disease Control and Prevention.

The Tribal Behavioral Health Grants: Native Connections program is intended to prevent and reduce suicidal behavior and substance abuse, and promote mental health among American Indian/Alaska Native (AI/AN) youths. This program will help grantees reduce the impact of mental and substance use disorders, and will foster culturally responsive models to reduce and respond to the impact of trauma on AI/AN communities through a public health approach. This is jointly funded by CSAP and the Center for Mental Health Services (CMHS).

Dr. Jorielle Houston next presented on the Division of Systems Development, which supports data management, tribal TA, CAPT, the CSAP Prevention Fellowship Program (PFP), and public health awareness initiatives. Dr. Houston provided the vision and mission statements for the Division:

Vision: A state-of-the-art prevention system where states and communities implement effective services.

Mission: Through collaboration, build systems capacity, transfer knowledge, develop and disseminate resources, and evaluate programs to promote wider adoption and practical application of effective substance use/misuse prevention practices.

¹ "States" refers to states, territories, and tribal entities here.

After discussing the Division's organization chart, Dr. Houston provided an overview of the SAMHSA/CSAP PFP, in operation since 2006. PFP recruits individuals for a 2-year program that contributes to the development of a highly trained workforce of prevention specialists with public health experience at the state and local levels.

CAPT provides training and TA to CSAP grantees to develop the skills needed to implement the SPF and accountability systems for performance management.

Highlighting the State Technical Assistance Contract, Dr. Houston reported that it provides TA to SABG recipients, Community Mental Health Services Block Grant recipients, Synar Act planners, and states affected by the Olmstead Decision; works with SAMHSA to assess underlying TA needs of states, territories, jurisdictions, and communities (collectively referred to as states); provides on-site and offsite TA; and works with the CSAP, Center for Substance Abuse Treatment (CSAT), and CMHS joint contract. Site visits are conducted 10 times per year.

Dr. Houston described the data functions of her division. For the Government Performance and Results Act (GPRA)/National Outcome Measures (NOMs) surveys, the Division coordinates CSAP's GPRA and NOMs activities, including liaising with offices responsible for data collection. Data collection points include binge drinking, heavy drinking, and past 30-day use. For data monitoring/SAMHSA's Performance Accountability and Reporting System (SPARS) work, it provides a common data and reporting system for all SAMHSA discretionary grantees and allows for programmatic TA on use of the data to enhance grantee performance monitoring and improve quality of service delivery. SPARS, using common metrics and a single point of entry, is scheduled to launch in 2017.

This Division is also responsible for materials development activities, including health communications and marketing for CSAP, education initiatives, and publications. Highlights included the STOP Act Annual Report to Congress; the STOP Act national media campaign; and materials and promotion for National Prevention Week (May 14–20, 2017).

Ron Flegel presented on the Division of Workplace Programs (DWP). His division focuses on the National Laboratory Certification Program, the Federal Drug-Free Workplace Program (DFWP), and the Workplace Helpline for businesses/the public. Mr. Flegel opened his presentation with an outline of topics he would cover:

- DFWP oversight of federal and federally regulated testing;
- Legalization versus decriminalization versus recreational;
- Driving under the influence of drugs;
- Adulteration products: safety-sensitive positions;
- Safety-sensitive positions and drug testing (opioids); and
- The scientific supportability of ongoing studies and future studies.

Discussing oral fluid testing, Mr. Flegel reported that Delta-9-tetrahydrocannabinol (THC) is the primary psychoactive ingredient in marijuana. Delta-9-tetrahydrocannabinol-9-carboxylic acid (THCA) is the primary metabolite of THC formed in the body after cannabis use. THCA is currently tested in urine specimens. SAMHSA proposes that the UrMG continue to test for THCA only. The proposed Oral Fluid Mandatory Guidelines is still being reviewed for THC versus THCA.

DWP serves as a primary information source for testing and workplace-related issues, sharing knowledge from a variety of professional and scientific resources to a wide range of audiences. More than 37 papers

and journal articles have been developed by the Division. Mr. Flegel also provided information on the *Marijuana and Other Drug-Related Issues Smartbook*, a compendium of articles, resources, and tools. He also addressed the online Marijuana Toolkit resource collection.

In addressing Medical Review Officer Manual revisions, Mr. Flegel noted that these include information on validity of prescriptions, whether the drug is being used properly, and whether employees should have their positions adjusted while they are using the prescription medication. He next discussed proposed mandatory guidelines for oral fluid testing. The Proposed Mandatory Guidelines for Federal Workplace Drug Testing Programs using Oral Fluid include adding oral fluid as an alternative specimen. The testing of THC to detect cannabis use or testing of THCA within the federal drug-testing process is still being reviewed. Proposed guidelines would allow Federal Executive Branch agencies to test four additional Schedule II narcotic prescription medications (i.e., oxycodone, oxymorphone, hydrocodone, and hydromorphone).

Mr. Flegel next discussed proposed mandatory guidelines for federal workplace drug-testing programs using oral fluid, which include the following:

- Oral fluid collection and/or device collection;
- Initial oral fluid drug test analytes and methods;
- Confirmatory oral fluid drug test analytes and methods;
- Standards for certification of laboratories;
- Medical Review Officer requirements; and
- Forensic acceptability of oral fluid testing.

Mr. Flegel provided information on the mandatory guidelines in place. The most current version of the Urine Mandatory Guidelines will include testing for four prescription opioids: hydrocodone, hydromorphone, oxycodone, and oxymorphone. The Oral Fluids Mandatory Guidelines are in the approval process and are expected to be implemented in the next year. The Hair Mandatory Guidelines are being drafted by the DWP, and will include information about hair as a specimen for drug testing and possible drawbacks to using hair as a matrix.

Mr. Flegel noted that the topic areas in which further research was required were identified as the following:

- Analytes/cutoffs;
- SVT/validity;
- Biomarkers for synthetic urine;
- Collection;
- Collection devices;
- Initial and confirmatory testing; and
- Other significant scientific, legal, and public policy concerns related to the oral fluid specimen have also been identified and are being discussed with the appropriate federal officials.

Students' perception of vaping being safer than consumption of combustible marijuana were discussed. Mr. Flegel stated that Johns Hopkins University is examining this perception versus scientific validity. Mr. Flegel will add the NAC members to the Marijuana Bulletin mailing list.

Discussion—Changing Landscape of Prevention
Facilitated Discussion with the NAC and CSAP Leadership

Following Tuesday's discussion, Ms. Harding reintroduced the topic of the changing landscape of prevention. She noted that some states are sharing the prevention dollar and using it to close treatment gaps. How are we going to ensure that data are uniformly presented as outcomes? Do we have a process or conversation about helping states and communities reach out to health and primary care? She asked the NAC members where they would like to begin the discussion. NAC decided to start with the landscape discussion, as it may drive the workforce development discussion.

The NAC members discussed the process of the states reaching out to SAMHSA. An integrated work group was planning to build a guidance document for working with states. This document is still in development and undergoing revisions. Ms. Harding offered to share the draft with NAC. Discussion also included the ACA, which a NAC member noted lends itself to a changing landscape. Resources have had to be channeled in response to acute situations, such as the opioid crises. What should be the prevention community's long-term response to this? What do the data tell us? What does the opioid crisis tell us about substance use initiation? Where do we begin the prevention process? Will the opioid crisis lead to continued responses of this nature to other abused substances?

A NAC member added that they need to make the case to the broader public. In his state, the current debate is whether to spend money on treatment or law enforcement. Treatment is dominant in the public's mind, so we need to make sure the prevention community is in the picture for the next crisis responses. Another member agreed, stating that they need to address the underlying cause regardless of the specific substance. It is important to have core factors of prevention in place. A member asked what this says in terms of behavioral health integration and the need for screening tools. Does this lend some energy to looking at things more broadly, looking at a wider range of issues?

Ms. Harding asked the NAC members how they thought this happened—how did we find the prevention field ignored in the light of such a crisis? Where does heroin come into this? Prevention is becoming reactive, which is not its natural role. "Louder voices" got the attention of the public, a member commented. Successful prevention is hard for the public to see, and treatment presents a clear data-verified response. Many people simply do not understand the importance of primary prevention or what it really is. Bridging the gap is important—primary prevention bridging with primary care.

A member noted that the response to the "drug of the day" leaves open the need to start examining foundational issues—what will sustain prevention when the next drug crisis hits? The issue of law enforcement was again raised. A member commented that the field needs to convince the health care professionals and school counselors that prevention works. NAC members discussed the need to reach out to public health and primary care professionals and convince them that their work with primary prevention professionals will help them bridge any gaps. They can also remind the health care professionals that tobacco and alcohol continue to affect more young people than other substances. Different approaches are needed—it is also important to determine what messages need to go out, and how to best work with the media.

A NAC member pointed out that prevention really comes down to helping people make a healthy decision in any situation—people can make better choices if they are informed. It is important to work with sustainable community coalitions on what that community most needs through capacity-building for local efforts.

Ms. Harding noted that there are more than 700 drug-free communities, and we are just now learning how to use the data to tell the prevention story. States are required to put 80 percent of their received prevention funding into communities. Adding in the Block Grant, this represents three pots of funding, but people are not talking to each other. From a federal perspective, we need to put some kind of guidance out that helps those receiving SAMHSA money work with each other more effectively. We have the

tools, but we need to determine what to do to move forward. We need to make the case that is supported by the data. The SPF data were evaluated, showing that underage drinking and abuse of prescription drugs were the main problems. In response, CSAP focused on these issues.

A NAC member asked if the opportunity to intervene and encourage early integration had been lost. If it has, how do we reorganize ourselves? Money is being diverted to treatment to stop deaths, so what are the next strategies for prevention? Mr. Goldstein noted that the opioid crisis is different than what the community is used to in terms of its devastation. A NAC member commented that prevention has **not** changed, but the crises have moved its impetus and resources elsewhere. The choice is to save lives, and prevention will lose out in comparison as public perceptions see it. Prevention is a process, not an event. We live in a crisis-driven society, but do we wait for the next crisis and respond, or start rethinking the issues now? A member posed the question, “are we here to prevent death? Abuse? Misuse? First use?” We are here to prevent first use—physicians are there to prevent deaths. Saving lives begins with never having used a substance, a member said, not with treatment.

Discussing outreach, a member asked about using the Internet to reach people more effectively. Can SAMHSA have a broader online reach and increased presence? Ms. Harding noted that social media has led to the conversation being about saving lives, not necessarily about prevention. This can lead to misperceptions of a lack of activity and effective progress from the prevention field. A member commented that it is important to get back to protective factors, such as resiliency and parenting skills. Communities can feel ready to take responsibility. Professionals need to get the media to start talking about why prevention is important. Saving lives, a member said, does not happen after there is a problem. It happens by avoiding the problem in the first place. In prevention, this means preventing first use of substances.

Discussion turned to the benefits of partnerships and coalitions, with members commenting on the idea of fellowships for potential partners to inform them about prevention; balancing the needs of the state and communities when it comes to funding distribution; ensuring communities have the resources they need to succeed; and the states helping communities collect, evaluate, and use their own data. Peer mentoring has a strong record of effectiveness.

A NAC member comments that communities have been trained in the SPF model, but that model does not always apply to communities’ needs. We do not get to choose the strategies in many cases. We do broad-based strategies that filter down, but cannot bring the preventionist as early-identification specialist as a directive from her state. There are requirements based on Block Grant SPF funding and state DFC data collection versus community data collection.

Another member commented that scientific advances have brought medications into the recovery field. Is there an opportunity for prevention to partner with recovery to add prevention knowledge to the treatment plan? In discussing this, a member commented that primary prevention can work with primary care, and that there is a prevention strategy in place among primary care providers. This is sometimes referred to as stepped care. A member noted that there are not a lot of locations where these activities can take place together—there are not really family health centers/clinics anymore. These facilities allowed providers to look at a family as a whole entity. We need to find out where prevention will occur—what is the best setting? Another NAC member commented that in studying health-seeking behavior, people often seek others in their families or networks for health-related matters before reaching out to professionals. We can increase our surveillance by working with families, and remembering to make families proximal to our thinking. Health systems and community care are good tools for providing prevention messages. Mr. Reynolds noted that SAMHSA has tried this model, but found it lacking for prevention, although it was effective for treatment and mental health.

Ms. Harding asked the NAC members what thoughts were particularly resonating with them regarding the landscape discussions. This will inform the next session and provide the substance for next steps. The NAC members noted the following ideas and thoughts:

1. [There needs to be] more focus on families.
2. Back to prevention's core roots; emphasize families, risk, and protection factors, resiliency, peer mentors.
3. Preventionists need to be essential figures in community systems, public health, schools, law enforcement, counseling, health centers, etc.
4. Understanding what prevention means [is important] to different stakeholder and professional disciplines (IOM).
5. Shifting or modifying prevention practices [is] needed.
6. If we are using data to drive intervention, we need to tell the stories.
7. Prevention is a process, not an event.
8. Community locations to provide integrated services.
9. Planting the seeds of prevention and partnering sectors (prevention fellowship for partners).
10. States drive call to action to bridge science of substance abuse prevention and mental health promotion with health and other key systems partners.
11. CSAP guidance documents—states need to step up to sustain infrastructure to support local efforts (i.e., to navigate the vast array of federal initiatives and grants programs).
12. Knowledge transfer to the new generation for prevention and stakeholders.

NAC members voted on idea groupings, and the 3, 9, 10, and 11 grouping received the most votes. SAMHSA will send the modified idea language out to the NAC members for discussion on next steps. NAC members were invited to flesh out the ideas before a conference call later in the year.

Discussion—Substance Use Prevention Workforce

Facilitated Discussion with the NAC and CSAP Leadership

Following Tuesday's discussion regarding workforce issues for the prevention field, Ms. Harding noted the following:

- Basic training is needed for all; does ICRC cover our current needs? If not, what else should we look at?
- Are we discussing skills or a profession?
- How do we translate the need for the skills into running community-based programs?
- How do we manage the fear of some current prevention professionals feeling that this discussion is putting them out of a job?
- How do we explain what prevention is to our health partners?
- We have the need to recruit younger people into the field. Are we looking at their culture, and how do we address old-school thinking that treatment comes first and prevention is second? Are we using social media enough?

A NAC member commented that the common skill set is essential, and that it is a value that we pull people from different fields into prevention—many people from many places. We do need a certification process for substance abuse prevention. People need to understand addiction and the continuum of care. We have to train people to have the skill set. Discussion included how to attract younger people to prevention, with NAC members commenting that money AND quality of life (e.g., ability to contribute to a greater cause) will help to attract them—there does seem to be a concept of supporting the greater good among younger people. Fellowship programs will be important. A NAC member noted that young people

may respond well to the knowledge that they can help fix health crises by becoming involved in behavioral health, and, more specifically, prevention.

Mr. Goldstein asked the NAC members if they are having trouble hiring entry-level interventionists. A NAC member noted that retention and the career ladder were issues, not necessarily hiring. The resources are finite, and recruiting can be challenging. There are also challenges in recruiting psychologists and interns. Discussion also included the need for prevention experience as a requirement for psychologists in training and the Society for Prevention Research's Early Career Professionals Network. Ms. Harding and a NAC member both noted that the prevention field was not necessarily one of trained interventionists. People had varied degrees, experience, and backgrounds. Many people in the prevention field left for the treatment side, historically. Prevention is now seen as a profession. This improves the ability to explain what prevention is.

A NAC member commented that the field needs to really evaluate the impact of social media on primary prevention, and rethink how we train those we work with. He provided an example of an intervention teaching families how to prepare healthy meals conducted by a community health center. It is important to think about how things are done, not just doing things that are already in place. This is a strong example of how the prevention and recovery networks can work together to provide a wellness function.

A NAC member asked if they have stifled the pipeline due to certifications. Have the certifications blocked some people from becoming preventionists? A fellow member commented that training has been a point of discussion—people who do not have the expertise are hired and trained. This is also the case in colleges and universities. Prevention training does not always meet the skill set needs of the profession. Mr. Reynolds noted that peer mentoring has exposed more young people to prevention, and that he would like to work with the states to continue mentoring and training toward a career path for prevention. A NAC member noted that working with Health Occupation Students of America (HOSA) to add prevention conversation would be beneficial.

Mr. Goldstein noted that as prevention grows, it is possible to have less skilled professionals in place. Do we need to professionalize prevention, or continue to rely on skill sets and training? Most states require certification in prevention. Is that something we need to discuss as a group? Are we geared for the future? A NAC member stated that this discussion needs to continue. He presented an example in which providers were trained within timelines, with certifications required at specific points to continue with the training program. The American College Health Association, a member noted, provides information on the required skill sets to succeed in professions.

Discussion also included different types of interventionists: one that oversees a program, or one with "boots on the ground." There are really two distinct levels of the role. A NAC member commented that it is important not to lose the certification requirements, but it could be revised and/or expanded to be broader-reaching. The IOM allows identification of skill sets needed. It is also important to provide additional support to the younger workforce, such as with social media. This could help lead to skill sets as well as choice of profession—more people conducting prevention. Ms. Harding noted that many states have two levels of credentialing in place: one they develop for beginners, and one for ICRC credentialing.

Ms. Harding noted that a minimum of two goals of workforce development are required to go into the strategic initiatives. She asked the NAC members for suggestions of strong development goals that can be provided to SAMHSA for inclusion. She referred to emerging issues, underage drinking, reduction of suicide, and prescription drug use and misuse. What are some of the goals for the prevention workforce?

NAC members stated that increasing interest among young people in prevention as a career; engaging young people at the high school and college levels (e.g., through HOSA). Ms. Harding will send the

information out to the NAC members for discussion. In response to a NAC member's comment, she indicated that developing a goal and objective regarding credentialing is a good step. Members also discussed skills endorsements, noting that they can cut across professions. Ms. Harding suggested that the outreach to younger people and credentialing ideas would be pursued by the NAC as objective development activities. Drafts will be shared among the NAC members for review and comment. If the NAC members see where prevention as a workforce component can be inserted into the objectives, they are free to discuss the potential inclusion. Ms. Harding noted that metrics must be included in the objective development exercise and resultant drafts. SAMHSA will work on the goals, and NAC will work on the objectives.

Wrap-Up

Greg Goldstein, Deputy Director, CSAP

Mr. Goldstein thanked NAC for the outstanding discussions, and thanked Mr. Aumen and Ms. Harding for their work with NAC. Next steps include CSAP putting together information on the highest-ranking grouping of ideas. CSAP will send this out for review, comment, and input prior to scheduling a conference call.

Mr. Goldstein asked the Council members to review the scheduled work groups for Thursday's SAMHSA NAC meeting, to be involved in the work group discussions, and represent CSAP. Ms. Harding asked NAC members about the potential hiring of a physician, researcher, or other clinical professional to advise CSAP. CSAT has hired a Medical Director, but would it be a value-added benefit to CSAP? Members commented that a Chief Medical Officer is important, but not necessarily a physician posting. It will be important for the person in the role to have expertise on ICD-10 and DSM-V diagnoses.

Public Comments

No in-person or telephone public comments were received. The conference call vendor reported that 42 individuals attended the meeting via telephone.

Adjournment

With no further business, the NAC meeting was adjourned at 4:15 p.m.

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

10-27-16

/Frances M. Harding/

Date

Frances M. Harding
Chair
CSAP National Advisory Council