

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
(Public Session)

August 6, 2014

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 6, 2014
(1:00 p.m.–4:00 p.m.)

Attendees

Council Members Present: Michael Compton, M.D.; Steven Green, L.C.S.W.; Dianne Harnad; Michael Montgomery, M.Ed.; Kathleen Reynolds, L.M.S.W., A.C.S.W.; Ruth Satterfield, L.S.W.; Mary Ann Tulafono; and Patricia Whitefoot, M.Ed.

Ex Officio Council Members Present: Fran Harding
Designated Federal Officer: Matthew J. Aumen

Call to Order

Mr. Matthew J. Aumen, Designated Federal Officer, called the meeting to order on August 6, 2014, at 1 p.m.

Welcome and Opening Remarks

Fran Harding, CSAP Director, welcomed Council members, SAMHSA staff, and public attendees. After having the Council members and others in attendance introduce themselves, she announced that the newly appointed Secretary, Sylvia Burwell, had met with the Executive Team at SAMHSA and had attended an all-hands meeting to share her vision and expectations.

Ms. Harding acknowledged the service of two Council members, Mary Ann Tulafono and Patricia Whitefoot, whose terms are set to expire by the end of the year.

Ms. Harding outlined the day's agenda, focusing on two main topics: 1) a discussion of priorities for integrating substance abuse prevention and mental health into primary care; and 2) a discussion of metrics and the revised goals and objectives of Strategic Initiative #1.

Prevention's Role in an Integrated Healthcare Environment

Ms. Harding provided a synopsis of recent prevention activities. She noted that the CSAP National Advisory Council (NAC) discussed the integrated health care environment at its last meeting, held in April 2014. CSAP also held a separate integration meeting with outside experts in substance abuse prevention, treatment, and mental health that included doctors, researchers, community members, and business representatives.

Ms. Harding provided an overview of the expert meeting discussion. Participants shared their experiences and helped shape SAMHSA parameters for moving forward. They talked about successes, challenges, and

opportunities, as well as cross-system collaboration and gaps in services. It was learned that primary care was too limited, and needed to include state and community perspectives. But questions remain on how to measure the ideal integration. How do we build bridges, and who do we build them with?

Ms. Harding said that the experts engaged in a robust conversation on the topic of integration and identified 27 priorities for successful implementation. NAC members had an opportunity to review and individually rank these 27 priorities prior to the council meeting. Mr. Matthew Aumen said that the NAC would consider the comments and rankings provided by individual members and may vote on how to proceed. The idea was to narrow down the 27 priorities and focus on the top five.

Mr. Aumen reported the results of members' rankings: Three of the members who preliminarily responded ranked #7, #11, and #14 in their top five (see attached for numbered list of 27 priorities). These priorities surrounded providing support to statewide coordinating coalitions to achieve prevention in primary care (PC); providing leadership and strategies around advancing a public health approach to prevention; and providing leadership for aligning, leveraging, and coordinating resources in a way that creates point of interface with PC or other disciplines.

Other members preliminarily selected #13, #17, and #27 as priority choices. These suggested approaches involve developing specific guidelines or toolkits for use in PC settings; expending more effort and resources toward engaging champions, such as youth, physicians, and community leaders, in advocacy planning and strategy implementation to promote integration in PC; and developing a business plan that builds upon current workforce strengths using a common language. Ms. Reynolds agreed with the idea of providing definitive guidance and building on a community coalition that included prevention to help build a successful whole-health system.

Priority #14: Mr. Aumen then invited members to provide verbal comments on these rankings. Ms. Kathleen Reynolds expressed her support for #14 by stressing SAMHSA's role in leadership. She said that when SAMHSA issues RFPs, it could lead by example by helping to create the interface with primary care. Integration is a major way to bring prevention to the forefront, and the RFPs could possibly be structured around integration. Ms. Reynolds added that #14 aligns with the public health approach that encompasses behavioral health, mental health, and addiction.

Priorities, #6, #12, #13, #15, #27: Mr. Steven Green added his support for #27 because it stipulates language to ensure that an integrative structure is built into any plan. Ms. Harding said the business plan idea came up in the expert meeting a lot. They discussed learning how to align and leverage with primary care. Ms. Reynolds suggested that 3 decades (ref. #27) may not be reasonable due to the ways and speed in which health care is changing.

Ms. Reynolds indicated that other agencies have worked on a "common language" but asked *which* common language the council/ CSAP will be referring to. Ms. Harding reported that SAMHSA has a common language for prevention, but not for integration. She said the topic of language also was discussed at the expert meeting and acknowledged that it will be a challenge, so CSAP will need help from the Council.

Ms. Dianne Harnad spoke to building on strengths of the current workforce (ref. #27). Many of her staff in Connecticut had concerns about working in a system that integrated substance abuse, mental health,

and primary care. She offered that priority #27 could allow CSAP to showcase working models and help identify concrete steps for staff to follow.

Mr. Green noted that it is hard to build a continuum of services in Indian country, but it is easy to build prevention programs, so he recommended the Council consider combining #6 with #27. Ms. Harding asked NAC members if they agreed with combining #27 and #6, and they all responded in the affirmative.

Ms. Harnad then suggested including #15 also because identifying state and local models fit well with the #6/27 combination for creating a successful business plan with workforce development. Another NAC member offered support for #12 as well because it spoke to capacity building within the community. Dr. Michael Compton offered his support for #13 and #15, stating that they provide concrete steps that can help practitioners who want to pursue integration.

Priorities, #7, #21: Ms. Harding noted that #7 brought up the notion of primary care quite clearly, which was the main reason we started these discussions, so she suggested it stand alone. Ms. Ruth Satterfield agreed. Ms. Harnad suggested that #21 *also* aligned well with #7.

Ms. Harding recapped that the group supported # 6, #7, #11, #13, #14, and #27 and stated that the council could vote on them upon establishing a quorum.

Ms. Reynolds asked Dr. Compton for his opinion on the practicality of screening in primary care. Dr. Compton replied that the primary care field is open to screening for substance abuse and major depressive and anxiety disorders, but practitioners need help with learning how to do it, so he liked the idea of providing a toolkit or best practices guidance. Mr. Green announced that their primary care practitioners are screening and that clients benefit from a full continuum of services in one location.

Mr. Aumen recapped at 2 p.m.—The group selected #27 (combined with #6, #12, #13, #15, and changing 3 decades to 1 decade); #11; #7 (combined with #21); and #14.

Ms. Harding brought up the PBHCI (Primary Behavioral Health Care Integration) Program and suggested that the NAC hold conversations with SAMHSA staff who are working with these programs. She spoke to the need to look at the different programming out there and align with that. She explained that it is important to tap the existing workforce for integration to work at the program level.

Ms. Harding asked NAC members if any of them would be interested in joining in conversations with other agencies as a next step. Three members replied in the affirmative: Ms. Reynolds, Ms. Harnad, and Mr. Green.

The Council moved to begin discussion of Strategic Initiative #1.

CSAP Program Update—Strategic Initiative #1

Mr. Rich Lucey reported that SAMHSA is working on an accomplishment report around all eight initiatives and then led the discussion on proposed changes to the current Strategic Initiative #1.

The first draft was provided to NAC members in April 2014 for their input on the goals and objectives. NAC comments were incorporated into the revised document, and Mr. Lucey proceeded to walk participants through where the comments fit into the revised document. In general, alterations were made

to incorporate prevention language across all four goals. He further explained some specific changes made to the following goals 1–4 based on NAC feedback.

Specifically, under the metrics section for Goal #1, “young adults” was changed to “youth” and “depression” was changed to “major depressive episode.” The current draft is circulating for public comment through August 18, so all NAC members were encouraged to distribute it through their networks and stakeholders for review.

Mr. Lucey reported that the agency tried to assign only one metric to each goal; some may have multiple parts, but they are essentially only one metric. For example, the stated metric for Goal #1 includes both substance use and major depressive episode. No quantities or percentages have been specified. The question for the NAC is whether to quantify or not, and if yes, by what percentage.

Ms. Harding noted that to meet the new Secretary’s objectives, SAMHSA must include metrics to determine if efforts have an effect on public health. She also acknowledged, however, that some communities may not be set up to collect data to SAMHSA’s specifications if a lower limit is set. She posed to the group whether there was an alternate way to show progress on these four goals.

Mr. Lucey opened the floor to NAC members for comment.

Ms. Harnad pointed out that the Partnership for Success grant offered an incentive for a 3 percent reduction, but agreed that it would be difficult to quantify here. Ms. Reynolds leaned toward quantifying metrics but doesn’t know how. Mr. Lucey used Goal #1’s metric to explain that the measurement would not be restricted to the 12–17 age group, but could include reductions in any age group within youth and young adult cohorts.

Ms. Reynolds asked how to discern between progress attributed to SAMHSA’s efforts versus progress that was the result of others’ efforts. Mr. Lucey and Ms. Harding acknowledged that this was indeed a challenge.

Ms. Beadle, CSAP Deputy Director, suggested the use of baselines. Mr. Lucey indicated that setting baselines would be challenging, and instead recommended the use of existing data provided through the National Survey on Drug Use and Health (NSDUH). NSDUH is a source of rich longitudinal data.

Ms. Harding indicated that the Council should continue the discussion of a common data platform and measures during the April 2015 meeting. SAMHSA has to look at this data and figure out how to report successes.

Mr. Lucey resumed the discussion on the Initiative’s metrics. He reported the issue with the metric in Goal #2 surrounding the stated age range (12–20). Measurable declines have been seen in the 12–17 year-old cohort, so how should the increases seen in the 18–20 cohort be offset, that are likely driven by college students?

The potential issue with the Goal #3 metric is in regards to the identified population. The metric contains no age cohort and no racial groups. Instead, it includes those most at risk for suicide, such as working-age adults; men in midlife; service members, veterans and their families; American Indians; as well as lesbian, gay, bisexual, transgender, and questioning youth.

Goal #4 has a very straightforward metric—number of overdoses, not deaths. Several participants questioned the reasoning behind exclusion of “opioid use” and the number of deaths. Ms. Harding indicated that the Centers for Disease Control and Prevention focus on deaths, so they have that data. Mr. Lucey explained that the main issue in the field over the past few years has been on the number of opioid overdoses presenting to the emergency room, so that’s why the metric is focusing on overdoses only. In addition, SAMHSA has toolkits on this topic that have been well received and have produced incredible results on reducing opioid overdoses.

Mr. Lucey recapped the question for the group: Should any of these metrics be quantified; if so, which metric? How should it be quantified?

Due to time constraints, the NAC was asked to consider these questions and provide input directly to Mr. Aumen before August 18. Ms. Harding suggested a quick follow-up teleconference after all comments have been received before the Council can make a recommendation.

Mr. Lucey suggested that the target release date for the revised Strategic Initiative could be October 1.

Mr. Aumen noted that any council recommendations would have to be deliberated in a public forum prior to a vote, so the timing would be tight.

Ms. Harnad suggested that many of the core measures currently in place should be used.

Ms. Mary Ann Tulafono from American Samoa asked if any data on Pacific Islanders would be included in Strategic Initiative #1. Mr. Lucy replied yes, that five racial/ ethnic groups would be examined for underage drinking, rates of binge drinking, and heavy drinking.

Ms. Harding shared with the group that the Initiative has been a helpful roadmap over the past 4 years, and that the agency has learned to look at the activities, add to them, and tweak them to this point. She is hoping that the extra time now spent with the latest version will give the same level of guidance and security moving forward. She encouraged members to look at the new version with a critical eye, adding that their ongoing comments and commitment is worth the effort and appreciated.

Public Comment Period

Mr. Aumen announced that there were 105 people logged onto webcast, plus others connected via telephone.

James Dillon, from Marquette, Michigan, spoke to the need for court-ordered suicide prevention services, in relation to Strategic Initiative #3. He asked the Council to consider recommending mandatory assessments (for suicide risk and legal services) for children of one-parent households who are referred to the court. Ms. Harding offered to share this request with Mr. Richard McKeon, SAMHSA’s suicide lead.

Mr. Dillon also asked if the Council had recommendations or requirements for forming coalitions and formal processes for conducting business. He was concerned about the activities of a substance abuse coalition that has been set up in his area. Mr. Dillon stated that the coalition is mainly comprised of self-appointed representatives, with no agreed-upon policies, rules, or bylaws for conducting business. Mr. Dillon said that decisions often were made as a result of bullying. Ms. Harding replied that SAMHSA has

structures in place for establishing coalitions and that Mr. Aumen would send out details via e-mail. Mr. Aumen asked Mr. Dillon to e-mail his full comments to him.

Amy Miller, from Northern New Jersey, spoke to recent research disproving benefits of mandatory student drug testing, stating that testing does nothing to prepare kids for college or prevent them from using. She reported that her community spent a year debating the issue, only to have it tabled due to results of the research. She asked if the Council would make a statement against it (in favor of education instead) to prevent other communities from wasting time debating. Ms. Harding asked Ms. Miller to send an e-mail to Mr. Aumen and he would return what SAMSHA has on the topic.

Ms. Harding provided closing remarks. She announced a joint meeting of SAMHSA councils on August 27, followed by a closed session grant review. The next open meeting of the CSAP NAC is tentatively scheduled for April 15-17, 2015.

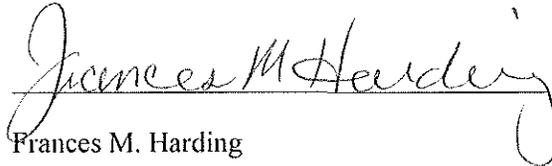
Approve Minutes from April 2, 2014 Meeting

Mr. Aumen announced a quorum and asked the Council to formally approve the minutes from the April 2 meeting. He explained that members of the Council had already reviewed them and they had been signed by Ms. Harding. Ms. Satterfield moved to approve the minutes, and Mr. Green seconded the motion. Hearing no objections, Mr. Aumen recognized the NAC meeting minutes to be approved for the public record.

Ms. Harding officially adjourned the meeting at 3:00 p.m. EST.

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

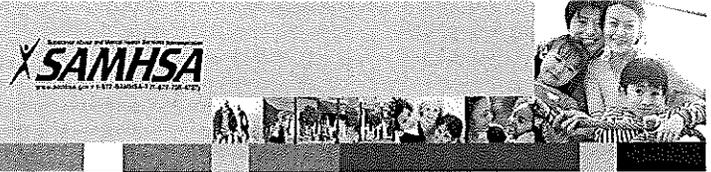
11/3/14
Date



Frances M. Harding

Chair

CSAP National Advisory Council



Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

CENTER FOR SUBSTANCE ABUSE PREVENTION National Advisory Council Meeting

6 August 2014
1:00 p.m. – 3:00 p.m. EDT

Toll-Free number (audio): 877-668-5013 Passcode: CSAP



National Advisory Council Meeting

Agenda:

- 1:00p- Call Meeting to Order/ Opening Remarks/ Introductions
- 1:15p- Approve Minutes from April 2, 2014 Meeting
- 1:20p- Prevention's Role in an Integrated Healthcare Environment
- 2:20p- CSAP Program Update- Strategic Initiative #1
- 2:50p- Public Comment
- 3:00p- Adjourn

(All Times Eastern)

Toll-Free number (audio): 877-668-5013

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Goals For Today

Discuss the Integration of Substance Abuse Prevention and Mental Health Into Primary Care (July 9, 2014 Expert Panel Meeting)

- Present agenda topics, discussion highlights, and participant-generated priorities
- Engage NAC in discussion of identified priorities
- Engage NAC in discussion of recommended next steps

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Goals For Today (continued)

Discuss Strategic Initiative #1

- Present revised goals and objectives
- Present metrics
- Engage NAC in discussion of metrics

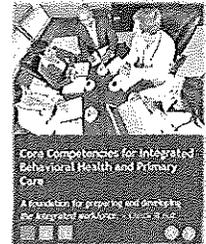
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National Advisory Council Meeting

Prevention's Role in an Integrated Healthcare Environment



ABOUT CHHS

SAMHSA-HRSA Center for Integrated Health Solutions

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Integration Meeting

CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP)

INTEGRATION OF SUBSTANCE ABUSE PREVENTION AND MENTAL HEALTH INTO PRIMARY CARE MEETING

WEDNESDAY, JULY 9, 2014

Toll-free number (audio): 877-668-5013

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Identifying Priorities for SAMHSA/CSAP

1. SAMHSA's leadership on prevention strategies that are not included in ACA
2. Expand training and health practitioner education
3. Identify what sites are doing to integrate prevention into primary care (including barriers and best practices)

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Identifying Priorities for SAMHSA/CSAP

4. Develop funding strings and teach how to braid so can have robust system within state
5. Engage stakeholders and improve outreach to keep SAMHSA's mission out there
6. Look closer at successes in Indian Country, develop an appropriate model, and develop capacity
7. Provide support to statewide coordinating coalitions to accomplish prevention in primary care coordination

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Identifying Priorities for SAMHSA/CSAP

8. Engage the do-ers with the policy makers to identify early wins and create demand
9. Get the information to the do-ers that is currently developed
10. Build, strengthen, and maintain relationships and collaborations
11. SAMHSA to provide leadership around advancing a public health approach to plan and implement multi-level comprehensive strategies

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Identifying Priorities for SAMHSA/CSAP

12. Build capacity in communities by working with SA and HIV grantees (e.g., training module and technical assistance)
13. SAMHSA can develop guidance or toolkits that could be provided to PC settings on screening and how and where to refer people when needed
14. SAMHSA can provide leadership of aligning, leveraging, coordinating resources in a way that creates point of interface with PC or other disciplines

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Identifying Priorities for SAMHSA/CSAP

15. Identify state and local models to showcase
16. Make sure this effort is in coordination with what's going on within organization to integrate BH and PC
17. More effort at recruiting and engaging champions, youth, physicians, and community leaders in advocacy planning and strategy implementation promoting integration in PC

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Identifying Priorities for SAMHSA/CSAP

18. Delineating distinction between SA prevention integration in overall health vs. SA prevention in PC and what is manageable and measureable within each bucket in 1, 3, and 10 years
19. Build coalition of organizations to work for policies, programs and practices to increase prevalence of nurturing families
20. Move conversation forward to be part of solution and create actionable steps at CSAP/SAMHSA

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Identifying Priorities for SAMHSA/CSAP

21. Increase SAMHSA staff capacity to assist coalitions by sharing knowledge of effective programs and tools and resources
22. Prioritize that we find the money—build business case and demonstrate how having money along continuum in a community leads to improvements in all systems
23. Go back and educate community and other coalitions and reaffirm belief that contributions are valued

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Identifying Priorities for SAMHSA/CSAP

24. Increase SAMHSA's visibility—leadership and project officers
25. Integrate discussion and facilitate process at SAMHSA
26. Re-engage membership in discussion about integration through a more targeted and specific lens and terminology
27. Develop a business plan that builds upon current workforce strengths, agrees upon common language, and sends on direction to become viable for the next 3 decades

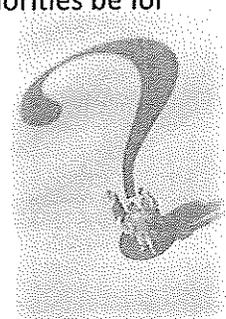
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Integration Meeting: NAC Discussion of Priorities

- What should the top five priorities be for CSAP?
- Next Steps



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National Advisory Council Meeting

CSAP Program Update-

Strategic Initiative #1



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Strategic Initiative #1

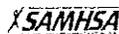
Goal 1.1

Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness and identify and respond to emerging behavioral health issues.

NAC members added text in red at last meeting.

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Strategic Initiative #1

Goal 1.2

Prevent and reduce underage drinking and young adult problem drinking.



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Strategic Initiative #1

Goal 1.3

Prevent and reduce attempted suicides and deaths by suicide among populations at high risk.*

* Populations at high risk include working-aged adults (ages 25–64); men in mid-life (ages 35–64); suicide attempt survivors; military service members, Reserve and National Guard components, veterans, and their families; American Indian/Alaska Natives; and lesbian, gay, bisexual, transgender, and questioning youth.

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Strategic Initiative #1

Goal 1.4

Prevent and reduce prescription drug and illicit opioid misuse and abuse.



PREVENTION...
Because it works!



SAMHSA

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Strategic Initiative #1

Goal 1.1: Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness and identify and respond to emerging behavioral health issues.

Metrics: Reduce the percentage of youth and young adult ages 12–17 reporting past 30-day substance use, and reporting major depression episodes in the past year.

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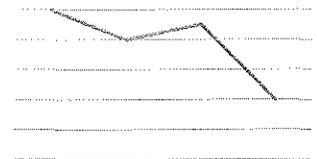
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Strategic Initiative #1

Goal 1.2: Prevent and reduce underage drinking and young adult problem drinking.

Metrics: Decrease the percentage of youth and young adults ages 12–20 engaged in underage drinking and reporting past 30-day alcohol use or binge drinking.



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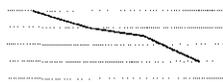
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Strategic Initiative #1

Goal 1.3: Prevent and reduce attempted suicides and deaths by suicide among populations at high risk.*

Metrics: Reduce the number of suicide attempts and deaths by suicide.



* Populations at high risk include working-aged adults (ages 25–64); men in mid-life (ages 35–64); suicide attempt survivors; military service members, Reserve and National Guard components, veterans, and their families; American Indian/Alaska Natives; and lesbian, gay, bisexual, transgender, and questioning youth.

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Strategic Initiative #1

Goal 1.4: Prevent and reduce prescription drug and illicit opioid misuse and abuse.

Metrics: Reduce the number of opioid overdoses.

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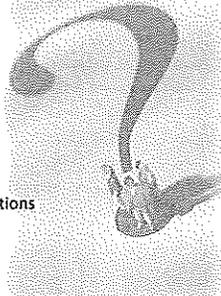


NAC Discussion of Metrics

- Should SAMHSA quantify these metrics?
- If so, how?

Leading Change: A plan for SAMHSA's Roles and Actions
2011-2014

<http://store.samhsa.gov/product/SMA11-4629>



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National Advisory Council Meeting

Public Comment

Closing Remarks

Adjourn

Next Meeting (tentative): 8-9 April 2015

Toll-free number (audio): 877-668-5013

Passcode: CSAP



