

*Department of Health and Human Services*  
*Substance Abuse and Mental Health Services Administration (SAMHSA)*  
*Center for Substance Abuse Treatment (CSAT)*  
*National Advisory Council*

*September 22, 2020*

*Open Session Minutes*

*5600 Fishers Lane*  
*Rockville, Maryland 20857*

## **Open Session Minutes**

### **Opening Remarks and Introductions**

The Center for Substance Abuse Treatment (CSAT) National Advisory Council (NAC) Designated Federal Officer (DFO), Tracy Goss, called the 83rd meeting of the CSAT NAC to order at 1:00 p.m., EDT, on September 22, 2020. Ms. Goss conducted a roll call to establish the quorum. Dr. Joseph Bullock, Chair, who presided over the meeting, welcomed attendees and thanked staff and guests who agreed to participate. The meeting was conducted virtually.

Dr. Bullock, the new CSAT Director, began his remarks by acknowledging Ms. Daryl Kade, who served as Acting CSAT Director and Acting NAC Chair before Dr. Bullock's arrival. He also thanked Dr. Elinore McCance-Katz and CSAT staff for welcoming and orienting him to the center. He next provided some information on his background.

Dr. Bullock has a background as a U.S. Marine and received his doctorate from Virginia Tech. He has done extensive work with the military as a preceptor for the substance abuse rehabilitation program in the Department of the Navy with active-duty naval counselors. Dr. Bullock recently served as the Director for the Re-Entry and Sanctions Center, a residential program serving individuals on probation and other forms of supervision under the Court Services and Supervision Agency. He was also the Bureau Chief and Program Director for Substance Abuse Services for Arlington County (VA) government.

### **Member Introductions and Updates**

Council Members in attendance were: Bertrand Brown; Trenette T. Clark Goings, Ph.D., LCSW; Kristen Harper, MEd, LCDC; Jason Howell, M.B.A., PRS; Sharon LeGore; Judith A. Martin, M.D.; Lawrence Medina, M.B.A.; Eva Petoskey, MS; A. Kenison Roy III, M.D., DFASAM, DLFAPA, and Kenneth Stoller, M.D.

Also in attendance were: C. Danielle Johnson Byrd, MPH; Thomas Clarke, Ph.D., MPH; Neeraj Gandotra, M.D.; Jessica Hartman; Richard McKeon, Ph.D., MPH; Krishnan Radhakrishnan, M.D., Ph.D., MPH; and Linda White-Young, MSW, LCSW.

Mr. Bertrand Brown introduced himself as a person in long-term recovery. He is from Georgia and has been serving with NAC for almost four years.

Dr. Trenette Clark Goings is a professor in the School of Social Work at the University of North Carolina at Chapel Hill. In addition to teaching and service, she conducts research focusing on substance abuse prevention among youth and emerging adults of color.

Ms. Kristen Harper noted that she is also in long-term recovery. She works for C4 Innovations, which operated the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) contract for about nine years.

Dr. Judith Martin introduced herself next. Dr. Martin is an addiction medicine doctor and specialist who has spent most of her career in opioid agonist treatment at methadone clinics. For the past five years, she has served as the Medical Director for Substance Use for the City and

County of San Francisco. Dr. Martin remarked that 2019 fentanyl overdose data was just released, and the rate is almost double what it was in 2018. The City and County of San Francisco are working to increase access to treatment, particularly to buprenorphine and naloxone. The pandemic has halted some of their efforts, including planned sobering centers.

Mr. Lawrence Medina is the Executive Director of the Rio Grande Alcoholism Treatment Program in northern New Mexico. He is also part of the Golden Willow counseling program that specializes in grief and loss. Mr. Medina is an advocate for rural and frontier areas; Coronavirus Disease 2019 (COVID-19) has also impacted service provision in these areas, and a better funding mechanism is needed. He is in long-term recovery.

Ms. Eva Petoskey is the Behavioral Health Manager for the Intertribal Council of Michigan, a consortium of the 12 federally recognized Michigan tribes. The Intertribal Council provides various services and collaborative ventures with the Michigan tribes, including naloxone distribution, medication-assisted treatment (MAT), and peer recovery support. Ms. Petoskey discussed the pandemic's effect on the area—the pandemic has spread more extensively in recent months than initially. This increase has presented challenges to maintaining the workforce and continuity of services, as well as having to switch to virtual services. Ms. Petoskey is in long-term recovery.

Dr. A. Kenison Roy was next to introduce himself. Dr. Roy is in long-term recovery and has spent his career as a physician in the private sector in abstinence-based programs. Recently, he became Director of an addiction medicine fellowship. It has been rewarding to help expand physicians' training experience in addiction medicine to include methadone maintenance, intensive outpatient treatment, involvement with the criminal justice system, and insertion into primary care clinics. Dr. Roy is a longtime member of the American Society of Addiction Medicine and serves on the Board of Directors.

Dr. Kenneth Stoller is an addiction psychiatrist from Baltimore who is on faculty at the Department of Psychiatry for Johns Hopkins University School of Medicine. Also, he directs the hospital's Outpatient Addiction Program, which includes an opioid treatment program (OTP) component, intensive and standard outpatient treatment, a recovery house, and a halfway house. Dr. Stoller sits on the board of the American Association for the Treatment of Opioid Dependence. He acknowledged the dedication of individuals who staff the OTPs who have continued to provide treatment during the pandemic. He also acknowledged the support of SAMHSA and other health agencies.

Mr. Jason Howell, who is in long-term recovery from both mental health and substance use issues, is Executive Director of the nonprofit organization, RecoveryPeople. This organization is based in Texas and has begun work in other states and provides training, technical assistance, and recovery housing certification. Mr. Howell is on the board of the National Alliance for Recovery Residences.

## **Consideration of the March 26, 2020 Minutes**

Dr. Bullock called for a motion for approval of the March 26, 2020, minutes for the 82<sup>nd</sup> meeting of the CSAT NAC. Mr. Medina moved to adopt the minutes, and Dr. Martin seconded the motion. The motion was passed without objections or abstentions. The Council then approved the March 26, 2020, minutes.

## **CSAT Updates**

Dr. Bullock began with a review of the agenda, which was developed to highlight significant updates since the last NAC meeting. He stated that NAC members would hear about the DATA Waiver Program, the State Opioid Response (SOR) Program, the Substance Abuse Prevention and Treatment Block Grant (SABG) maintenance of effort (MOE), and the Pregnant Women Pilot program. Also, NAC members would hear presentations about the SAMHSA Strategic Plan, SAMHSA's response to prevent suicide due to the COVID-19 pandemic, and the latest findings from the National Survey on Drug Use and Health (NSDUH).

### *Topic: DATA Waiver*

Dr. Bullock next introduced Dr. Neeraj Gandotra, Acting Director of the Division of Pharmacologic Therapies (DPT), who delivered a presentation on the DATA 2000 Waiver Program. Dr. Gandotra is also Chief Medical Officer at SAMHSA.

DPT is responsible for several activities, including certifying that OTPs conform with federal regulations; processing waivers for qualified practitioners under the DATA waiver management system; managing the Providers' Clinical Support System (PCSS), which includes the PCSS-MAT, a national training and clinical mentoring program developed in response to prescription opioid misuse, and the PCSS Universities, which ensure the education of students and residents entering professional training to expand and enhance MAT services. The PCSS Universities program seeks to ensure that students fulfill the training requirements needed to obtain a DATA waiver.

DPT has processed more than 6,000 OTP exception requests and approved 6,000 newly waived providers. DPT also increased the patient limits of 1,600 providers and granted about 175 temporary increases to the 275-patient limit to address emergency situations.

During the COVID-19 pandemic, DPT has recognized the importance of staying in regular contact with the State Opioid Treatment Authorities (SOTAs) to understand the states' situation—whether there were shortages of methadone or other medications or provider shortages. DPT provided guidance in several areas, including OTPs for quarantined patients, and offered technical assistance on implementing telehealth. Also, DPT—in collaboration with the Office of Civil Rights—relaxed enforcement of HIPAA requirements for individuals and providers using telehealth and telemonitoring.

Dr. Gandotra also discussed bringing the processing of DATA 2000 waivers in-house, utilizing SAMHSA staff and resources within DPT in collaboration with the Center for Behavioral Health

Statistics and Quality (CBHSQ) to maintain the data and the Drug Enforcement Agency (DEA) to verify the information. In September, DPT began processing X-waiver provider applications.

Dr. Gandotra ended by reflecting on flexibilities such as expanded telehealth that may remain after the pandemic comes to an end. He would like to hear from the NAC members about what they find feasible and clinically sensible.

*Topic: SOR Program*

Dr. Bullock next introduced C. Danielle Johnson Byrd, Director of the SOR Program, who updated the group on program activities. According to grantees' Programmatic Progress Reports between September 30, 2018, to March 30, 2020, more than 521,000 clients received treatment services. Almost 232,000 clients received recovery support services, more than 1,036,000 naloxone kits were distributed, and nearly 50,000 overdose reversals were reported. In addition, about 180,000 clients received MAT through the program. Because many states are allowed to use Medicaid expansion funds to pay for MAT, grantees have been able to use more funds for prevention and recovery support services. The most common SOR programs' most common services are case management, alcohol/drug testing, substance abuse education, treatment/recovery planning, and referral to treatment.

Ms. Byrd shared some SOR success stories. For example, Florida entered into an interagency agreement with the Florida State Courts to provide training and Technical Assistance (TA) to judges and court staff regarding opioid use and its impacts on their clients to determine sentencing and selecting treatments. They have found that a significant number of people involved in the court system have substance use disorders, and the court system judges and staff are essential partners in facilitating access to treatment and support services. She also described successful program activities in West Virginia and Iowa.

Ms. Byrd next reviewed effective SOR strategies employed by grantees, including implementing evidence-based practices (EBPs), enhancing the network of MAT providers through continuous trainings, integrating wrap-around recovery support services, and implementing and improving telehealth.

COVID-19 has impacted all grant programs, including the SOR program. SOR-funded programs deemed nonessential have been shut down, and services have been modified, and restrictions have been placed on other SOR-funded programs. School-based prevention events have been forced to reschedule, and some mental health care workers and public health staff have been deemed nonessential, leading to workforce challenges. Grantees have been creative in overcoming some of these barriers. For example, some recovery support teams have made socially distanced home visits or provided support through telehealth and other technologies. Ms. Byrd highlighted the types and characteristics of TA provided to grantees during the COVID-19 pandemic. They include policy updates, training on opioid use disorder (OUD) treatment and best practices, COVID-19 resources and webinars, virtual platforms, state-to-state support, and others.

Ms. Byrd closed with an overview of SOR II. SOR II has the same goals as the first program: increasing access to MAT, reducing unmet treatment needs, and reducing opioid overdose-related deaths. A total of 57 states and territories have received \$1.4 billion in funding, with a 15 percent set-aside for the ten states with the highest drug overdose mortality rate (West Virginia, Delaware, District of Columbia, Maryland, Pennsylvania, Ohio, New Hampshire, New Jersey, Massachusetts, and Kentucky). In addition to treating OUD, grantees may use funds to address stimulant misuse and use disorders, including cocaine and methamphetamine.

*Topic: SABG MOE*

The next presentation covered the SABG MOE and was delivered by Jessica Hartman, Public Health Advisor in the Division of State and Community Assistance, and a MOE subject matter expert. State project officers have received inquiries from several states about MOE requirements during the COVID-19 public health emergency.

COVID-19 has presented a unique situation for states; some have experienced shutdowns and other challenges that have impacted the availability of treatment services and states' ability to meet SABG requirements. SAMHSA is working to alleviate states' concerns with written correspondence sent July 17 from the Assistant Secretary. There is a copy of the letter on the SAMHSA website. The letter addresses concerns states may have in meeting MOE requirements in light of COVID-19 and outlines potential resolutions.

While SAMHSA cannot offer a blanket waiver to all states, states will receive a notification letter letting them know if it has been determined that they have a MOE shortfall and explaining how to request a waiver. If traditional waiver criteria do not apply, SAMHSA has an alternative option for potentially granting waivers: Section 1957 of the Public Health Services Act permits the Secretary to waive requirements of a grant during a federally declared public health emergency. The waiver at this time may only be applied to FY2020, and it is important to note that only the MOE requirements are currently being considered. If the state does not qualify for a waiver for any reason, it still has the option to request a determination of material compliance decision.

*Topic: PPW Evaluation*

Next, Dr. Bullock introduced Ms. Linda White-Young, who presented an update on the State Pilot Program for Treatment of Pregnant and Postpartum Women (PPW-PLT). Ms. White-Young is a Public Health Advisor in the Division of Services Improvement.

The purpose of the PPW-PLT program, authorized under the Comprehensive Addiction and Recovery Act of 2016, is to support PPW family-based services, expand and enhance continuing care in nonresidential settings, and promote coordinated, effective, and efficient state systems by encouraging new approaches and service delivery models. Three cohorts have been funded, the most recent of which was a cohort of five states funded in September 2020: Arizona, Connecticut, Illinois, Montana, and Oklahoma.

Ms. White-Young described some of the results that the program has achieved, including the following:

- Bridged gaps in the continuum of care in nonresidential treatment settings for women, minor children, and their family members affected by substance use disorders.
- Adapted service delivery in nonresidential treatment settings to offer gender-specific and culturally appropriate family-centered treatment and recovery support services.
- Served as an alternative specialized level of care, following the completion of residential treatment. This is important because there are times when residential treatment is not available in community outpatient settings.
- Provided intensive, high-level care, and recovery support services in outpatient treatment for women.
- Expanded access to care for diverse populations of women, particularly for those living in rural settings.
- Developed capacity in communities that currently do not provide specialized care for women or family-centered treatment.

Ms. White-Young also reviewed some of the promising practices being implemented in the pilot program, including certifying family-based clinical treatment as a level of care and expanding the role of peer recovery coaches to increase access and retention in care. A program evaluation will be completed, and findings reported to Congress in FY2021.

### **Council Discussion**

Following the presentations, Dr. Bullock opened the floor to questions and discussions. The following points and questions were raised:

- Dr. Roy remarked on a problem he has observed - pharmacies in Louisiana must count buprenorphine as an opiate and report it to DEA as part of their total opiate distribution. As a result, some pharmacies have been resistant to filling new buprenorphine prescriptions. He asked if SAMHSA could change this policy. Dr. Gandotra responded that SAMHSA is aware that buprenorphine is counted as an opioid. There has been a growing subset of buprenorphine products that have been increased -- increasing in the diversion. He also acknowledged that DEA tracking is important, but the policy change would be left to DEA.
- Dr. Martin commented on Dr. Gandotra's request for feedback on telemedicine. She said that first impressions indicate that some people like it very much, improving their contact with treatment programs. Others would instead attend in person. It would be good to have options, including telephone-based telehealth. She remarked that being able to prescribe buprenorphine by telephone during an emergency has increased access. In addition, being able to waive the time-in-treatment decisions about take-home MAT has been useful. Dr. Martin also asked Ms. White-Young about the definition of "postpartum" used in the PPW pilot program. Ms. White-Young replied that the program considers "postpartum" to be 12 months post-delivery.

- Dr. Stoller, a member of the PCSS Steering Committee, stated that he was not in favor of some of the congressional pressures to reduce training requirements to prescribe buprenorphine, noting that providers are poorly trained in the use of narcotic medications contributed to the opioid epidemic. There is emerging evidence that buprenorphine is being misused as it becomes more available. There is little evidence to suggest that the training requirement significantly reduces the number of prescribers. Providing more education and mentorship would increase the provision of buprenorphine treatment. Dr. Gandotra replied that CSAT agrees with Dr. Stoller on the need for highly trained and educated providers to address OUD. Having substance use disorder (SUD) meaningfully integrated across the curriculum for professional schools would make it easier to recommend removing an X-waiver requirement, but that is far away. Dr. Gandotra commented on buprenorphine diversion, noting that DEA tracking is essential and their decision to track buprenorphine prescriptions.
- Dr. Stoller asked whether data collected by buprenorphine waived to treat 275 patients is available for analysis. It is essential to see the data to ensure that the quality of care was not sacrificed in the interest of using this method to increase access. He also asked whether the SOR program data is available for analysis. Regarding the reporting requirements for providers who are at the 275-patient limit, SAMHSA is just beginning to receive data. Thus far, the response rate has not been outstanding because SAMHSA has decided not to roll back any provider who did not submit the report without contacting them first. Regarding SOR program data, Ms. Byrd stated that only performance data is currently available, not meant for research. However, this data has been used to generate reports to Congress, and at least one of these reports will be available to the public in the near future.
- Ms. LeGore asked Ms. Johnson about school-based prevention events that have been rescheduled—have all events been rescheduled, or are some still occurring? She also asked about mental health caseworkers and public health staff being deemed nonessential. With the pandemic producing many mental health stressors, it would help have mental health care workers and public health staff be deemed, essential employees. Ms. Byrd responded that the status of school-based prevention events varies by the school district. If students are going to school, prevention events are continuing as usual. In other cases, students are receiving prevention programming online or via apps. In response to Ms. LeGore’s question about mental health, Ms. Byrd said she would provide some information from the Center for Mental Health Services on that issue.
- Ms. Harper asked whether alternative pain management for PPW is part of the pilot program, i.e., whether there are strategies or suggested tools for pregnant and postpartum women to be discussing with their providers. She also asked about the supervision and training of peer support specialists. She has seen research suggesting that outcomes seem to be better when there is adequate supervision of peers by trained staff familiar with peer work. Ms. White-Young replied that she is not aware of any emphasis on alternative pain management for PPW. Also, she pointed to Virginia as an example of a program with strong infrastructure development to increase the peer support specialist workforce.

- Ms. Harper asked Dr. Bullock to provide some guidance around how CSAT is defining recovery support services. Dr. Bullock explained that recovery support services are divided into two categories: 1) services, including peer mentors, recovery coaches, housing linkages, and other supports; and 2) infrastructure to support recovery, such as public education, addiction training, and peer recovery coach training.
- Dr. Martin commented favorably on the decision to include stimulants in SOR II and asked if there is an explicit statement that it is acceptable to use the money for contingency management as part of treatment. Ms. Byrd responded that contingency management is allowable for stimulant misuse or use disorders, although expenses are capped at \$75.
- Ms. LeGore asked about the Florida program discussed during the SOR presentation and whether the data would be available to all states. Ms. Byrd replied that the data is what is collected through GPRA or grantees' Performance Progress Reports. States are encouraged to learn from each other, and the program hosts a webinar series where states present on different topics, particularly successful activities. Ms. LeGore noted that sharing this data could lead to successful programs being replicated in other states.

### **SAMHSA's Strategic Plan Update**

Following the break, Dr. Bullock introduced Dr. Thomas Clarke, Director of the National Mental Health and Substance Use Policy Laboratory, who delivered an update on SAMHSA's Strategic Plan. He also provided a history of the Policy Laboratory.

SAMHSA's Policy Laboratory was developed as a result of the 21st Century Cures Act, which went into effect in December 2016. The Cures Act requires that the Policy Lab identify and coordinate policies and programs, including evidence-based practices related to mental and substance use disorders. The Policy Lab also coordinates and facilitates the implementation of policy changes that significantly affect mental health and substance use disorders; thus, much of its work is aligned with all of SAMHSA's programmatic areas. The Policy Lab coordinates with the Office of the Chief Medical Officer, National Institutes of Health, and other federal agencies. Over the past two years, much of the Policy Lab's focus has been on serious mental illness, serious emotional disturbances, and the opioid crisis.

Dr. Clarke moved to a discussion of the Policy Lab's portfolio, comprising the SAMHSA Strategic Plan, the Evidence-based Practice Resource Center, the Healing Communities Study, the Mental Disorder Prevalence Study, Emergency Department Alternatives to Opioids, and Workforce Projections.

#### *Strategic Plan*

The plan was developed in 2018 as part of the Cures Act and covers: 1) combating the opioid crisis; 2) addressing serious mental illness; 3) advancing prevention, treatment, and recovery support services for substance use; 4) improving data collection, analysis, dissemination, and program and policy evaluation; and 5) strengthening health practitioner training and education. In addition to developing the plan, the Policy Lab is also responsible for monitoring SAMHSA activities that support the plan and submitting a report to Congress every two years.

Priorities 1 and 3 are most closely aligned with CSAT's work. Concerning combating the opioid crisis, the Policy Lab is working to strengthen public health surveillance; advance the practice of pain management; improve access to, utilization of, and engagement and retention prevention, treatment, and recovery support services; target the availability and distribution of overdose-reversing drugs such as naloxone, and support cutting edge research on pain and addiction. Priority 3's objectives are to increase public awareness and subsequent behavior change regarding the risks of substance use; expand community engagement around substance use prevention, treatment, and recovery; and reduce youth substance use through strengthening protective factors and reducing risk factors.

#### *Evidence-based Practice Resource Center*

The Evidence-based Practice Resource Center is a repository of EBPs focused on prevention, treatment, recovery, and mental health. The focus is on EBPs that are practical, feasible, and cost-effective to implement. Practices are added to the resource center via a review committee composed of individuals at SAMHSA and other federal agencies. The Policy Lab draws on the EBPs to develop a series of guidebooks with information on particular substance use or mental health issue, recommendations for EBPs, and guidance on evaluating the usefulness of the intervention. EBP guidebooks have been developed on emerging adults, marijuana prevention among women of childbearing age, co-occurring disorders, MAT for OUD in criminal justice settings, and recovery, focusing on employment and education. Guidebooks scheduled for release in 2020 include stimulants, HIV, vaping, serious emotional disturbance, and suicide.

#### *HEALing Communities Study (HCS)*

SAMHSA is partnering with the National Institute on Drug Abuse (NIDA) on this study to determine if an integrated set of EBPs can reduce opioid-related fatalities when implemented within health care, behavioral health, justice systems, and community organizations. The states of Ohio, Kentucky, New York, and Massachusetts are testing this approach in 16 communities in each state. Expected outcomes include a decrease in opioid overdose events, increased use of MAT or OUD, and a reduction in high-risk opioid prescribing.

One of the study's key elements is that each community will develop a data dashboard that will monitor opioid use or deaths in that community. The data would then help tailor the types of EBPs that the community members would decide are best for the community. There is also a health communications component with a campaign to increase demand for EBPs and reduce stigma.

#### *Mental Disorder Prevalence Study*

This study aims to determine the prevalence of severe mental disorders, such as schizophrenia and bipolar disorder, in the U.S. The study will focus on household and non-household populations, including persons in prisons and hospitals who frequently are not captured in other data collection efforts. The grant began in 2019 and is being led by RTI International, which has partnered with several universities across the U.S. The first year has focused on planning and developing the research protocols primarily using the Structured Clinical Interview for DSM

Disorders (SCID DSM-5) instrument. Year 2 will be focused on data collection, and Year 3 on analysis and reporting. The interview will cover schizophrenia, major depressive disorder, generalized anxiety disorder, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, anorexia nervosa, and use and abuse of alcohol, benzodiazepine, opioids, stimulants, and cannabis.

#### *Emergency Department Alternatives to Opioids Grant Program*

This new program was authorized as part of the SUPPORT Act, and ten grants were funded in August 2020. Grantees are expected to develop or continue strategies to provide alternatives to opioids, including innovative pain management approaches. The grants will also be used to train providers and other hospital personnel on protocols and best practices related to opioid prescriptions and alternatives to opioids for pain management and then disseminate EBPs within the organization. More information about this program should be available at the next NAC meeting.

#### *Behavioral Health Workforce Grant Program*

SAMHSA and the Policy Lab are working with George Washington University to develop a database that enumerates the various behavioral health professions, including psychiatrists, addiction psychiatrists, counselors, social workers, psychologists, marriage/family therapists, nurses, peer specialists, and others. Much of the data will be pulled from secondary data sources such as the Bureau of Labor Statistics and professional associations. There has been a strong focus at SAMHSA on expanding the behavioral health workforce, so this is one step in this process.

### **Council Discussion**

Dr. Bullock opened the floor to questions and comments on Dr. Clarke's presentation. Council members raised the following questions and discussion points:

- Dr. Martin asked if the data dashboard being developed for the HLC study is similar to the cascade model used in Vancouver that shows whether an individual is on MAT and whether they had an effective dose. She also asked how data is added to the dashboard. Dr. Clarke responded that communities have some differences in what is presented in their dashboards because the information is tailored to the community. State governments collect some of the data, but there are sometimes restrictions on how this data may be used and shared. Dr. Martin followed up, noting that two helpful data points are the number of community bystander reversals using naloxone and breaking down the overdose and treatment data by ethnicity. The latter data point shows racial disparities in the rates of overdose and which MAT programs work best for different communities.
- Dr. Stoller inquired how the pandemic has disrupted SAMHSA's regular data collection efforts. He noticed that nicotine use disorder was not included in the HCS diagnosis list and wondered whether morbidity related to tobacco use would be addressed in the study. He also wanted to know whether SAMHSA has an estimate—official or unofficial—of deaths currently determined to be due to overdose that may actually have been due to

suicide. Dr. Clarke responded that most data collection and other activities have continued using technology. The pandemic may delay the Prevalence Study, but virtual data collection will begin in October. Dr. Clarke stated that nicotine use disorder and vaping are included in the Prevalence Study. He does not have information on suicide rates but will look into the question and get back to Dr. Stoller.

- Ms. Harper asked why there were relatively few EBPs on recovery support services included in the EBP resource center. Dr. Clarke acknowledged the importance of recovery support services but said that the evidence base is currently not as strong. A guidebook on employment recovery support services is under review. He invited Ms. Harper to send him or CSAT resources and tools to consider for inclusion.
- Ms. LeGore asked whether the HEALing Communities study is looking at the effect of family involvement. Dr. Clarke replied that there might be some questions on family support in the data collection instrument. Ms. LeGore added that she appreciates that the Prevalence Study is including non-household populations.

### **SAMHSA Response to Prevent Suicide to the COVID-19 Pandemic**

Dr. Richard McKeon delivered the next presentation on SAMHSA's efforts toward suicide prevention during the pandemic. Dr. McKeon is the Branch Chief of the Suicide Prevention Branch within the Division of Prevention, Traumatic Stress, and Special Programs at the Center for Mental Health Services.

SAMHSA has several existing programs focusing on suicide prevention, including the Garrett Lee Smith (GLS) State and Tribal Suicide Prevention and Intervention Program, GLS Campus Suicide Prevention Grant Program, Suicide Prevention Resource Center, Native Connections, and the National Suicide Prevention Lifeline. Most recently, SAMHSA has released the COVID Emergency Suicide Prevention grants.

Suicide is a significant and growing problem in the U.S. and is the 10th leading cause of death. It is a problem across the lifecycle; it is the second leading cause of death for Americans from ages 10 to 39. Also, suicide rates have increased in almost every state, with many states experiencing increases of more than 30 percent.

Since the beginning of the COVID-19 pandemic, significantly more Americans have seriously considered suicide, according to *the Morbidity and Mortality Weekly Report*. Increases were particularly significant for young adults, people of color, unpaid caregivers, and essential workers. SAMHSA has awarded 50 COVID Emergency Suicide Grants totaling \$40 million to states, community organizations, community providers, and tribes to meet this challenge. SAMHSA also gave supplements to all Native Connections grantees and expanded the Lifeline and Disaster Distress Helpline services. There was a requirement that 25 percent of the COVID Emergency grant funds must be focused on the interface between suicide and domestic violence because of concerns about potential increases in domestic violence during the pandemic.

The Suicide Prevention Resource Center has provided several COVID-related resources, including a webinar on treating suicidal patients during COVID-19, emphasizing remote

treatment and response, a video series that included information on collaborative safety planning, and a soon-to-be-released document called "Screening for Suicide Risk in Telehealth."

SAMHSA has also been engaged with the Surgeon General's Office on the "Call to Action to Implement the National Strategy for Suicide Prevention." The call to action will emphasize bringing successful efforts to scale nationally. It may also include promoting a comprehensive approach, addressing upstream factors, lethal means safety, evidence-based care, and crisis care enhancement. One other area of emphasis is trying to improve care after people leave emergency rooms. Recent research has found that mortality rates are much higher in the year after an emergency department visit for a suicide attempt than for other issues.

Dr. McKeon closed his presentation with an update on the National Suicide Prevention Lifeline. In July, the Federal Communications Commission assigned the number 988 as the new national suicide prevention number. All landline, cell phone, and voice over internet protocol provider in the U.S. must make 988 operational by July 16, 2022. The new number is envisioned as the centerpiece of transformed mental health and behavioral health crisis system.

### **Council Discussion**

Following the presentation, Dr. Bullock opened the floor to questions. Council members raised the following questions and discussion points:

- Dr. Martin asked if rates of suicide after making a call to the Lifeline had ever been studied. She also queried whether emergency department patients should be told of their significantly increased risk of death in the year after the visit. Dr. McKeon said that providers should share their concerns. He mentioned that the National Institutes of Health (NIH) research has found that asking every visitor to the emergency room whether they have suicidal thoughts, doubles suicidal individuals' identification. Studies from the Department of Veterans Affairs (VA) and NIH indicate that screening for suicide risk in the emergency room, doing a collaborative safety plan with patients, and following up with them in the next 24 to 48 hours helps link them to care.
- Ms. LeGore asked how linkages and resources could be maintained after the grant programs ended. She also asked about promoting the crisis text line. Dr. McKeon said that SAMHSA has been working with the National Action Alliance for Suicide Prevention, the American College of Emergency Physicians, and other stakeholders to disseminate the information to a broader audience. Ms. LeGore pointed out the importance of first responders having access to suicide prevention information. What may seem to be an accidental overdose could have been a suicide attempt.
- Dr. Stoller mentioned a Netflix show called "The Social Dilemma" that associated the advent of accessibility of social media platforms on smartphones with an uptick in suicide rates. He asked if there is reliable evidence supporting the causal association and whether SAMHSA is investigating this possible association. Dr. McKeon said there is no evidence showing a causal relationship between social media use and suicide, but there is a correlation. Suicide among youth and young adults has increased at a faster rate than among other age groups. Dr. McKeon said that SAMHSA routinely communicates with

the media about safe messaging around suicide. Also, efforts have been made to look at social media and promote recommendations and best practices.

- Ms. Harper remarked that she had lost friends and loved ones to suicide this year, and many people in long-term recovery are relapsing and dying by suicide. She asked if there is any research on the intersection of long-term recovery with suicidality or severe mental illness. Dr. McKeon replied that NIH had analyzed NSDUH data, estimating 110,000 suicide attempts annually among people in substance abuse treatment. It is an area that needs more attention moving forward.
- Ms. LeGore said that discussion on suicide must continue in light of the continuing pandemic and isolation people experience. Dr. Martin asked if there was a slide set available for teachers. Dr. McKeon replied that SAMHSA has a toolkit to prevent suicide in high schools, respond to suicidal ideation, and deal with a suicide attempt. The toolkit is currently being updated.

### **Latest Findings from the National Survey on Drug Use and Health (NSDUH)**

Dr. Bullock introduced Dr. Krishnan Radhakrishnan, Director of CBHSQ, who presented the 2019 findings from the NSDUH and discussed data collected by SAMHSA.

Dr. Radhakrishnan explained that SAMHSA collects data to evaluate the impact of a treatment or intervention, determine appropriate public health interventions, monitor progress, determine populations to target for intervention, determine values to care and influence public policy. In addition to collecting data, SAMHSA cleans, analyzes, and interprets it and makes it publicly available. CBHSQ is the lead federal agency for collecting and disseminating behavioral health data.

CBHSQ also provides statistical and analytical expertise to other SAMHSA centers and supports the Assistant Secretary for Mental Health and Substance Use and the HHS Secretary. The center collects data at the population, facilities, and patient-level through electronic health records and surveys.

The NSDUH, conducted annually in the U.S., examines the prevalence, correlates, and trends of substance use and mental health issues. It does not look at treatment in depth. The data collected encompass tobacco, alcohol, marijuana, and illicit drug use, misuse of prescription drugs; substance use disorder and treatment; and any mental illness, serious mental illness, suicidality, and mental health service use. The NSDUH covers the civilian, noninstitutionalized population aged 12 and older, excluding active military, long-term hospital residents, incarcerated individuals, and homeless people and not in shelters. Around 67,500 people are interviewed annually, beginning each January. Results from 2019 were just released and included the following:

- Approximately 51.5 million people over age 18 have some mental illness, and 19 million adults have some SUD; around 9.5 million have issues with both. Of those with a SUD, 40 percent struggled with illicit drugs, 73 percent with alcohol abuse, and 11 percent with substance and alcohol abuse.

- After caffeine, alcohol is the most commonly used drug in the world. There was a continued decrease in alcohol use among the 18-25 age group, but the incidence of underage drinking continues to be around 10 percent, which is concerning.
- Marijuana is the most commonly used illicit drug in the U.S., with 17.5 percent of the population reporting use in the NSDUH. This is a significant increase from 2018.
- The use of psychotherapeutic drugs such as stimulants, tranquilizers, and sedatives has been declining since 2015, while hallucinogens have increased in the last two years, as has the use of inhalants.
- Methamphetamines are a serious problem worldwide and are now the third most used illegal drug. Use among youth and youth-related deaths increases because the purity and potency of this drug have increased while the cost has decreased. In the western U.S., it is the number one cause of drug-related death.
- Although opioid use has decreased significantly since 2016, death rates continue to be depressingly high.
- Misuse of marijuana has been increasing rapidly, which may be associated with increased legalization or perceived decrease in risk, especially among the young. There was a large jump in marijuana use among 12- to 17-year-olds between 2018 and 2019, and almost 700,000 children have marijuana use disorder. However, it has decreased significantly compared to 2016 among 18- to 25-year-olds, who are generally considered the highest risk group.
- Substance abuse is associated with a substantial risk of suicidality. There has been a considerable increase over the last ten years in suicidal thoughts, making a plan, and attempted suicide.
- Self-help groups were the most common location where substance abuse treatment was received, with outpatient rehabilitation centers and outpatient mental health centers, the second and third most common locations. Emergency rooms and prisons or jails are numbers 6 and 7, respectively.
- There is a large gap between treatment and need. Among adults 18 or older with a past year SUD and serious mental illness, 33 percent received no treatment, and only 12 percent received treatment for their co-occurring disorders. For SUDs overall, 90 percent did not receive any treatment.

### **Council Discussion**

Dr. Bullock opened the floor for questions and comments. They included the following:

- Ms. Harper asked about the unwillingness to go to treatment and how that question was framed in the survey, given the stigma, discrimination, and equity issues people experience. Dr. Radhakrishnan did not have all of the details about the questionnaire but noted that providers who have the DATA waiver complain that SUD and OUD patients do not seem to go to them. Ms. Harper also suggested adding questions about recovery support services. Dr. Radhakrishnan remarked that they were considering additional questions on this topic.

- Dr. Martin asked about reasons for not seeking treatment for a SUD. The majority of respondents in previous surveys did not perceive the need for treatment. This finding emphasizes the need for low threshold outreach. Dr. Radhakrishnan said that only 4.9 percent of those surveyed perceived the need for treatment. Ms. Harper commented that discrimination and equity are often associated with individuals saying they do not need treatment; for example, pregnant women may fear losing their children.
- Ms. LeGore asked if self-medicating for mental health problems could account for some of the increase in marijuana use. Dr. Radhakrishnan responded that they have considered that another factor might be increased willingness of respondents to say they are using marijuana because of the reduction of stigma if it is a legal product.

### **Public Comment**

Dr. Bullock opened the floor for public comments. There were no public comments.

### **Recap: Putting It All Together**

Dr. Bullock thanked the council members for welcoming him to CSAT and said he looks forward to working with the Council. Upon his request for the last comments, Ms. LeGore introduced herself since she was unable to at the beginning of the meeting.

### **Adjournment**

There being no further comments or questions, Ms. Goss asked for a motion to adjourn. Ms. Harper moved to adjourn the meeting, and Ms. LeGore seconded the motion. Ms. Goss adjourned the meeting at 5:04 p.m.

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