

**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
National Advisory Council (NAC) Meeting
5600 Fishers Lane
5th Floor, Conference Room 5A04
Rockville, MD**

August 10, 2017

Chairperson

Paolo del Vecchio, M.S.W.
Director, Center for Mental Health Services (CMHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)

Designated Federal Official

Pamela Foote
Office of Program Analysis and Coordination, CMHS
Substance Abuse and Mental Health Services Administration

Council Members Present

Paul Gionfriddo, B.A.
Wenli Jen, Ed.D. (by telephone)
Jeffrey W. Patton, M.S.W.
Gilberto Romero, B.A.
Jeremiah Simmons, M.P.H., M.S.

Council Members Absent

Lacy Kendrick Dicharry, M.S., M.B.A.
Jeremy Lazarus, M.D.
Juanita Price, M.Ed.
Stacy Rasmus, Ph.D.
Katia Reinert, Ph.D., R.N., CRNP, FNP-BC, PHCNS-BC
Alan Sokolow, M.D.
Jürgen Unützer, M.D., M.P.H., M.A.

Other SAMHSA Attendees

Priscilla Clark, Ph.D., P.C.C., Deputy Director, CMHS
Cyntrice Bellamy, M.S., M.Ed., Division Director, Division of State and Community System
Development (DSCSD), CMHS
Gary Blau, Ph.D., Branch Chief, Child Adolescent and Family Branch (CAFB), CMHS
Anita Everett, M.D., Chief Medical Officer, Office of the Chief Medical Officer
Patricia Gratton, Director, Office of Program Analysis and Coordination, CMHS
Charlene Jenkins, Staff Assistant, Office of the Director, CMHS
Daryl Kade, M.A., Director, Center for Behavioral Health Statistics and Quality (CBHSQ)

Steve Fry, M.S., Public Health Analyst, Office of Consumer Affairs (OCA), CMHS
Anne Mathews-Younes, Ed.D., D.Min. Director, Division of Prevention, Traumatic Stress, and Special Programs, CMHS
Audra Stock, L.P.C., M.A.C., Center for Substance Abuse Treatment
Keris Jän Myrick, M.B.A., M.S., Director, OCA, CMHS
Kelley Smith, Ph.D., Senior Advisor, CBHSQ
Tison Thomas, M.S.W., L.M.S.W., Branch Chief, State Grants Eastern Branch, DSCSD, CMHS
Luis Vasquez, L.I.C.S.W., Division Director, Division of Service and Systems Improvement, CMHS
Eric Weakly, Branch Chief, State Grants Western Branch, DSCSD, CMHS

Other Attendees

Phyllis Ampofo, M.P.H., National Institute of Mental Health
Jon Katov, Open Table Organization

CALL TO ORDER AND ROLL CALL

Ms. Foote called the Council meeting to order at 10:45 a.m. and conducted the roll call of the NAC members.

WELCOME AND OPENING REMARKS

Mr. del Vecchio welcomed the members to the open session of the meeting. He asked attendees from CMHS to introduce themselves and then reviewed the day's agenda.

CMHS DIRECTOR'S REPORT

Mr. del Vecchio announced two CMHS personnel updates. Dr. Elinore McCance-Katz, M.D., Ph.D., was confirmed by the Senate in August 2017 as the new Assistant Secretary for Mental Health and Substance Use. In addition, Dr. Justine Larson, M.D., M.P.H., M.H.S., joined CMHS as the Senior Medical Advisor.

Mr. del Vecchio reviewed the FY 2017 enacted budget for CMHS, noting the total is \$1.181 billion. The Programs of Regional and National Significance total is \$398,659,000; Children's Mental Health Services \$119,026,000; Projects for Assistance in Transition from Homelessness (PATH) \$64,635,000; Protection and Advocacy \$36,146,000; and the Mental Health Block Grant (MHBG) \$562,571,000. This budget includes increases in funding for the MHBG and for a new Zero Suicide program.

The proposed President's Budget for fiscal year (FY) 2018 is \$912,347,000 with an overall reduction of approximately 22 percent. There are proposed reductions for the following programs:

- Project AWARE state and community school-based mental health efforts;
- Mental Health First Aid and Youth Mental Health First Aid;
- Healthy Transitions;
- The Primary and Behavioral Health Care Integration Program;

- The Center for Integrated Health Solutions (currently co-funded by the Health Resources and Services Administration).

In addition, the Minority AIDS Initiative program would see a 50 percent funding reduction and the Mental Health Block Grant would sustain nearly a 25 percent reduction in funding. The President's budget would fund two new efforts: the Assertive Community Treatment grant program and a 10 percent set aside from the Childrens' Mental Health Initiative to focus explicitly on delivering services to youth and young adults up to the age of 25 who are at clinical high risk for psychosis.

The proposed House budget also includes substantial budget reductions, but with some differences if compared to the President's proposed budget. For example, the House budget would sustain the Mental Health First Aid program and the Primary and Behavioral Health Care Integration Program but reduce the PRNS Practice Improvement and Training program funding lines.

Mr. del Vecchio reviewed efforts in several of CMHS's programs over the past fiscal year:

- Creation of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), as authorized by the 21st Century Cures Act. Committee members include representatives from 10 federal agencies and 14 subject matter experts from across the country. The Committee is charged with:
 - Identifying advances in meeting the needs of individuals with serious mental illness (SMI) and children with serious emotional disturbances (SED).
 - Reporting on outcomes and data associated with federal efforts to serve these populations; and
 - Offering recommendations on how to improve coordination of such efforts to Congress and federal agencies.
- The Integration Incentive Grants and Cooperative Agreements program, authorized under the 21st Century Cures Act, promotes the integration of primary and behavioral health care. The program replaces the Primary and Behavioral Health Care Integration (PBHCI) program with the following specific changes:
 - States, not facilities, must be the primary applicant;
 - States must partner/collaborate with at least one qualified community program;
 - The program must include care for children and adolescents as well as adults;
 - The program would include an emphasis on co-occurring physical health, conditions, chronic diseases, and substance use disorders; and
 - Grant awards are up to \$2 million for up to five years.
- The MHBG 10 percent set-aside for first episode serious mental illness (SMI) continued in 2017. More than 200 sites are collecting outcome data and the electronic data platform is expected to be operational by October 1, 2017. Challenges experienced within this program include budget limitations, inadequate health insurance

reimbursement for many adolescents and young adults, and the need for privacy protections.

- The Zero Suicide program targets people over age 25 and includes evidence-based efforts to implement comprehensive suicide prevention strategies in health or behavioral health systems.

Mr. del Vecchio reviewed FY 2017 Grants and Contracts, including eight new funding opportunity announcements (FOAs), ranging from the CMHI program to opportunities to work with American Indian/Alaska Native communities. SAMHSA also funded six “off-the-shelf” grant programs, including efforts focused on supported housing, child traumatic stress, and statewide family and consumer networks. The three new major contracts in FY 2017 are CMHS Wellness, Resilience and Recovery Campaigns; Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Training and Technical Assistance Center; and Service Members, Veterans, and their Families Technical Assistance Center. CMHS anticipates 87 new grant awards for FY 2017. Overall, CMHS manages a total portfolio of 729 grants and 40 contracts.

Mr. del Vecchio reviewed FY 2017 performance-based measures to date, noting that 99 percent of the set goal was met for training in suicide prevention grant activities. For the number of consumers served in all discretionary programs, 71 percent of the set goal was achieved. In addition, data shows improvement in all consumer outcomes for discretionary programs, including tobacco use, stability in housing, school attendance, and social connection.

CMHS efforts to increase stakeholder engagement included the Children’s Mental Health Awareness Day held on May 4, 2017. Analysis of media coverage confirmed the success of this event, which included appearances by U.S. Olympians Michael Phelps and Allison Schmitt. In conjunction with Awareness Day, SAMHSA released a set of informational materials for family members of children and youth with SED. The 2017 Voice Awards will be held August 16, 2017 to honor military service members, veterans, and their families. Celebrity Chef Robert Irvine, Food Network Host, will host this event which acknowledges television and film portrayals that have exhibited outstanding work in the depiction of mental illness and addictions.

New educational materials cleared for publication in FY 2017 include the following:

- Creating Safe Scenes: An Online Course for First Responders;
- Helping Survivors Cope with Grief
- Coping with Grief after a Disaster or Traumatic Event; and
- Clinical Decision Support Courses for Co-occurring Disorders.

New Expert Panels are scheduled as follows:

- Eating Disorders: August 8, 2017;
- Enhanced Discharge from Emergency Departments: August 10- 11, 2017;
- Case Management: August 14 – 15, 2017; and
- Suicide Prevention, Bipolar Disorder, and Suicidality: August 22, 2017.

In addition, the SAMHSA blog has addressed topics such as “Mental Health Days Are Good for Business,” “Meeting the Growing Need for Behavioral Health Services on Campuses,” and “Does a Digital Lifestyle Affect Our Mental Health.”

Mr. del Vecchio concluded by showing a video clip of a public service announcement for Project LAUNCH, which communicates the importance of social-emotional development and social connection for children and adolescents.

Council Discussion

Mr. del Vecchio clarified that reports from CMHS Expert Panels are often used for internal planning purposes. Other panels are convened to produce fact sheets. However, he will provide NAC members with copies of the reports upon request. CMHS also has an internal newsletter, “CMHS Rocks”, which can be made available to NAC members.

NAC members agreed that with the possibility of impending reductions in federal funding, it will be important to harness community resources and to approach state, city, county, and local governments to compensate for lost funds. An emphasis is needed on healthy communities as well as healthy individuals.

REPORT FROM SUBCOMMITTEE ON CONSUMER ISSUES

Speaker: Mr. Gilberto Romero, B.A., Acting Chair, CMHS NAC Subcommittee on Consumer Issues

Mr. Romero reported on the findings and recommendations from the August 9, 2017 meeting of the Subcommittee on Consumer Issues. The meeting focused on current changes to advance suicide prevention efforts, including faith-based efforts and peer workforce activities. Highlights included faith-based efforts to equip faith leaders with the knowledge and skills to help people who have experienced events that have led to moral injury, social isolation, and other challenges that may contribute to suicidal ideation. The Subcommittee acknowledged that efforts to address gaps in suicide prevention are essential.

One of the gaps in suicide prevention is the lack of consumer engagement in care post-emergency room and hospital discharge. Research indicates suicide risk increases after discharge. Mr. Romero and the CMHS NAC Subcommittee on Consumer Issues recommended that the NAC encourage CMHS to promote greater adoption of peer and family engagement models to help prevent suicide, including the use of existing technical assistance (TA) efforts. Specific recommendations were as follows:

- *Recommendation 1:* Expand the use of evidence-based peer support, family support, and engagement models, such as Didi Hirsh peer group model and the Mental Health Association of San Francisco (MHA-SF) Hope model, throughout the entire system of care.
- *Recommendation 2:* Develop protocols for peers and families to increase knowledge and use of evidence-based suicide prevention tools such as collaborative safety plans.
- *Recommendation 3:* Ensure World Suicide Prevention Day and Suicide Prevention Week is recognized during SAMHSA’s recognition of National Wellness Week.

Council Discussion

Mr. del Vecchio noted that the Suicide Prevention Resource Center (SPRC) has been leading efforts to determine how the involvement of peers could be helpful in suicide prevention. Mr. Romero responded that many people who are at risk for suicide are emotionally driven and impacted by social frustration in response to factors such as long-term unemployment and the inability to attend educational institutions.

Mr. Gionfriddo commented that 67 percent of persons in SAMHSA programs are neither employed nor in school. However, this percentage has decreased slightly due to ongoing initiatives.

Mr. Gionfriddo also described MHA's successful reaction to the show "13 Reasons Why". There was substantial concern that this show could lead to an increase in suicide events. MHA held a Facebook live chat that demonstrated the willingness of the peer community to engage in a discussion about suicide prevention. MHA plans to more formally develop outreach efforts leading up to the next season of "13 Reasons Why". Mr. Romero suggested that a multi-media approach in response to "13 Reasons Why" is needed, including distribution of print material on the streets and the use of social media. One advantage of social media is that it depersonalizes the conversation so that people are not embarrassed to discuss their experiences.

Mr. Romero commented on the importance of suicide prevention programs targeting people in their middle years. At this stage of life, people with mental illness are more likely to require integration of physical and mental health services. Mr. Weakly responded that a prior Subcommittee meeting had focused on this population. The Subcommittee discussed the need for: (1) an integration of efforts targeting mental and physical health for suicide prevention; (2) federal oversight of mental health and aging best practices; (3) strategies to apply future best practices; and (4) funding issues. The Subcommittee made recommendations on these topics to the NAC. Mr. Weakly will provide NAC leadership with a summary of the meeting and Subcommittee recommendations.

SAMHSA UPDATES

Dr. Anita Everett, M.D., DFAPA, Chief Medical Officer, Office of the Chief Medical Officer (OCMO), stated that she joined SAMHSA in August 2016. She leads efforts related to the 21st Century Cures Act that was enacted by Congress in December 2016, in part, to combat the opioid epidemic in the United States. Dr. Everett engages in policy coordination across SAMHSA, conducts performance metrics that encourage evidence-based practices, and engages external professional organizations. She stated that Dr. Kris McLoughlin, DNP, APRN, PMH-CNS, DC, CDAC-II, FAAN, recently joined the OCMO to explore ways to strengthen the role of psychiatric nursing in the treatment of opioid addiction.

Dr. Everett provided a summary of her activities since joining SAMHSA. Her office reviewed the soon-to-be-released Treatment Improvement Protocol (TIP) "Clinical Guidance for Treatment of Pregnant and Parenting Women with Opioid Use Disorder (OUD) and their Infants". The TIP is designed in a new millennial-friendly format. It will be searchable online and not produced in print format. In addition, "Facing Addiction in America: The Surgeon General's Report on

Alcohol, Drugs, and Health” is a valuable downloadable resource. Dr. Everett also recently attended a CMHS meeting on eating disorders and treatment.

Dr. Everett stated that SAMHSA, in partnership with CMHS and various professional organizations, recently held a meeting on the integration of pediatric mental and behavioral health care into primary care settings. She also discussed the University of New Mexico (UNM) School of Medicine’s work with the Extension for Community Healthcare Outcomes (ECHO) model of medical education and care management. UNM researchers are quantifying and characterizing this tele-psychiatry technique for use in the treatment of substance use disorders. In addition, a program in Ohio is exploring the possibility of applying the ECHO model to treatment-resistant schizophrenia.

Council Discussion

Dr. Everett clarified that the ECHO model may encourage physicians to begin to treat disorders that they might not have been comfortable treating based on their expertise. For example, ECHO might provide access to prescribing psychologists with expertise in treating opioid addiction. Council members commented that tele-psychiatry works well and is preferred by some subgroups of patients who wish to avoid the stigma that may be associated with mental illness or substance use. For example, an adolescent may prefer the ECHO model to personal contact with a psychiatrist. Adolescents may also be more likely to use ECHO if it is offered within a school-based setting rather than in a less private space such as a community clinic. Older individuals, who are more used to one-on-one care, may adapt well to the ECHO model as they become more familiar with the model.

SAMHSA LEARNING AGENDA

Speaker: Daryl Kade, M.A., Director, Center for Behavioral Health Statistics and Quality, SAMHSA and Kelley Smith, Ph.D., M.S.W.

Discussant: Jeremiah Simmons, M.P.H.

Ms. Kade stated that the Learning Agenda is a component of the President’s Budget for FY 2018. The objectives are to:

- Identify the most important questions to be answered to improve program implementation and performance.
- Strategically prioritize these questions given current understanding, available resources, and feasibility.
- Identify the most appropriate tools to answer each question.
- Make better use of existing administrative data to build evidence.
- Utilize new tools and methods, such as rapid-cycle iterative evaluation and approaches that utilize behavioral science.
- Disseminate findings in ways that are accessible and useful to stakeholders.

The development of SAMHSA Learning Agenda activities will require an agency-wide effort. Ms. Kade’s team has begun to compile an inventory of SAMHSA activities by topic area and research

question. This effort involved collaboration with the SAMHSA Executive Leadership Team (ELT) to upgrade the SAMHSA National Registry of Evidence-based Programs.

Information gathering efforts are focusing on three sets of topics: (1) opioids, SMI, and SED; (2) alcohol, marijuana, and HEF; and (3) suicide and other topics. The team has created a dashboard of current activities, evaluated policy and procedures, and assessed procedures for dissemination of Learning Agenda results. Team members will present findings and recommendations to the SAMHSA Executive Leadership Team (ELT) and later to the new Assistant Secretary for Mental Health and Substance Use Disorders. They will develop a plan for needed activities over the next three to five years which links to SAMHSA's strategic plan.

Dr. Smith reviewed examples of priority research questions related to SMI and SED identified by expert panels. The questions address topics such as the nature and extent of SMI and SED, the impact on certain populations, treatment capacity and approach, use of wraparound services, and metrics. Outside experts have vetted the questions which are now under SAMHSA review.

Ms. Kade discussed a sample of current and planned Learning Agenda activities that focus strongly on identifying gaps in program efforts. Next steps will be to: (1) engage the ELT on suicide and cross-cutting vulnerable populations; (2) identify additional priority topic areas; (3) engage CMHS senior staff and subject matter experts on current and future activities; (4) coordinate with the Office of the Assistant Secretary for Planning and Evaluation to develop a Behavioral Health Evaluation Plan; and (5) initiate outreach to Department of Health and Human Services partners. Ms. Kade emphasized the need to embrace the Learning Agenda, not only for SAMHSA activities, but also for the overarching behavioral health system.

Council Discussion

Mr. Simmons affirmed the value of the Learning Agenda research approach to guide investment of resources. It may be particularly valuable to guide efforts to assess the appropriateness of evidence-based or empirically driven treatments for populations that experience the most health disparities. Furthermore, most clinics have existing in-house data on many of the measures needed to answer questions on this topic. Mr. Simmons added that the Learning Agenda approach does not stop at describing health disparities, but focuses on applying evidence-based practices to improve health equity and to consider structural determinants of health.

Mr. Simmons observed that the Learning Agenda is inherently multidisciplinary and multi-level and will require a steep learning curve. It will be necessary to merge individual- and community-level datasets, merge policy and economic variables, incorporate advanced hierarchical statistics, develop intersectional framing of data, and integrate qualitative and quantitative analysis. Also needed are participatory research and dissemination, testable theories, and comparison populations to assess causal changes. This effort will likely require collaboration among multiple agencies as well as outside expertise. Dr. Smith noted that the Learning Agenda team is currently engaged in much of the work described by Mr. Simmons.

Mr. Gionfriddo commented on a Learning Agenda strength: it collects data with the purpose of describing, explaining, or evaluating something. He stated that much of the currently available

data on SED is not useful for assessing how to direct resources to improve health. He discussed discrepancies among data sources, noting that the data on the number of children with SED differ among Department of Education, SAMHSA, and National Institute of Mental Health (NIMH) sources. In particular, the SAMHSA and NIMH estimates are 28 times higher than the estimates from the Department of Education. He posed the question of how to incorporate these disparate data into a Learning Agenda framework, noting the importance of including the Department of Education in the process, because children spend a large percentage of their time in school and a primary objective is to maintain school attendance.

Mr. Romero commented on the importance of communicating Learning Agenda findings to the public in an understandable way that does not require statistical expertise.

FAITH-BASED EFFORTS

Open Table

Speaker: Jon Katov, Founder and CEO, The Open Table Organization

Discussant: Gilberto Romero, B.A.

Mr. Katov described the background, founding, and success of the Open Table Organization. Open Table was founded by his church leaders as they learned how to best interact with homeless persons to improve outcomes. For example, they learned to ask the people they serve what they need instead of assuming that their needs would be met by donations of food and clothing. They realized that congregations had a wealth of intellectual and social capital and community connections for goods and services not available to homeless persons. They developed a model in which several volunteers meet regularly with the person served in an “Open Table” format. The person served is in charge of the Table and sets his own plans and goals. The volunteers provide assistance to help meet the goals. Mr. Katov described two case studies of successful Open Table outcomes.

The “Open Table” model is based on the premise that relationships transform communities. Tables are multigenerational, are socially integrated, provide social support, and include an after-plan. The Organization’s partnership with SAMHSA has led to a national faith-government co-investment model, demonstrating that communities can support sustainable transformation. Open Table sites have been initiated in Pennsylvania, New York, Florida, Michigan, Virginia, Indiana, and Missouri.

As a license-driven model, Open Table requires that sites adhere to the core steps of the process developed over 15 years of practice. Open Table has built fidelity tools to ensure that drift does not occur and to help sites celebrate their successful implementation of the model. SAMHSA’s contribution includes training support for Open Table sites and intellectual and social capital.

Mr. Katov described several Open Table research efforts exploring manualization of the model, theory of change, logic modeling, replicable training, and descriptive qualitative and early longitudinal studies of outcomes. A 2015 study of 2013 graduates showed that more than 85 percent of Open Table graduates were still in frequent contact with their Table after 2 years.

An ongoing study is examining the “Ripple Effect,” based on observations that Tables have a long-term positive influence on others in the served individual’s family networks.

Faith. Hope. Life.

Speaker: Anne Mathews-Younes, Ed.D., D.Min., Director, Division of Prevention, Traumatic Stress, and Special Programs

Discussant: Gilberto Romero, B.A.

Dr. Mathews-Younes discussed the Action Alliance’s “Faith.Hope.Love.” campaign, which works with Christian, Muslim, and Jewish faith-based communities to enhance suicide prevention. The campaign seeks to improve mental health literacy in the clergy and laity, address the reluctance of many faith communities to discuss suicide, and to build skills to engage in such discussions. Participation in faith communities provides relationship and community, which are powerful protective factors.

Dr. Mathews-Younes provided a link to the Faith.Hope.Love. Facebook campaign page <https://www.facebook.com/Faith.Hope.LifeCampaign> and to the webpage http://actionallianceforsuicideprevention.org/faithhopelife_v2 which contains links to resources for clergy.

The campaign is preparing to launch a National Day of Prayer on September 10, 2017. This campaign encourages people to pray for persons with mental health challenges, people who are suicidal, and families that may have experienced a loss to suicide. Dr. Mathews-Younes played a video clip of faith leaders Rick and Kay Warren, who lost a son to suicide, encouraging participation in the National Day of Prayer.

Council Discussion

In response to a question from Mr. Romero, Mr. Katov clarified that although the Open Table model began as a faith-based movement, its reach expanded to secular organizations after collaborating with SAMHSA. The main principle is that it is a “for one another” movement, regardless of the setting. For example, the YMCA, Rotary Clubs, and Universities host Tables. There are also efforts to initiate Tables in business settings.

Mr. Romero commented that secular settings may be suitable for people who have had bad experiences with religious organizations and for people who prefer to avoid institutional settings. He commented that the Open Table model encourages healthy relationships, meets the desire to feel accepted, and provides a nurturing environment for growth and development.

Mr. Simmons suggested that the Open Table model would be a good fit for the tribal community in which the concept of interdependency is culturally consistent. Dr. Jen commented on the importance of human contact, relationships, hope, trust, encouragement, and the concept of future self.

CO-OCCURRING SMI AND OUD

Center for Substance Abuse Treatment (CSAT) Opioid-Focused Initiatives and Programs

Speaker: Audra Stock, LPC, MAC, Division Director, Division of Services Improvement, Center for Substance Abuse Treatment, SAMHSA

Discussant: Jeffrey Patton, M.S.W.

Ms. Stock reviewed statistics on the opioid epidemic, noting the trend of increased usage and overdose deaths. In the United States, the number of deaths from drug overdoses have overtaken the number of deaths from car accidents and from guns.

CSAT opioid-related grants, initiatives, and programs include:

- Oversight of compliance and training for the Drug Addiction Treatment Act of 2000 (DATA 2000) Waivers. The waivers permit qualified physicians to prescribe medications for the treatment of opioid use disorders (OUD).
- The Providers Clinical Support System for medication-assisted treatment (MAT), an online system for training and mentoring for physicians who have obtained DATA 2000 waivers.
- Oversight of the certification of Opioid Treatment Programs.
- Technology and apps (e.g., the MATx app) which provides quick hands-on information about prescribing, clinical decision support, and other resources.
- Development of the Comprehensive Addiction Recovery Act opioid MAT TIP series.
- The National Center for Substance Abuse and Child Welfare.
- The State Targeted Response to the Opioid Crisis Grants (Opioid STR).
- The MAT—Prescription Drug Opioid Addiction Program (MAT-PDOA) grant.
- State Block Grant: Priority Population, Persons Who Inject Drugs.
- Access to MAT across discretionary grants programs.

Ms. Stock emphasized the importance of the Opioid STR and the MAT-PODA grants in the opioid crisis. The Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, and Center for Substance Abuse Treatment (CSAT) met earlier this week to discuss how Opioid STR grants will be used to coordinate care between the states and Medicaid. The MAT-PODA program was launched in 2015 to help states develop a MAT infrastructure, recruit providers, and provide the supports needed for medical providers to be comfortable prescribing medications to treat opioid addiction.

CSAT is partnering with the Center for Substance Abuse Prevention (CSAP) to create the business case needed to sustain evidence-based practices for opioid addiction, and to establish a sustainable long-term effort to reverse this crisis using a balanced national approach.

Co-Occurring SMI and OUD

Speaker: Tison Thomas, M.S.W., LMSW, Branch Chief, State Grants Eastern Branch, Division of State and Community Systems Development, CMHS, SAMHSA

Discussant: Jeffrey Patton, M.S.W.

Mr. Thomas reviewed statistics showing the seriousness of the opioid crisis in the United States. OUD has increasingly significant effects on American's health, social, and economic well-being. An estimated 1.9 million people in the United States struggle with addiction to opioid analgesics and an estimated 586,000 with addiction to heroin. Statistics show a disproportionate use of opioids among persons with SMI. Thus, attention to psychiatric disorders is important when considering opioid therapy. Research from the 1970s and 1980s demonstrate the benefit of multidimensional services addressing, for example, mental health, employment, housing, criminal justice services in methadone treatment programs.

Mr. Thomas discussed challenges and opportunities inherent to efforts to stem the epidemic, beginning with funding and financing. CMHS does not have a specific funding line item for OUD, and there is no targeted funding for integrated treatment of SMI and OUD. In addition, there is insufficient research on pain treatment in general and on co-occurring SMI and OUD in particular. Provider workforce issues present an ongoing challenge, particularly regarding shortage of prescribers for treatment of OUD, a reluctance of primary care providers to prescribe for OUD, and a lack of integration of mental health and substance abuse services.

SAMHSA resources for co-occurring OUD treatment include:

- "Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring OUDs"
- "General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders"
- "TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders"
- "Medications for Opioid Use Disorder—A new TIP"
- A shared decision-making tool on MAT

Mr. Thomas closed by asking NAC members for input on treatment challenges in co-occurring SMI and OUD; treatment modalities for various SMIs; potential areas for collaboration to build awareness; strategies to integrate SMI and OUD treatment; needed supports for data collection, prevention, treatment, and recovery; and treatment modalities for various SMIs. He asked how SAMHSA could assist in these areas.

Council Discussion

Mr. Patton framed the discussion by describing the state of the opioid epidemic in Kalamazoo County, MI. From 2015 to 2016, accidental drug-related fatalities in Kalamazoo County doubled from 37 to 72 in a population of nearly 200,000. Eight out of ten of these deaths involved opioids. However, few providers are prescribing the opioid-dependency medications needed for treatment programs. Mr. Patton sees this shortfall as one of the leading challenges to combatting the opioid epidemic.

Mr. Simmons commented on challenges to receiving treatment for substance use disorder (SUD) in individuals with a co-occurring SMI. He anecdotally described situations wherein substance abuse treatment facilities would tell a patient that they must receive treatment for the SMI before being seen for the SUD. However, mental health clinics tell the same person to

address the SUD first, before receiving treatment for the SMI. This scenario emphasizes the need for trans-diagnostic facilities that will concurrently treat SUD and SMI.

Mr. Gionfriddo noted that addictive and behavioral health treatment facilities typically do not communicate with one another due to barriers constructed by 42 CFR Part 2. When records are shared, information about prescription drug use and opioid use is usually lacking, which leads to prescribing in a vacuum. There is a need to allow sharing of the relevant medical records to ensure appropriate treatment.

Mr. Romero emphasized the importance of removing socially created barriers to recovery by including social support and social integration supports in recovery programs. There is a need for community supports that allow people to access support groups, jobs, educational opportunities, etc. Treatment programs should also emphasize the importance of quality of life. Dr. Stock stated that CSAT has funded a few initial grants focused on building communities of support.

Mr. del Vecchio asked Mr. Thomas to discuss past efforts of the now discontinued SAMHSA Co-Occurring Center of Excellence (COCE), which was a CSAT contract. Mr. Thomas stated that the COCE was created to explore integrated treatment approaches, develop resources, and provide national leadership to states attempting to integrate care. The COCE explored strategies to achieve such integration and considered confidentiality issues. The literature published by the COCE remains a valuable resource. Yet, there remains a critical need for integrated services that treat people “where they are at” instead of sending them to separate systems for each disorder. Mr. Thomas and his team are currently developing a report on the treatment of depression, anxiety, and OUD. The report is expected to be released by the end of October.

Before joining SAMHSA, Mr. Thomas worked for the state of Michigan to explore integration of mental health and SUD treatment programs. His team worked with peer support specialists, workforce staff, and communities to raise awareness, identify resources, and initiate a program. However, much work remains. Legal barriers to sharing medical records present a difficult challenge.

Mr. del Vecchio stated that more than 40 states have combined the mental health authority and state substance abuse authority into a single state authority. Yet many challenges remain in treating co-occurring disorders.

Mr. Patton commented on SAMHSA’s PBHCI grant that supports community-based agencies to integrate health services. One such effort supported development of a system to access Medicaid claims data to allow health care providers to view prescriptions filled by their patients. These data are available to an integrated team of primary care providers, psychiatrists, and care coordinators who hold regular team meetings.

Ms. Stock commented that integration of SMI and OUD treatment is feasible and the challenges surmountable. What is needed are the funds to finance its development. CSAT is exploring a business case approach and value-based payment. CSAT is also developing a framework for measuring SUD outcomes and exploring strategies for moving persons with SUD into treatment.

Ms. Stock and Mr. Thomas observed that treatment programs also need to address alcohol abuse, and Mr. Romero added the need to address compulsive behavior.

WRAP-UP AND ADJOURNMENT

Mr. del Vecchio stated that the White House had just announced that President Trump intends to declare the opioid crisis as a national emergency.

Mr. del Vecchio thanked Council members and meeting participants for attending. He previewed the agenda for the next day's meeting.

Ms. Foote adjourned the meeting at 4:41 p.m.