

**U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administration  
(SAMHSA)**

**Minutes of the**

**13th Joint Meeting of the**

**SAMHSA National Advisory Council (NAC)  
Center for Mental Health Services (CMHS) NAC  
Center for Substance Abuse Prevention (CSAP) NAC  
Center for Substance Abuse Treatment (CSAT) NAC  
Advisory Committee on Women's Services (ACWS)  
SAMHSA Tribal Technical Advisory Committee (TTAC)**

**August 27, 2015**

**SAMHSA Headquarters  
Rockville, Maryland**

**SAMHSA Joint National Advisory Committee/Council Members Present:**

**SAMHSA:** Eric Broderick, D.D.S., M.P.H.; Henry Chung, M.D. (via telephone); Lorrie Rickman Jones, Ph.D.; Harold Kudler, M.D. (ex officio); Kenneth J. Martínez, Psy.D.; Charles Olson; Elizabeth A. Pattullo, M.Ed.; Cassandra L. Price, M.B.A., GC-ADC-II

**CMHS:** Lori Ashcraft, Ph.D.; Lacy Kendrick Burk (via telephone); Vijay K. Ganju, Ph.D.; Paul Gionfriddo; Jeremy Lazarus, M.D. (via telephone); Juanita Price, M.A. Ed.; Gilberto Romero; Jeremiah D. Simmons, M.P.H.; Jürgen Unutzer

**CSAP:** Michael Compton, M.D., M.P.H.; Dianne Harnad; Steve Keel; Kathleen Reynolds, M.S.W., LMSW, ACSW

**CSAT:** OmiSadé Ali, M.A., CADC, CCS; Leighton Y. Huey, M.D.; Jeanne Miranda, Ph.D.; J. Paul Molloy, J.D.; Indira Paharia, Psy.D., M.B.A., M.S., LCP; Arthur Schut, M.A.; Lori Simon, M.D.

**ACWS:** Anita Fineday, J.D., M.P.A.; Hendree Jones, Ph.D.; Dan Lustig, Psy.D.; Sarah Nerad; Carole Warshaw, M.D.

**TTAC:** Jerome "Brooks" Big John; Travis Brockie; Kristi Brooks; Amber Kanazbah Crotty; Anthony Francisco; George Hamilton; Lisa Wade

**SAMHSA Leadership:**

Kana Enomoto, M.A., Acting Administrator

Paolo del Vecchio, M.S.W., Director, CMHS

Frances M. Harding, Director, CSAP

Daryl Kade, M.A., Acting Director, CSAT

RADM Peter J. Delany, Ph.D., LCSW-C, Director, Center for Behavioral Health Statistics and Quality (CBHSQ)

Mike Etzinger, M.B. M., M.S., Acting Deputy Administrator

Monica Feit, Ph.D., M.P.H., Acting Director, Office of Policy, Planning, and Innovation (OPPI)  
Deepa Avula, M.P.H., Acting Director, Office of Financial Resources (OFR)  
Anne Herron, M.S., Ph.D.; Director, Division of Regional and National Policy Liaison  
Tom Coderre, Chief of Staff  
Elizabeth Lopez, Ph.D., Deputy Director, CMHS  
CDR Carlos Castillo, M.S.W., Designated Federal Official

**Presenters:**

Jeff Coady, Psy.D., SAMHSA Region 5 Administrator  
Charles Smith, Ph.D., SAMHSA Region 8 Administrator  
Jean Bennett, Ph.D., SAMHSA Region 3 Administrator  
Rob Lyerla, Ph.D., CBHSQ  
Lisa Patton, Ph.D., Chief, Quality, Evaluation, and Performance Branch, CBHSQ  
Larke Huang, Ph.D., Director, Office of Behavioral Health Equity  
Ken Martinez, Psy.D. SAMHSA NAC  
Jerome "Brooks" Big John, TTAC member

**Other Participants:**

Linda White-Young, CSAT  
Carter Roeber, Ph.D., CBHSQ

**Call to Order**

CDR Castillo called the meeting to order at 8:45 a.m. (EST).

**Welcome and Introductions**

Ms. Enomoto welcomed participants to the 13<sup>th</sup> joint meeting of SAMHSA's national advisory committees/councils. Committee members and senior SAMHSA leaders introduced themselves.

Note: a review of prior meeting minutes revealed that the sequence of earlier meetings was listed incorrectly in prior minutes. This is the 13<sup>th</sup> Joint National Advisory Committee meeting, not the 11<sup>th</sup> (as indicated by the prior meeting minutes).

**Administrator's Remarks**

- Ms. Enomoto, newly named Acting Administrator, paid tribute to former Administrator Pamela Hyde, who recently left SAMHSA. Ms. Enomoto credited Ms. Hyde with working to make prevention a priority at the agency and elsewhere in the healthcare field, along with programming for children, adolescents, and adults with the most serious behavioral health needs. During her tenure, Ms. Hyde led efforts to expand access to mental health services, expand the behavioral health workforce, and reorganize SAMHSA's infrastructure, among other priorities.
- Ms. Enomoto pledged to proceed with SAMHSA's strategic initiatives in continuing the

agency's work, and commended the efforts of SAMHSA staff. She stated her intent to continue to seek advice from advisory committee members on how SAMHSA might do its work better, to identify opportunities, and to provide guidance in helping SAMHSA to reexamine its approaches.

- Ms. Enomoto introduced new SAMHSA leaders, including Acting Deputy Administrator Mike Etzinger, who will oversee SAMHSA's move to new quarters; Chief of Staff Tom Coderre; Senior Advisor Tom Morford; and OPPI Acting Director Monica Feit. Efforts are underway to fill several vacant leadership positions.

### **SAMHSA's Priorities**

- Senior SAMHSA leaders highlighted current and upcoming activities. According to Ms. Kade, CSAT is developing opioid work-plan activities, developing an action plan for the Pregnant and Postpartum Women program to bring family-centered care up to scale, and managing a new medication-assisted treatment program in 11 states.
- Ms. Avula reported the OFR is taking steps to streamline, systematize, and otherwise improve SAMHSA's RFA, grant review, and grant management processes.
- Mr. del Vecchio enumerated major undertakings at CMHS: increased access to quality mental health and substance use treatment nationwide; facilitation of earlier intervention; bringing crisis response to scale along the continuum of prevention, intervention, and postvention supports; suicide prevention; and public awareness and engagement.
- Mr. Coderre stated that he brings to his work as SAMHSA's chief of staff his experience and perspective as an individual in long-term recovery.
- Dr. Feit stated that SAMHSA's regional administrators are completing workforce summits in order to share strategies, initiatives, and partnerships; that SAMHSA's Office of Behavioral Health Equity, in partnership with the Trauma and Justice Workgroup, has brought together representatives of six cities to address community trauma; and that a publication addressing trauma and justice will capture innovative strategies and lessons learned. A Medicare parity analysis indicates that parity may not exist in three major areas: behavioral health services and coverage, pharmacy benefits, and issues with providers. SAMHSA is working with the Centers for Medicare and Medicaid Services (CMS) on this matter. Regulatory change to 42 CFR Part II continues, and a draft Notice of Proposed Rulemaking has been forwarded to the Office of Management and Budget.
- Ms. Harding reported that National Survey on Drug Use and Health (NSDUH) data revealed an unanticipated steady decline in underage drinking from 2002 to 2013, evidence of SAMHSA's impact in lowering use and death rates and in making the country healthier. Highlights of CSAP's activities include imminent approval of mandatory guidelines for urine and oral fluids testing, with hope for an increase in workplace drug testing, and efforts with the Food and Drug Administration to include e-cigarettes under SYNAR legislation. Also, two SAMHSA employees will lead work on a

U.S. Attorney General's report to address the growing heroin crisis.

- RADM Delany described SAMHSA's efforts to help people think differently about using its data, including a new regional version of the Behavioral Health Barometer. He also announced a new format and additional data modules for the next NSDUH report. The Institute of Medicine will soon issue a report on the science of changing social norms that was commissioned by SAMHSA in order to address discrimination against people seeking services. RADM Delany reported that SAMHSA has achieved success in its quality work, having developed 11 measures, three of which have been adopted by CMS: a cardiovascular screen, diabetes screen, and controlling blood pressure for people with severe mental illness.

### **SAMHSA's Role in Public Health Crises Response**

*Facilitator:* Dr. Herron

*Panelists:* Dr. Smith, Dr. Coady, Dr. Bennett, and Dr. Lyerla

- In a discussion of ways in which SAMHSA might help coordinate a behavioral health response when communities that experience a behavioral health-related crisis request support, a panel of SAMHSA regional administrators described aspects of SAMHSA's recent crisis responses. Dr. Smith discussed SAMHSA's support for the Oglala Sioux Tribe Pine Ridge Reservation following a series of 10 suicides. SAMHSA mapped and assessed data about the young people and the communities involved; coordinated and communicated among the tribal communities, families, healthcare systems, federal agencies, and SAMHSA grantees; and mobilized resources. Dr. Coady described SAMHSA's response, in conjunction with the Centers for Disease Control and Prevention (CDC) and the Indiana Department of Health, related to an HIV outbreak mainly among intravenous drug users in Scott County, Indiana. SAMHSA deployed staff from CBHSQ to capture data that described the need and the existing inadequate resources and infrastructure. In addition, SAMHSA provided buprenorphine training for local physicians, and the agency continues to work with CDC and the state to rebuild the county's system of care. Dr. Coady stated that SAMHSA represented a calming presence, offered broad coordination with a single voice, and clarified the community's need for prevention, treatment, and recovery services; additionally, the metrics generated as a result of SAMHSA's involvement shed light on an appropriate point at which to terminate support. Dr. Bennett described SAMHSA's response to the civil unrest in Baltimore, which consisted largely of convening, coordinating, and communicating with Baltimore officials and SAMHSA regional and central office staff regarding resources and technical assistance. SAMHSA provided much of this assistance in response to Baltimore's request related to trauma-informed care.
- Dr. Lyerla described two new epidemiological software tools developed by CBHSQ to inform communities' decisions and choices related to public health crises.
- Following a small-group discussion of SAMHSA's potential crisis-response roles, Council members reconvened and reported out on the following key needs: community empowerment rather than rescue; SAMHSA's expertise on behavioral health; need for a

strong plan for information dissemination and utilization; phased involvement by SAMHSA; inventory of SAMHSA, state, and community resources; special consideration for the needs of Native communities; case studies compiled for technical assistance regarding best practices; branding of SAMHSA; public/private/organizational partnerships at the local level; SAMHSA serving in a liaison role; focus on resiliency, prevention and preparedness; entrance and exit strategies for SAMHSA support; acknowledgment that crisis is part of a broader continuum under a public health approach; and a data-driven framework to assist communities.

### **Practice-Based Evidence: National Registry of Evidence-based Programs and Practices (NREPP) Update and Implication for SAMHSA**

*Presenter:* Dr. Patton

- Dr. Patton discussed SAMHSA's plans to update NREPP, which aims to help organizations understand programs and practices that they might implement effectively in different settings and for different populations. Going forward, SAMHSA will conduct independent reviews of well-studied programs submitted to NREPP, as well as continue to review the customary voluntary submissions. SAMHSA will view a broad spectrum of studies and their full range of outcomes, and will publicize all of their reviews regardless of findings and outcomes. NREPP also will include information on programs deemed ineffective, programs with negative or adverse outcomes for the population(s) of interest, and programs with insufficient evidence at the time of review. SAMHSA expects its new effectiveness ratings, currently under development, to enhance the NREPP website's usability.
- SAMHSA plans also to activate NREPP's Learning Center to address promising, but perhaps not yet tested or not sufficiently tested, programs and practices, including programs and practices that relate to the needs of more vulnerable populations.
- In response to Council members' questions, Dr. Patton explained that SAMHSA will not prescribe specific outcomes; outcomes will emerge from available literature as well as from the field. Dr. Patton introduced Dr. Carter Roeber, CBHSQ, who helped field questions from members. Dr. Roeber stated that SAMHSA's and stakeholders' priorities will help guide program selection for review; SAMHSA has established minimum criteria for inclusion on the registry; effectiveness ratings will reflect the calculated effect size, quality of the research, and significance of outcomes; and rating explanations will be provided. NAC members also commented on the need to incorporate program costs and financing information (such as Medicaid reimbursement eligibility) on NREPP, suggested reviewing evidence-based programs described in SAMHSA's toolkits that do not appear on NREPP, noted the need for fidelity assessment tools for evidence-based practices, pointed out the need to consider programs with the "best evidence available," and inclusion of (or links to) implementation principles and resources. SAMHSA is attending to linkages between behavioral health quality measures and the research to be reviewed, and has created an inventory of resources not yet captured on NREPP. Conversations are underway among CBHSQ, NREPP, Addiction Transfer Training Center (ATTC) staff, and members of the TTAC on incorporating "promising" traditional

practices in the reformulated Learning Center process.

### **Maximizing NREPP as a Tool for Quality and Effectiveness for Ali Populations**

*Facilitator:* Dr. Huang

*Panelists:* Dr. Martinez and Mr. Big John

- Dr. Huang resumed the discussion of NREPP's redesign by posing a series of questions to a panel of Council members who described SAMHSA's niche in the arena of evidence-based registries and suggested key points to consider. Dr. Martinez noted some funders' requirements for programs that are listed in a national registry, but sees no need to align with other registries. He suggested considering alternative gold standards for evidence, urged SAMHSA to fund again its service-to-science approach, and called for disclosure and transparency in costs and duration of reliance on a program developer. Mr. Big John described Indian Country's progress in using evidence-based practices and practice-based evidence. He voiced concern over aligning NREPP with science-based registries that may endanger practice-based models rooted in culture. He stated that few tribal communities will embrace clinical trials and commended SAMHSA's plan to re-think NREPP.
- In discussion, Council members suggested that SAMHSA consider the U.S. Preventive Services Task Force's format for evidence ratings, stated that the Department of Veterans Affairs is investigating the actual costs of evidence-based therapy, observed the need for grantsmanship training on reservations, and urged selecting outcome measures beyond merely access to services. Though research grants are scarce and many practices are expected to earn "insufficient evidence" ratings from NREPP, that rating may prompt research on effectiveness. NAC members urged adoption of a broad definition of evidence-based medicine and forging an alliance with the National Institute of Mental Health to sponsor research on widely used programs. Members noted that some SAMHSA programs still require use of the evidence-based practices listed on NREPP, which limits adoption of universal intervention and prevention programs. Mr. Big John called for change in the U.S. government's position that traditional healing, though a successful intervention, is not a medical intervention or service, and he urged conducting studies on promising practices. Members stated that no evidence-based practices have been evaluated on indigenous populations in this country; discussed the issue of generalizability, noting the need to focus on outcomes; and considered the need to consider the role of spirituality in healing.
- Dr. Martinez then discussed ways in which NREPP can increase program relevance and applicability for diverse minority populations, urged adequate funding of NREPP's Learning Center to permit promising practices to raise their ratings with subsequent positive research results and perhaps move to NREPP, cautioned against relegating forever to the Learning Center practices that lack an experimental design, asserted that an effective practice in one community need not be replicated elsewhere, noted the need to investigate whether developers include sufficient numbers of populations of color in standardization samples, discussed community-defined evidence, and stated that NAC members would be willing to help design the Learning Center. Mr. Big John called

attention to dignity among Indian nations and among Indian people, and the need for culture-specific approaches, and he urged viewing the issue of sovereignty through the eyes of Native individuals as contrasted with forced paternalism.

- In discussion, members pointed out that deeming a program or treatment to be evidence-based--or not--may impact eligibility for reimbursement, that some outcomes captured may not necessarily be outcomes most meaningful to the individuals who receive services, and expressed interest in the involvement of ATTTCs and the Center for Application of Prevention Technologies.
- Dr. Patton assured Council members of the collaborative, engaging, and dynamic qualities anticipated for NREPP's Learning Center.

### **Establishment of the Office of Chief Medical Officer**

*Presenter:* Ms. Enomoto

- Ms. Enomoto described SAMHSA's preliminary, exploratory efforts to expand its chief medical officer function into a new Office of the Chief Medical Officer (OCMO) and solicited advice. Some Council members endorsed incorporating multiple disciplines in a new OCMO, with representation from a variety of behavioral health settings, to ensure a balanced approach, and some members called for a strong medical voice. Members also suggested constituting a dedicated advisory group; aligning the OCMO with SAMHSA's strategic initiatives; exploring interaction with the National Association of State Mental Health Program Directors' Medical Directors Council, the Health Resources and Services Administration, CMS, and other relevant organizations; selecting a chief medical officer with both academic and clinical experience; and focusing attention on reform, parity, integration, curriculum development for primary care, and social determinants of health. Important skill sets for a chief medical officer also include policy analysis, development, implementation, and communication on policy and practice.
- Some SAMHSA Center leaders stated that SAMHSA's chief medical officer should be a physician. They noted that a multidisciplinary office should include a psychiatrist and a clinical social worker; SAMHSA should focus on its convening function, both at SAMHSA and beyond, to facilitate integration; and staff from SAMHSA centers and offices should be embedded in OCMO. Dr. Lazarus suggested launching the OCMO with a director and building staff from there. Ms. Enomoto stated that the OCMO will focus some efforts on prevention.

### **General Discussion**

- Ms. Enomoto enumerated potential topics for future Council meetings, as suggested during the day's discussions: engaging communities in data-driven crisis response, promoting fidelity in evidence-based practices, understanding costs and other details of evidence-based practices, the need to recognize the sovereignty and practices of indigenous populations, and further conceptualization of the OCMO.

- In discussion, Council members also suggested that SAMHSA offer a legislative update, a discussion of SAMHSA's (and other agencies') roles in integration, parity, Accountable Care Act behavioral health outcomes to date, progress on 42 CFR Part 11 and an update on health information technology. Mr. Olson reminded SAMHSA to focus on the youth perspective.
- Ms. Wade explained her view of tribal sovereignty and asserted the need for NREPP's Learning Center to educate the public about why evidence-based practices do not work in Native communities. Several members concurred that residents should define the needs of and outcomes for Native and other communities. Dr. Martinez asserted that NREPP should be designed from the bottom up.

### **Public Comment**

Time was set aside for public comment, but no one chose to speak. Mr. Sean Bennett submitted electronic comments, which appear in the appendix.

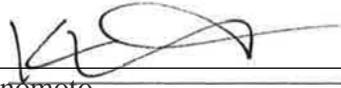
### **Adjournment**

CDR Castillo adjourned the meeting at 3:45 p.m.

### **Certification**

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

Date 11/20/15

  
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 Kana Enomoto  
 Acting Administrator, SAMHSA

### **Appendix: Public Comment**

On the question of whether the federal government should be working to protect or disregard the individual's fundamental constitutional right (and the right of informed consent) to refuse counter-therapeutic, harmful, fraudulent, costly forced/non-consensual psychiatric drugging and other medically intrusive treatments.

1. Our constitutional law requires that laws and policies which infringe upon fundamental liberties be presumed unconstitutional and subjected to strict scrutiny.
2. Antipsychotic drugs, the leading drug prescribed to persons with serious mental illnesses, not only can cause great mental impairment of all mental functioning, the drugs can and often do damage the brain.

3. Forced psychotropic drugging invades a person's most sacred personal interests and fundamental liberties including freedom of thought, court access and participation, political communications, social engagement, religious exercise, education, work, privacy, bodily integrity, quality of life and pursuit of happiness.
4. Antipsychotic drugs very often cause mental illnesses including serious anxiety and psychological distress, severe depression, and worsen psychosis.
5. APDs have no therapeutic benefit for the majority persons prescribed the drugs.
6. Doctors have no ability to predict whether the drugs will be beneficial or harmful. Only the consumer of the drugs can know if the drugs are beneficial or the contrary.
7. Most persons with serious mental illnesses do know they have an illness.
8. In light of the medical fact and our legal standards, non-consensual psychiatric drugging (except for 1-3 <lay dangerousness emergencies) frequently constitutes criminal abuse, criminal fraud, criminal assault, and a criminal violation of civil rights.
9. Every person who under color of any law of any state subjects any citizen of the United States to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable in an action at law for redress. Persons who conspire for the purpose of depriving any person or class of persons the equal protection of the laws or the equal privileges and immunities shall also be liable for damages. 42 USC 1983, 85, 86. Obviously Congress should not be supporting laws or policies which deprive vulnerable persons with mental disabilities their equal rights or liberties.
10. Congress most urgently needs to obtain honest truthful medical facts to make and to evaluate mental health policy. Uncorrupted, accurate evidence-based research literature, the personal accounts of those who have consumed psychiatric drugs, and the shameful history of psychiatry, leave us with no doubt that patients not doctors should have the final say on the consumption of psychiatric drugs and other medically intrusive treatments.

Thank you. Sincerely, /s/ Sean Bennett [contact information omitted]