

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

Minutes of the

14th 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 (STTAC)**

**February 25, 2016
Rockville, Maryland**

SAMHSA Advisory Committee Members Present:

SAMHSA: Eric Broderick, D.D.S., M.P.H.; Henry Chung, M.D. (via telephone); Kenneth J. Martinez, Psy.D.; Charles Olson; Elizabeth Pattullo, M.Ed. (via telephone); Cassandra L. Price, M.B.A., GC ADC-II; Gail Wiscarz Stuart, Ph.D., R.N., FAAN; Christopher Wilkins, M.H.A.

CMHS: Lori Ashcraft, Ph.D.; Vijay K. Ganju, Ph.D.; Paul Gionfriddo; Jeremy Lazarus, M.D.; Juanita Price, M.A.Ed.; Gilberto Romero; Jeremiah D. Simmons, M.P.H.; Jurgen Unutzer, M.D., M.P.H., M.A.

CSAP: Anton Bizzell, M.D.; M. Dolores Cimini, Ph.D.; Pamela Drake; Scott Gagnon, M.P.P., PS-C; Stefano "Steve" Keel, M.M.H.S., M.S.W., LICSW; Michael Lindsey, Ph.D., M.S.W., M.P.H.; Valerie Mariano, M.A., CPS; Craig PoVey; Ruth Satterfield, LSW.

CSAT: OmiSadé Ali, M.A., CADC, CCS; Andre Johnson, M.A.; Indira Paharia, Psy.D., M.B.A., M.S., LCP; Arthur Schut, M.A.; Lori Simon, M.D.; Mohammad Yunus, M.A., M.S. (via telephone)

ACWS: Anita Fineday, J.D., M.P.A.; Shelly Greenfield, M.D.; Hendree Jones, Ph.D.; Dan Lustig, Psy.D.; Karen Mooney, M.S.W., LCSW; Carole Warshaw, M.D.; Rosalind Wiseman, M.A.

TTAC: Timothy Ballew, II; Kristi Brooks; Amber Kanazbah Crotty; Anthony J. Francisco, Jr.; Victor Joseph; Keith Massaway; Alberta Unok

SAMHSA Leadership:

Kana Enomoto, M.A., Acting Administrator, SAMHSA

Amy Haseltine, Acting Principal Deputy Administrator, SAMHSA

Tom Coderre, Chief of Staff, SAMHSA

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

Frances M. Harding, Director, CSAP

Kimberly A. Johnson, Ph.D., Director, CSAT

Daryl Kade, M.A., Acting Director, Center for Behavioral Health Statistics and Quality (CBHSQ)

Mirtha R. Beadle, M.P.H., Director, Office of Tribal Affairs and Policy, SAMHSA

Monica Feit, Ph.D., Acting Director, Office of Policy, Planning, and Innovation (OPPI)

Deepa Avula, M.P.H., Acting Director, Office of Financial Resources, SAMHSA

CDR Carlos Castillo, Committee Management Officer and Designated Federal Official, SAMHSA

Presenters:

Richard G. Kronick, Ph.D., Director, Agency for Healthcare Research and Quality (AHRQ)

Frances M. Harding, Director, CSAP

Mirtha R. Beadle, M.P.H., Director, Office of Tribal Affairs and Policy, SAMHSA

Call to Order

CDR Castillo called the meeting to order at 8:35 a.m. (EST).

Welcome, Introductions, and Administrator's Remarks

Ms. Enomoto, welcomed participants to the 14th Joint NAC (JNAC) meeting of SAMHSA's advisory committees. Ms. Enomoto welcomed new members of SAMHSA's leadership team, including Acting Principal Deputy Administrator, Amy Haseltine; CSAP's Deputy Director, Greg Goldstein; Director of Legislative Affairs, Peggie Rice; Associate Administrator for Women's Services and Chief, National Policy Liaison Branch, OPPI, Mary Fleming; Senior Advisor for Addiction and Recovery, Tom Hill; and CSAT's Director, Kimberly A. Johnson. Committee members, senior SAMHSA leaders, and other participants introduced themselves.

Update on SAMHSA's Budget and Priorities

Presenters: Kana Enomoto and Center and Office Directors

- Ms. Enomoto updated JNAC members on the President's highly favorable budget proposal for SAMHSA and the agency's priorities for fiscal year (FY) 2017, recruitment of a new chief medical officer, and SAMHSA's move to new quarters.
- SAMHSA leaders highlighted selected priorities and activities. CSAT's priorities include: promulgating regulations on confidentiality; expanding buprenorphine prescription capacity; increasing access to medication-assisted treatment (MAT); and expanding international work. CMHS continues to work on prevention and early intervention; implementing the Certified Community Behavioral Health Clinic program; peer workforce development; and community civil unrest/crisis assistance. CBHSQ is creating a new associate director of science position; redesigning the National Survey on Drug Use and Health; and expanding and enhancing the National Registry of Evidence-based Programs and Practices (NREPP). SAMHSA is refining its business operations; strengthening internal controls on its portfolio; enhancing communication with Congress; working collaboratively on the upcoming surgeon general's report on substance use, addiction, and health; devising a more robust review process; and clarifying SAMHSA's story and budget. CSAP is addressing opiate use and misuse, oral fluid testing, and underage drinking.
- Participants discussed SAMHSA's research and surveillance efforts on marijuana and synthetic substance use, SAMHSA's expanding international work on substance abuse and HIV/AIDS, prevention and mental health promotion efforts, linkage between suicide and substance use disorders, SAMHSA's work with the White House to address high suicide rates among young African American and American Indian boys, NREPP update, the SAMHSA/Health Resources and Services Administration partnership to infuse behavioral health into the National Health Service Corps, and social determinants of health. JNAC members urged SAMHSA to ask

Congress to establish a tribal set-aside to deal with disproportionate rates of heroin use in Indian Country, and to focus on prevention and treatment of synthetic marijuana, or “spice,” use.

Engaging Patients in Quality Care: Agency for Healthcare Research and Quality’s Roles, Research, and Intersection with Behavioral Health

Keynote Speaker: Richard G. Kronick, Ph.D.

- In a presentation that highlighted its research into patient engagement and behavioral health, Dr. Kronick explained that AHRQ aims to improve the health of the nation by investing in research and evidence on how to make health care safer and improve quality; creating materials to teach and train health care systems and professionals to catalyze improvements in care; and generating measures and data to track and improve performance and evaluate progress of the health system. Dr. Kronick pointed to improvements in hospital patient safety from 2010 to 2014: a 17 percent reduction in hospital adverse consequences, 87,000 fewer deaths, 2.1 million patient harms avoided, and \$19.8 billion in savings achieved. AHRQ-funded safety research has found that better communication, teamwork, and checklists have rendered central-line infections, for example, to virtually zero. Technical assistance, collaboration in the field, and Medicare payment penalties have driven safety measures, as have AHRQ-sponsored tools and training materials that promote a culture of safety.
- Dr. Kronick described AHRQ’s behavioral health work on, for example, delivery models’ effectiveness; impacts of innovative models on patient engagement, experience, and outcomes; benefits for patients with multiple chronic conditions, including behavioral health, from emerging models; and strategies to support primary care physicians in achieving better outcomes. AHRQ worked to increase MAT availability, has published patient and clinician guides for treatment of alcohol disorder, has promoted telemedicine to train providers to administer buprenorphine, and linked rural health care providers to medical school clinicians.

The U.S. Preventive Services Task Force, an independent expert panel supported by AHRQ, has recommended providing screening for major depressive disorders among adolescents and children, a recommendation that requires most health plans to cover the screening with zero copay. Other behavioral health research areas that AHRQ funds include overuse of antipsychotic medication, particularly among children covered by Medicaid; incorporating patient-centered outcomes research into clinical practice; and integration of behavioral health into primary care and pediatric care.

- Dr. Kronick noted the challenges involved in engaging patients in treatment, and he described aspects of the agency’s work on integration of primary care and behavioral health, and on the patient experience. He discussed obstacles and incentives that affect providers’ engagement with patients, and vice versa. AHRQ funds an academy that has developed a lexicon and guidance to determine best integration strategies, has sponsored development of a decision aid for depression treatment, has developed a guide to patient and family engagement in hospital quality and safety, and has under development a similar guide for providers. Though measures are not optimal, recent AHRQ survey data reveal that half of respondents express satisfaction with providers’ attention to emotional or mental health. Dr. Kronick asserted that developing a better measure of patient engagement is essential to encourage providers to improve.
- In discussion, participants expressed interest in adverse consequences in psychiatric hospitals,

strategies to disseminate AHRQ's findings and resources to policy makers and health care providers, incentives to incorporate evidence-based practices into practice, research on the peer workforce, school-based health care and prevention, need to redefine evidence in the context of emerging behavioral health practices, impacts of community prevention on the health care system, and engaging colleges and universities as laboratories for behavioral health prevention research. Dr. Kronick explained that AHRQ conducts systematic reviews of existing evidence about what works and for whom; works to ensure that evidence is understood and used; and sponsors research on what types of systems of care result in better outcomes.

National Heroin Task Force Report and Recommendations

Presenter: Frances M. Harding

- Ms. Harding presented an overview of the congressionally mandated, multiagency National Heroin Task Force, convened in response to the national epidemic of opioid use, and its “National Heroin Task Force Final Report and Recommendations” (www.justice.gov/file/822231/download). The December 2015 report addressed the most critical areas of concern: 1) Education and Community Awareness; 2) Treatment and Recovery; 3) Coordinated Community Responses; and 4) Law Enforcement Responses. Report findings include the need for integrated and complementary responses to opioid use in the context of public safety and public health; policies grounded in the scientific understanding that substance use disorders are a preventable, treatable chronic brain disease; and community-based recovery supports that are available, affordable, and accessible. SAMHSA provided input regarding the importance of incorporating prevention, treatment, and recovery into the final report.
- In discussion, participants commended SAMHSA for focusing attention on treatment and prevention of opioid use, noted the need for strategies to monitor or report on recommendations' progress, suggested the usefulness of accountability measures, and noted the need to increase capacity for medical detox.

Engaging Patients in Treatment: Reports from Breakout Groups

Facilitator: Monica Feit, Ph.D.

- Dr. Feit solicited input on five of SAMHSA's high-profile programs and priorities, with emphasis on devising strategies to narrow the gap between those who need treatment and those who get treatment. The following are highlights of conversations that took place in small breakout groups.
 1. ***Protecting Access to Medicare Act, Section 223: Development of Certified Community Behavioral Health Clinics***
 - a. Engage individual and group stakeholders at the state and community levels, dovetailing the planning process with existing structures and networking among states.
 - b. Continue the momentum for states that do not receive implementation awards by using the planning process to identify health homes and waiver programs, court new payers, use quality measures, tailor programs to serve veterans, and use current technical assistance structures.
 - c. Measure behavioral health costs to assess whether states can meet the statute's requirements.

- d. Continue to discuss whether evaluators can judge a demonstration’s effectiveness, including measurement development and sustainability measurement.

2. *Efforts to Address Early Serious Mental Illness*

- a. Treatment models should be followed with fidelity, while recognizing the need for adaptability and implementing the required evaluation; nevertheless, fidelity is less important than flexibility.
- b. It is wise to permit some mission creep in order to serve additional populations, to generate additional revenue, or to continue services when the target population ages out.
- c. Include peer services and supports in health systems, but do not necessarily adhere to a specific model; veteran-to-veteran peer services are important, as are other cultural considerations.
- d. The best coaching for fidelity occurs when coaches are in close proximity to model implementers.
- e. Barriers to identifying individuals and providing care include lack of widespread screening and awareness of early symptoms, stigma, nonintegrated systems, significant cultural differences, and lack of access to equitable care.

3. *Mental Health Parity and Addiction Equity Act*

- a. Parity has increased access to care; reimbursement to behavioral health providers aligns with that of other practitioners.
- b. Problems of logic in reimbursement remain a barrier; definition confusion can impede parity.
- c. SAMHSA should make information on parity available to providers; the continuing medical education credits can serve as incentives; SAMHSA presentations at provider conferences would be helpful.
- d. SAMHSA should continue to support providers and patients, and work with other organizations.
- e. Ms. Enomoto suggested that states’ attorneys general might partner in setting standards and working with insurance companies on denial-of-coverage issues.

4. *HHS and SAMHSA Initiatives Related to the National Opioid Crisis*

- a. CSAP should expand naloxone availability and link people to treatment by conducting state analyses of cost and geographical barriers to naloxone use; developing and disseminating naloxone toolkits across systems; offering education to the collegiate recovery movement; developing (social) media strategies; making naloxone available to, and provide training for, all first responders, community members, reentrants to the community after incarceration, Mental Health First Aiders, and others; promoting greater access to over-the-counter naloxone; providing education on opioids’/naloxone’s impact on pregnant, postpartum, and parenting women, and on overdose symptoms; educate managed care companies on naloxone’s benefits; promote naloxone in nontraditional settings; develop data; increase treatment capacity, including detox facilities, peer supports, and incentives for “warm handoffs” to the next level of care.
- b. To link MAT with peer support and recovery services, as well as improvement and

measurement of treatment systems, participants suggested that SAMHSA develop a media strategy to remove stigma surrounding MAT; promote billing for peer support services; increase individuals' access to others with lived experience; help to resolve turf issues between peers and certified addictions counselors; provide assistance to individuals waiting for addictions treatment—peer recovery coaches can be helpful in the interim before care; recognize the cultural basis for some barriers to MAT, including suspicion of drug companies and stigma against MAT; peer services may help in the paradigm shift, recognizing the importance of peers' lived experiences; expand peer support in diverse settings and populations; make traditional healing a reimbursable service in Indian Country; and educate state medical boards on the benefits of peer services.

5. Integration of Social Determinants of Health into Behavioral Health Care

- a. Tailor and deliver services to engage people in behavioral health services; consider ways for people to build community and build their own social capital; community health workers can help navigate as part of community-based organizations that provide services; community health providers should learn from the peer model; capitalize on opportunities for an integrated focus using paraprofessionals and by empowering people who need services.
 - b. Move toward a public health population focus and a systems health orientation.
 - c. Decrease barriers between prevention and treatment; use grant mechanisms, such as disparity impact statements, and encourage grantees to tackle disparities sequentially.
 - d. Develop creative finance strategies.
 - e. Disseminate the public health skill set to a broader segment of the workforce, stressing the importance of data to measure cost savings in addressing social determinants of health.
 - f. Acknowledge that equity in social determinants is a shared responsibility, and involve public health agencies and the Departments of Housing and Urban Development, Labor, and Justice.
 - g. Focus on crossover training in grant-making centers.
 - h. Consider the developmental disability community's practice whereby individuals derive financial benefit from incentives related to their good health.
 - i. Promote reconsideration of insurance reimbursement solely for medical necessity. A chronic disease or biopsychosocial model can bridge between the medical and public health models.
- Participants stated a preference to hear about next steps and urged attention to community-based action.

National Tribal Behavioral Health Agenda

Presenter: Mirtha R. Beadle, M.P.H.

- Ms. Beadle described the ongoing development of the National Tribal Behavioral Health Agenda, a national statement of behavioral health priorities for American Indian/Alaska Native communities beset by high rates of severe, disproportionate behavioral health problems, and a range of other serious issues. The agenda, which reflects the tribal voice and perspective, aims to harmonize the currently disparate activities by tribes, federal agencies, states, and other

agencies in order to attain better wellness outcomes for Native people. The impetus for this effort originated with the STTAC, and the National Indian Health Board, Indian Health Service, and other federal partners, tribes, and tribal leaders have collaborated with SAMHSA in developing the agenda.

- Key issues to be addressed include, for example, healing from multiple types of trauma, strengthening families, devising solutions that match the problems, prevention and recovery from a tribal perspective, infrastructure necessary for service delivery systems, and support for unique tribal practices that de-stigmatize behavioral health issues.
- In discussion, participants expressed interest in ways the agenda might address disparities among tribes, particularly in Alaska, and noted the absence of attention to elders and veterans in the draft document. Ms. Beadle stated that the broad audience for the agenda would include tribes and tribal communities, the many federal government agencies that participate in the agenda's development, states and state agencies, and communities in general.

General Discussion

- With participants' endorsement, Ms. Enomoto stated that SAMHSA will continue to host JNAC meetings. Mr. Massaway suggested holding two-day STTAC meetings.
- Suggested topics for future meetings included continued conversation on the successful integration of behavioral health with primary care in the context of social determinants of health, research and policy issues related to marijuana, strategies by stakeholders to use population health data on the opioid epidemic, issues of 18–25 year olds, strategies for organizations to collaborate in tackling serious problems, suicide prevention and investigation of lethal means, and progress on the NREPP redesign.

Public Comment

Although time was set aside for public comment, no one chose to speak.

Adjournment

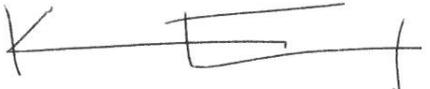
CDR Castillo adjourned the meeting at 4:47 p.m. (EST).

Certification

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

MAY 13 2016

Date



Kana Enomoto
Principal Deputy Administrator, SAMHSA