

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

**Minutes of the**

**60th Meeting of the**

**SAMHSA National Advisory Council (NAC)**

**August 26, 2016**

**SAMHSA Headquarters  
Rockville, Maryland**

**Council Members Present:**

- Kenneth J. Martinez, Psy.D.
- Eric B. Broderick, D.D.S., M.P.H.
- Victor Joseph
- Cassandra L. Price, M.B.A., GCADC-II
- Gail W. Stuart, Ph.D., M.S.C.
- Henry Chung, M.D. (via telephone)
- Harold S. Kudler, M.D.
- Elizabeth A. Pattullo, M.Ed. (via telephone)

**Council Members Absent:**

- Lorrie Rickman Jones
- Christopher Wilkins

**SAMHSA Leadership Present:**

- Kana Enomoto, M.A., Principal Deputy Administrator
- CDR Carlos Castillo, Committee Management Officer and Designated Federal Official, Office of Policy, Planning, and Innovation (OPPI)
- Tom Coderre, Chief of Staff
- Amy Haseltine, Deputy for Operations
- Paolo del Vecchio, M.S.W., Director, Center for Mental Health Services
- Frances M. Harding, Director, Center for Substance Abuse Prevention
- Kimberly A. Johnson, Ph.D., Director, Center for Substance Abuse Treatment
- Monica Feit, Ph.D., M.P.H., Director, OPPI
- Daryl W. Kade, M.A., Director, Center for Behavioral Health Statistics and Quality (CBHSQ)
- Deepa Avula, M.S.P.H., Acting Director, Office of Financial Resources
- Jonaki Bose, Branch Chief, CBHSQ
- Neil Russell, Ph.D., Statistician, CBHSQ

**Others Present:**

- Carole Warshaw, M.D (ACWS)

**Call to Order**

- CDR Castillo called the 60th meeting of the SAMHSA NAC to order on August 26, 2016.

**Welcome, Opening Remarks, and Consideration of Minutes of the February 26, 2016, SAMHSA NAC Meeting**

Presenter: Kana Enomoto, Principal Deputy Administrator, SAMHSA

- Ms. Enomoto welcomed all attendees, and introductions were made around the table. Ms. Enomoto then recognized Ms. Pattullo and Ms. Price for their service as they will be finishing their terms with SAMHSA this year.
- Council members unanimously approved the minutes of the SAMHSA NAC meeting of February 26, 2016.

**Reflections on the Joint National Advisory Council (JNAC) Meeting**

- Ms. Enomoto initiated conversation concerning the previous day's JNAC meeting. Feedback from members included:
  - Dr. Martinez believes there should be a means of initiating more interaction and discussion between attendees.
  - Ms. Price thought Dr. Karen DeSalvo's presentation was impressive and important, but suggested that future speakers focus their talks on how SAMHSA's federal initiatives could be enacted and work in concert with state systems, to work collaboratively within each system's infrastructure.
  - Dr. Stuart suggested better integration of insights garnered from the Wednesday meetings by having a representative present each committee's findings at the beginning of the JNAC meeting.
  - Mr. Joseph and Dr. Martinez felt they left the meeting with more questions than answers. They would like to be better prepared, and be sent reading material and updates on what all of the SAMHSA constituents had been doing.
  - Dr. Kudler said it's hard to make the translation, for trained psychiatrists, to think of their responsibilities within a public health mentality. He plans to publish on this point soon.
  - Dr. Chung said health care providers crave more interaction with organized behavioral health.
  - Dr. Stuart suggested that the breakout groups have specific recommendations to present, to keep participants from rambling. Dr. Martinez agreed and said they should also report on what was implemented from the previous meeting and what was not.
  - During the Group 3 breakout session, Ms. Pattullo learned about pockets of the country where public health initiatives were working really well and would like more focus on communicating positive developments in order to learn from them.

- Mr. Joseph asserted that, generally, there was progress to be made to ensure all national efforts were also effective outside of the “lower 48.” He also wants to make sure that as the government moves on to tackle other problems (like the opioid epidemic), that it doesn’t abandon progress made on other projects, like the meth problem in Alaska.
- Dr. Broderick would like to have the minutes include what actions the council recommended, and then give feedback at the next meeting as to how and whether or not those recommendations were enacted. Dr. Broderick said that participants should weigh in on the recommendations they were unable to enact, so that the council can learn how to problem solve these specific situations.
- Ms. Enomoto detailed the internal transitions of SAMHSA since the last meeting in February. She credited the meeting in February as having set the council on the right path to improve and evolve the agency.

### **Keynote Speaker**

Presenter: Michael Botticelli, M.Ed., Director of the Office of National Drug Control Policy (ONDCP), White House

- Mr. Botticelli began by discussing larger drug policy issues currently facing the Administration and the history of his department and how its responsibilities have evolved. He reported that the President’s budget is providing significant funding on public health.
- His office is focused on the ties of addiction and criminality, and the larger issue of necessary criminal justice reform. Mr. Botticelli reported that local police are vocal proponents of addiction prevention measures and further treatment capacity in their communities.
- Mr. Botticelli said the opioid epidemic has brought to light long-standing systemic issues, including the bifurcated systems of care and a lack of mental health and addiction training among medical professionals. As one of several federal-sponsored measures, Mr. Botticelli announced that the Surgeon General’s Turn the Tides program would be launched the following day.
- Mr. Botticelli brought up additional questions that ONDCP is focusing on, including:
  - How to deal with geographical treatment deserts.
  - How to tackle the cultural stigma around addiction.
  - How to create better standardized treatment and recovery programs with built-in, objective, and scalable goals and metrics.
- Mr. Botticelli said the HIV/AIDS movement is an excellent model of how the opioid epidemic treatment system might hope to evolve, particularly with regard to decreased cultural stigma and a systemic cascade of care in local communities. Mr. Joseph agreed and stated that being an addict is still treated as a moral issue, much as HIV once was. In

mental health, substance abuse is still not taught as a disease. He stressed that it's important to look at the gaps in the treatment continuum.

- Dr. Stuart asserted that the only way to have academia incorporate teaching on substance abuse care training is by mandating these core issues into the exams of students. Mr. Botticelli agreed, and suggested exploring ways to collaborate with academia to add questions to the licensing exams.
- Dr. Kudler referred to Mr. Botticelli's conversation about the HIV movement's similarities and suggested that his team focus on measurable outcomes. He asked what the defined ideal outcome was, specifically, what abstinence looks like, clinically. Mr. Botticelli agreed, and said the goal of treatment needs to be clinically defined, and suggested studying the example of other chronic diseases that have a clinically defined measure of success. Dr. Kudler concurred, stating that abstinence is actually a moral definition of success, not a clinical one.
- Dr. Martinez posed a self-described rhetorical question asking why the opioid epidemic is only now getting attention, as white, middle-class children have begun dying from it. He also asked how the federal government was fighting the legalization of marijuana by states. Mr. Botticelli said that, with regard to marijuana's illegality, the U.S. Department of Justice has stated that it's not going to use federal law enforcement on marijuana offenses. However, he insisted that the cultural barriers that are currently restricting the study of medical marijuana need to be relaxed so that the government can fund research. The federal government has begun to chart the impact of legalization in states that have already legalized it so that its effects can be properly studied. Dr. Martinez said that the research that has been conducted – particularly around adolescents and adults – had been disseminated as well. Mr. Botticelli said the National Institute on Drug Abuse (NIDA) has begun longitudinal studies, but they need to determine who the trusted communication messengers of these results might be. Ms. Enomoto added that the work on prevention of tobacco use is working on young adults, but there needs to be a concentrated effort to communicate with the out-of-college and older populations too.
- Ms. Harding thanked Mr. Botticelli for changing the messaging and the terminology to “medical marijuana” (with no clinical use of “recreational use”). She added that, with regard to the opioid discussion, there is pushback from professionals in the prevention field who are resistant to using naloxone to save lives.
- Dr. Broderick mentioned that some of the difficulty of the clinical study of marijuana is that it's a constantly changing entity – often synthetic marijuana is studied when it bears little resemblance to what's being circulated on the street. Furthermore, he stated that the scientific community should be less concerned with clinical purity and focus more on what they'd like the clinical outcomes to be.

### **Council Discussion: National Survey on Drug Use and Health (NSDUH) Redesign**

- Ms. Enomoto recapped the JNAC meeting, and said that what was most exciting was hearing the Deputy Surgeon General echo much of what SAMHSA believes in and has been working to achieve. Ms. Enomoto began a discussion around the current the NSDUH survey and what SAMHSA is looking to possibly change, improve and modernize, under the direction of Ms. Kade.
- Ms. Kade gave a brief overview of the challenges faced in modernizing the survey and then asked attendees to discuss which parts of the survey the members currently use and which they don't need. Ms. Price said she likes the survey, thinks it's valuable, and believes that generally the main framework should stay the same. She was concerned, however, that mentions of trauma will disturb survey takers and hinder the likelihood of their completion and follow-up. Ms. Price suggests approaching this process by defining an answer to the question: "What is the analytical information you hope to gain from this study?"
- Dr. Stuart suggests looking into web-based surveys and social media to get a larger survey pool and cut down on costs but Ms. Bose explained that due to several complications, social media is not an ideal option for the survey currently. Ms. Bose also said that they're unable to do a rotating module system because the order in which the survey is laid out impacts the answers. Further complicating matters is that this survey is also taken by children and any editing or changing of the survey would affect this process as well, and is overseen by a stringent oversight umbrella of agencies.
- Dr. Martinez insisted that it's imperative that questions addressing trauma be included as trauma is a strong marker for most mental health issues (including substance abuse and PTSD). Dr. Stuart agreed and said that a means of measuring it is important too, and that it needs to be incorporated into the teaching program.
- Dr. Broderick questioned the reasoning behind increasing the financial incentive to \$50. Ms. Bose explained that though it seems to be a lot of money, their department has calculated that it actually saves money (through 2023) because of the percentage of respondents that convert into health system users from this outreach.
- Mr. Coderre said that he and others in the recovery community have reasserted the need for including recovery measures in the survey's redesign, along with ways of measuring it. He believes we should be able to tell where people are addicted as well as where people are getting well.
- Dr. Broderick addressed concerns – expressed throughout – that most decisions on new topics and edits would have detractors by saying that it's important to take the initiative and then learn from the feedback, rather than not make any progress. Ms. Enomoto qualified the comment by reminding everyone that NSDUH is a hard ship to turn, which is why some are reluctant to make changes that will be in place possibly for decades.

- Ms. Bose addressed complications of follow-up studies, which receive no funding and are only based on volunteers from first round of survey. Mr. Joseph mentioned that having more data on recovery could help states secure more funding to operate programs long-term, as they'd have concrete data on how long a program needs to run and what qualifies as recovery.
- Dr. Chung asked what the response rate was comparatively, and whether or not negative stigma around the topic had affected it. Ms. Bose said that the survey actually has a higher response rate than other national studies. She mentioned that, surprisingly, people who had higher markers for depression were more likely to want to be included in additional surveys and follow-up.
- Ms. Bose added that the survey is missing “positive components,” and questions that would address recovery or measures of flourishing.
- Dr. Kudler suggested field-testing children through SAMHSA’s National Child Program, but Ms. Enomoto said that their work is done in a clinical setting, whereas NSDUH’s surveys are done at home.
- Ms. Kade said that though the survey revision process is frustrating, that it’s been a positive experience of figuring out what each group needs and how to tradeoff.

### **Public Comment**

- Ms. Enomoto asked for public comment.
- The public commenter was a psychiatric nurse from Massachusetts who described her challenges with her mentally ill son and his marijuana addiction which negatively affects his medication. She also mentioned that, with regard to studying trauma, the survey could more accurately (and objectively) study bodily stress, which is more easily quantifiable. She said that a stress study out of Boston is developing a wearable stress monitor for these purposes.
- Dr. Warshaw asked if the risk and protective factors were incorporated into the survey to address the users’ initiation to drug use, particularly by a coercive and/or abusive partner. Dr. Russell said they collect information on initiation age, but not motivation.

### **Closing Remarks and Adjournment**

- Ms. Enomoto closed the meeting with a question as to what the next meeting’s theme or aims should be. She suggested the committee:
  - Bring in representatives from the three institutes – the National Institutes of Health (NIH), NIDA, National Association of Area Agencies on Aging – and see what partnerships overlap and what their priorities are.

- Look at public perception of substance abuse and treatment and have a conversation on bias and discrimination, and how that crosses over into prevention, and what impact it has on the agency's efforts.
  - Look at critical issues and partnerships, and what clinically should be done to tackle some of these issues collaboratively.
- Dr. Stuart said her preference was to bring in the team from NIH. Dr. Martinez agreed, and said that the speakers at JNAC were helpful. He suggested that instead of formal presentations, they could talk about what issues they're struggling with, and would like to partner with SAMHSA by having an exchange about the challenging issues SAMHSA and other agencies are having. Dr. Stuart and Mr. del Vecchio agreed.
  - CDR Castillo adjourned the meeting at 12:17 p.m. (EST).

**Certification**

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

November 3, 2016  
 \_\_\_\_\_  
 Date

/Kana Enomoto/  
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 Kana Enomoto

Minutes will be formally considered by the SAMHSA NAC at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.