

Substance Abuse and Mental Health Services Administration

54th Meeting of the SAMHSA National Advisory Council

August 16, 2013

Rockville, Maryland

Minutes

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council convened in open session for its 54th meeting on August 16, 2013, at SAMHSA headquarters in Rockville, Maryland. SAMHSA Administrator Pamela S. Hyde chaired the meeting.

Council Members Present: Megan Gregory; Arturo Gonzales, Ph.D.; Lorrie Rickman Jones, Ph.D.; Charles Olson; Cassandra Price; Donald Rosen, M.D.; Dee Davis Roth, M.A. (by telephone); Benjamin Springgate, M.D. (by telephone); Marleen Wong, Ph.D. (see Tab A, Council Roster)

SAMHSA Administrator: Pamela S. Hyde, J.D.

Designated Federal Official: Matthew Aumen

Non-SAMHSA Federal Staff Participating: 10 individuals (see Tab B, Federal Attendees List)

Representatives of the Public Participating: (see Tab B, Public Attendees List)

Call to Order

Mr. Matthew Aumen, Designated Federal Official, called the meeting of the SAMHSA National Advisory Council to order at 9:00 a.m.

Welcome and Opening Remarks

Ms. Pamela S. Hyde, SAMHSA Administrator, welcomed participants to the meeting, and SAMHSA senior staff and Council members introduced themselves. Ms. Hyde acknowledged the valued contributions to SAMHSA of Drs. Stephanie Le Melle, Donald Rosen, and Arturo Gonzales, whose tenure on the Council neared a close. Ms. Hyde announced that Drs. Eric Broderick, Henry Chung, and Junius Gonzales were slated to join the Council.

Consideration of Minutes from the April 2013 Meeting of the SAMHSA Council Meeting

Mr. Aumen confirmed the presence of a quorum, and Council members unanimously approved the minutes of the meeting of the SAMHSA National Advisory Council held on April 12, 2013.

SAMHSA of the Future: Council Discussion

Ms. Hyde invited Council members to describe SAMHSA's role in the future. Dr. Gonzales asserted that SAMHSA must be the nation's voice for mental health, substance abuse, and recovery. He noted the importance of SAMHSA retaining its identity and influence, particularly in the areas of workforce development and best practices for behavioral health. Dr. Gonzales commended the model under which state behavioral health agencies run Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs at federally qualified health centers, where medical providers are key partners, and SAMHSA provides data and guidance on best practices for behavioral health and primary care integration. He urged SAMHSA's regional offices, staff, and administrator to intensify their interactions with states, and also noted the criticality of behavioral health providers attaining proficiency with electronic health records.

Dr. Marleen Wong observed the need for SAMHSA to increase its staff and diminish its reliance on contractors. Ms. Hyde responded that SAMHSA has been considering how to develop its staff's capacity related to both programmatic expertise and contract management. Dr. Lorrie Rickman Jones suggested important future roles for SAMHSA: bullhorn, gatekeeper, and leader. SAMHSA must ensure the clarity of its messages about what is important in the field; work with the Health Resources and Services Administration (HRSA) by building relationships and collaborations, and demonstrating that SAMHSA has the expertise and the data on behavioral health; and lead states in understanding how to navigate systems integration, relying on the evolution of the Barometer and NBHQF as the field's most important documents. In addition, Dr. Rickman Jones stated that SAMHSA must attend to its traditional role in the public sector.

When asked which of the ideas about the SAMHSA of the Future discussion from the Joint NACs meeting the Council felt should be the cross-council topic for the next joint meeting, the Council overwhelmingly identified integration as the topic most critical for the future of the behavioral health field, and therefore most critical as SAMHSA considers its role for the future.

Ms. Megan Gregory recommended appointing more young people to each of SAMHSA's advisory councils and establishing a mechanism for young leaders to work together. Though she also expressed her willingness to advise SAMHSA on an ongoing basis, Ms. Hyde pointed out that federal rules govern how advisors can communicate. Dr. H. Westley Clark, Director, Center for Substance Abuse Treatment (CSAT), suggested communicating via social media, and other Center leaders offered to introduce the young Council members to staff members involved with issues of interest to them. Ms. Hyde stated that arrangements would be made for the young adult members of SAMHSA's advisory councils to meet together during the next round of face-to-face meetings.

Dr. Donald Rosen noted his long experience as a clinician educator and stated that last year, for the first time, more individuals graduated from U.S. medical schools than there were first-year internships available. This represents an important opportunity for SAMHSA to work with HRSA and the Department of Veterans Affairs (VA) on this workforce and funding issue. Dr. Rosen stated that cultural competence and prevention represent natural areas for SAMHSA's leadership. He also urged that SAMHSA advocate for increased federal resources for professional education and suggested that SAMHSA partner with the American Psychiatric Association.

Ms. Hyde extolled the quality of the collaborations that SAMHSA and HRSA have forged to increase the population of behavioral health providers, and to take advantage of the authorities that Congress has conferred on the agencies. Though the population of people who need behavioral health services is small relative to the overall population, SAMHSA has advocated that this special population creates additional costs for healthcare: Behavioral health disorders are among the top five causes of emergency room readmissions, and untreated mental health and substance use adds additional costs to healthcare systems. SAMHSA's authorities involve mostly training and technical assistance to the current workforce. HRSA has welcomed SAMHSA's SBIRT program, depression screening, and other types of screening into its federally qualified health centers (FQHC).

Dr. Gonzales suggested leveraging enrollment resources under the Affordable Care Act (ACA) to identify people at risk for substance abuse, mental health, and trauma. Ms. Hyde explained that Congress has appropriated funds for navigators to address enrollment, and some recipients are mental health organizations. She stated that SAMHSA encourages people involved in behavioral health to train as certified application counselors.

In a conversation on SAMHSA's role with regard to clinical issues, Dr. Wong noted the importance of science, especially brain science, within social work and explained the recent trend to establish robust, science-based, social work research centers in universities. Ms. Hyde stated that SAMHSA has relied in

recent years on Dr. Clark's clinical expertise in the absence of a Chief Medical Officer, a position filled recently by Dr. Ellie McCance-Katz. Dr. Clark noted that the Centers for Disease Control and Prevention (CDC) and HRSA turn to SAMHSA to discuss critical clinical aspects of health reform implementation, including, for example, medications, clinical strategies, and strategies to enable behavioral health providers to bill for services and address waste, fraud, and abuse issues. He noted the importance of multiple partners—including peers, institutional settings, governments, nonprofit organizations, for-profit organizations, and other stakeholders—to devise reasonable approaches. Dr. Rickman Jones suggested that SAMHSA develop a framework for discussions on clinical issues. Dr. Wong noted that minority students in social work now represent the majority of students, many of whom are survivors of early childhood trauma and motivated to enter the field of social work.

Dr. Laurent Lehmann stated that the VA values SAMHSA's activities to link federal efforts with states and communities, for example, the policy academies that convene community providers, local government employees, and state employees to collaborate on local issues. Dr. Lehmann pointed out the difficulty in motivating providers to use evidence-based practices. He asserted that SAMHSA has a role, in collaboration with the VA and the Department of Defense, to assist academic medical centers to train clinicians and professionals, and to work with states and communities.

Council members suggested the following topics for future SAMHSA Council meetings: youth, workforce, and clinical/issues; collaborations with federal and state partners; communications and marketing; Council meeting formats; measurement of ACA implementation/integration, impacts, and successful models; SAMHSA as a public health agency; conversation with an HRSA official; reduction of gun violence as a public health issue; mental health services for transition-age youth related to suicide prevention; expansion of clinical services; use of quality frameworks by states and communities; leadership; and lessons learned by the VA regarding systems integration. Dr. Wong stated that SAMHSA's priorities must encompass prevention, intervention, and levels of care along the spectrum of intensity. Ms. Price, Dr. Rickman Jones, and Dr. Gonzales concurred. Council members noted the advisability of constituents communicating with their congressional representatives on this issue.

Mr. Charles Olson expressed interest in advising SAMHSA on issues outside Council meetings. Ms. Hyde noted that in the past Ms. Dee Roth has advised SAMHSA on measurement issues and Dr. LeMelle had advised on a medication matter.

Wellness

Center for Mental Health Services (CMHS) Director Paolo del Vecchio explained to Council members that wellness is a holistic approach to meeting the needs of individuals, families, and communities. For example, a 2012 study by the National Institutes of Health found a walk in the woods and antidepressant medication to be equally effective, the challenge remains to transform that finding into policy and practice. Mr. del Vecchio noted that behavioral health facilities' top accreditation compliance problems result from issues include record keeping, assessment of the spiritual beliefs of the people they serve, and meeting nutritional needs. This points to the need to examine and respond to all aspects of a person's life. The conversation on wellness in America has focused on high rates of obesity, emphasis on diet and exercise, and exploration of wellness through yoga, mindful meditation, and other practices.

Mr. del Vecchio asserted that the concept of wellness rests at the intersection of prevention, treatment, and recovery; of behavioral health and primary care; and of health care and social services. SAMHSA has approached wellness not just as the absence of disease, illness, or stress, but also as the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness. Wellness is a holistic concept that incorporates mind, body, and spirit, along with financial, environment, occupational, intellectual, and social wellness.

Mr. del Vecchio welcomed Council members' input on how to define wellness and how to identify effective practices to achieve wellness, how SAMHSA can provide technical assistance to implement effective practices and policies, how to finance wellness approaches, how to measure wellness, and how to increase public awareness and mobilize individuals and communities to promote wellness. He noted that SAMHSA has focused on wellness issues in the context of shockingly high rates of early mortality and comorbid health conditions experienced by people with behavioral health problems, as well as the personal and human costs of these health conditions.

Ms. Wilma Townsend, Public Health Advisor, CMHS, explained that SAMHSA's participation in the Department of Health and Human Services' (HHS) Million Hearts Campaign, whose goal is to prevent one million fatal heart attacks and strokes by 2017, is part of a broader SAMHSA Wellness Initiative. As part of the campaign SAMHSA funded 12 community-based projects that promote wellness; projects included nursing students who volunteered to take people's blood pressure, community gardens, walking clubs, and dancing clubs—activities that have made a difference in people lives. Ms. Townsend pointed out that SAMHSA's target population represents two-thirds of people with cardiovascular disease—a statistic that made the case for the Million Hearts Campaign to establish a partnership with SAMHSA. The campaign has added a behavioral health focus to its website, providing concrete information plus links to SAMHSA's Wellness Initiative.

To help integrated healthcare organizations understand how to help persons with substance abuse and mental health problems improve their wellness, SAMHSA has developed a toolkit to engage communities to focus on behavioral health and wellness, made recommendations on wellness to the Million Hearts Campaign, and has a list of its own activities to pursue. She urged Council members to participate in local Recovery Month activities.

Ms. Claudia Richards, Senior Advisor to the Director, Center for Substance Abuse Prevention (CSAP), described a pioneering SAMHSA dialogue to advance the conversation on the intersection of prevention and recovery. Ms. Richards noted that wellness can play a pivotal role in creating communities that support individuals and families dealing with behavioral health problems. Prevention's more holistic focus on the multiple contexts that influence individual behavior and the protective factors that keep people healthy offers a complementary approach to enhancing recovery along with community wellness.

In April 2013 SAMHSA convened an expert panel, *Building on Common Ground for Wellness: Prevention and Recovery Communities Coming Together*, based on SAMHSA's working definition of recovery. Participants aimed to develop greater understanding about the commonalities of and differences between prevention and recovery; to promote a more unified behavioral health field; to understand and identify barriers and provide a more seamless continuum of services; and to understand the nature of better coordinated and/or integrated treatment and wellness services for individuals, families, and communities. Participants worked to develop practical strategies and action steps for enhanced collaboration and/or integration of supports and services, and they discussed possible "vision ideas" around which to coalesce. Though the meeting allowed insufficient time to develop consensus, a workgroup has continued the dialogue to move toward a shared vision for bringing together prevention and recovery.

Ms. Richards stated that SAMHSA views the dialogue as a first step to embracing a prevention and recovery vision, and laying the groundwork for identifying capacity needs and opportunities to help states and communities build more seamless infrastructure; collaboration and/or integration of services in expanding state recovery networks; developing new behavioral health networks that are prevention- and resiliency-focused and recovery-oriented, and that would focus on social determinants of health and wellness strategies; and collaborating to achieve positive outcomes. A common language would enable communities to understand that supporting recovery also supports health and wellness.

Mr. del Vecchio noted that SAMHSA's tobacco cessation efforts complement those of the Food and Drug Administration (FDA) and other agencies. He noted that SAMHSA's primary and behavioral health care integration programs, which co-locate primary healthcare in mental health treatment settings across the country, have served more than 32,000 individuals to date. SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) soon will issue a study on early mortality, and SAMHSA's HIV/AIDS program has supported integrated care for many years. An HIV/AIDS integrated continuum of care pilot project is being implemented for FY 2014.

Discussion. Ms. Cassandra Price suggested that SAMHSA's policy academies address wellness, integration, and the insurance marketplace, and involve all systems affected by health reform.

In response to Dr. Rickman Jones's observation about a focus on family and community wellness, Ms. Townsend stated that families may be essential in helping individuals with behavioral health problems follow through on wellness strategies. She explained also that consumer groups have established walking and running groups, and community members often join them, positively blurring lines between people with behavioral health problems and the general community. Ms. Townsend described a community that has coalesced to promote dental wellness in response to a methamphetamine problem; individuals with dental problems also began to seek recovery. Dr. Wong endorsed partnerships among SAMHSA, health foundations, and schools. When Los Angeles established health clinics in its high schools, 45% of the students were found to have behavioral health issues; establishing wellness centers has prevention implications and the ability to address serious health needs. Ms. Townsend stated that communities can address wellness by working with urban planners and other nontraditional partners, improving safety, and welcoming stores that sell healthy food. Dr. Rickman Jones suggested teaching advocacy for environmental improvements such as bicycle and walking paths, and Dr. Wong suggested promoting walking and talking, perhaps through cultural adaptation of an Israeli model to address PTSD.

In response to a suggestion by Mr. Olson, Ms. Townsend stated that SAMHSA engages its grantees in the agency's wellness work, as they do their prevention, treatment and recovery services work. Dr. Gonzales suggested partnering with the National Association of Radio Broadcasters to run public service announcements on wellness topics. Dr. Rosen pointed out that wellness programs often serve as access points to treatment. Ms. Price added that a wellness approach opens doors to many types of care and community supports, and stated that Georgia's peer approach has been effective in helping individuals assess their own wellness and link to supports. She asserted the importance of emphasizing individual goals rather than unattainable metrics. Ms. Townsend and Mr. del Vecchio noted that a focus on wellness also tends to diminish the impact of negative stereotypes of mental illness.

To address wellness among young people, Ms. Gregory suggested that SAMHSA partner with 4-H, Girls on the Run, and Every Mile is Worth It; sponsor local races; disseminate information about programs and grants; sponsor a well-known runner who advocates for behavioral health; and partner with *Runner's World* magazine. Mr. Olson noted the importance of SAMHSA's entrée into schools, which should teach a curriculum that stresses health, practical economics, and independent living skills. Ms. Gregory suggested that SAMHSA work with the Department of Agriculture and 4-H to coordinate community gardens with school systems. Dr. Wong added that existing gardening curricula should be rewritten with a wellness focus. Ms. Hyde expressed appreciation for CDC's effort to promote community gardens and in general to support wellness among SAMHSA's populations.

Ms. Hyde pointed out that though SAMHSA has focused increasingly on the behavioral health of young people and children, some believe SAMHSA should focus only on people, especially adults, with the most severe illnesses. She asked the Council's input. Several Council members responded that SAMHSA's role should cover the lifespan and encompass prevention and intervention for conditions that include more intensive levels of care. Ms. Price stated that health and wellness may prevent people from moving into systems of care for more severe and persistent illnesses, and robust community services and treatment are needed to avoid hospitalization. Dr. Rickman Jones asserted that behavioral health offerings

should be driven by values and principles for all levels of services. Dr. Gonzales highlighted the necessity to take a prevention approach given the lack of sufficient numbers of providers. Council members supported SAMHSA's emphasis on prevention and wellness.

Prescription Drug Abuse Issues

Ms. Hyde introduced the discussion of prescription drug abuse, including emerging issues and good news in recent data. She noted that many stakeholders address the issues of use, misuse, and overdose, and SAMHSA places a high priority on treatment and prevention efforts.

Ms. Frances Harding, Director, CSAP, welcomed Dr. Ellie McCance-Katz, SAMHSA's new Chief Medical Officer, and presented a high-level overview of the issue of prescription drug misuse. According to the National Survey on Drug Use and Health (NSDUH), during the last 10 years, 22 million Americans began using prescription drugs for nonmedical purposes. Among persons age 12 and older who misused prescription pain relievers in the past 12 months, 55% obtained them free from a friend or relative. Prescription drug misuse is second only to marijuana as the nation's top illicit drug problem. Nevertheless use of prescriptions for nonmedical purposes by people ages 18–25 declined 14% during the period 2010–11. Concern remains great because the number of deaths due to prescription misuse – especially opioid overdose – is rising.

SAMHSA has undertaken a series of efforts to prevent prescription drug misuse. HHS's Behavioral Health Coordinating Council (BHCC) has established a subcommittee to focus on prescription drug misuse and abuse. A subcommittee report reviewed current federal initiatives that identify opportunities to ensure safe use of drugs with potential for abuse and to treat prescription drug dependence. In addition, Ms. Hyde and other principals on the BHCC provided recommendations to the HHS Secretary to address opioid drug mortality and morbidity. SAMHSA's Partnerships for Success initiative has awarded \$41.9 million to 15 states to build capacity to address underage drinking or prescription drug misuse, or both, among young people ages 12–25. Ms. Harding stated that communities nationwide observed the May 2013 National Prevention Week by addressing prescription drug misuse among other behavioral health issues.

Dr. McCance-Katz explained that opiate misuse has caused problems for more than a century. Morphine, which came into general use during the Civil War, was prescribed liberally by physicians for minor pain and led to widespread addictions. Passage of the Harrison Act in 1914 prohibited prescription of narcotics for addicts under pain of prosecution, and into the 1920s many physicians were jailed and their lives ruined, and they feared prescribing opiates even for people with severe pain. In the 1990s the pain treatment community asserted that people with chronic pain deserve treatment, and, according to some opinion leaders, people with pain could not become addicted. The FDA approved OxyContin in the late 1990s for moderate to severe pain, with the understanding that the extended release formulation rendered it less addictive—unaware that its manufacturer had withheld data to the contrary. (The pharmaceutical company subsequently was severely punished.) That approval marked the start of the extraordinary rise in opioid misuse and overdose.

In her work before joining SAMHSA, Dr. McCance-Katz found that physicians are not taught how to treat pain, do not give patients all the information they need to make decisions on prescription drugs, and do not understand well the issue of drug interactions. She asserted that all prescribers of opiates must have better training. SAMHSA's CSAT runs the Prescribers Clinical Support System for Opioid Therapy. Dr. McCance-Katz stated that SAMHSA will take the lead with other agencies to get medications safely to people and provide best care for people with pain.

Dr. H. Westley Clark, CSAT Director, described several of SAMHSA's intervention and treatment programs. SAMHSA's Opioid Overdose Toolkit will provide a user-centric, action-oriented resource to

help at-risk individuals avoid overdoses; help families, communities, and front-line health workers reduce the potential for overdose; and mitigate the dangers and consequences of opioid misuse and abuse.

SAMHSA has placed a high priority on efforts to develop, expand, and enhance behavioral health information technology to provide front-line tools that operate in real time at the point of care. The tools facilitate patient treatment, mitigate substance misuse and abuse, and inform public health surveillance, planning, and policy making. To illustrate the importance of interoperable tools, Dr. Clark described Kentucky's successful prescription drug monitoring program (PDMP), credited with reducing from 2nd to 31st place Kentucky's ranking among states with the highest nonmedical use of prescription painkillers. In 2012, for the first time in a decade, overdose deaths declined in Kentucky. Kentucky has enacted legislation requiring clinicians to register with the PDMP, which shares data with other states, and to review PDMP records prior to prescribing specified controlled drugs. Dr. Clark stated that SAMHSA's efforts to support and accelerate data system integration and interoperability include recent Requests for Applications (RFA). The 2013 Electronic Health Records (EHR) and PDMP Data Integration awards will facilitate health care providers' access to PDMP data without disrupting their normal clinical flow, and will provide resources to states to enable EHRs in hospital emergency departments, private health care facilities, and retail store dispensing systems to link electronically to PDMPs to increase data utilization and application to practice. Awards from the Patient Continuity of Care Through Data Interoperability Initiative will enable opioid treatment programs to develop EHR systems that fulfill regulatory requirements, achieve certified status, and become interoperable with other patient health record systems.

Dr. Clark reported that the American Society of Addiction Medicine found that Medicaid agencies in only 28 states cover all three FDA-approved medications to treat opioid addiction, and that private insurers and Medicaid-status agencies frequently impose rigid, scientifically indefensible limitations on medically necessary opioid addiction treatment. By contrast, he noted, one would not deprive a diabetic of insulin or withhold statins from a patient with high cholesterol. Dr. Clark asserted the need to ensure that people with a legitimate need for the drugs can afford them and can access them.

Ms. Cassandra Price, Director, Division of Addictive Diseases, Georgia Department of Behavioral Health and Developmental Disabilities, offered a state directors' view of the issue of opioid misuse and abuse, based on a survey by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). State directors constantly monitor potential drug trends and their effects on their systems. Following crack cocaine in the 1980s and methamphetamine in the 1990s, prescription drug misuse is the current trend. Ms. Price noted that state directors have seen an increase in overdose deaths due to prescription drugs in detox and treatment admissions. They have also seen an increase in use of medication-assisted treatment programs. Prescription drugs often are implicated in crime-related events and child welfare cases.

State drug abuse directors deal with increases in substance trends in a number of ways, for example, with PDMPs, though many state legislatures have yet to establish such systems. States engage in such prevention activities as public awareness campaigns; community forums; collaborations with law enforcement to facilitate drug disposal; educating providers on issues and strategies. They work to ensure that providers have tools to treat prescription drug abuse; understand pain management options; deal with denial regarding prescription drug abuse; promote research, education, and partnerships that ensure that primary care physicians understand addiction; and engage peers to demonstrate that recovery is possible.

Ms. Price expressed concern that, because most prescription painkillers are prescribed in primary care settings, with more people covered, overdose deaths due to prescription drugs will accelerate. She stated that SBIRT is an excellent intervention model that can be replicated. She pointed out that careful attention must be paid to accommodate trends in drugs of choice in a market driven by supply and demand.

Discussion. To a question from Mr. Olson, Dr. McCance-Katz explained that opioid overdose death rates have risen due to medication interactions and to better identification of causes of death. Ms. Hyde added that agencies and report on deaths differently. SAMHSA's prevention efforts tend to work best and first

on low-level users—for example, to prevent young people from starting to take drugs or to encourage parents to be careful with their own medications—but those efforts typically do not reach heavy users. Treatment efforts can reach these individuals and can result in recovery. Dr. Clark stated that death may occur if an opioid-naïve person cannot tolerate a drug. He noted that 70% of users get drugs free (or steal them) from friends and family, and drugs may be acquired through heavy prescribing and doctor shopping. Individuals in relapse may discover that their tolerance for a drug has changed, which also can result in overdose. Dr. Clark stated that prescribers will feel increased pressure to prescribe more judiciously. Dr. Rosen added that 10% of people admitted to general hospitals are prescribed chronic opiates. Compounding the problem is the fact that pain management standards differ among five medical specialties, though efforts have begun to reconcile differences. Dr. McCance-Katz pointed out that most physicians cannot recognize and treat addiction.

Ms. Hyde summarized issues involving opioid medications—prescribing problems from ignorance or intent, inadvertent and intentional diversion problems, training, doctor shopping, and regulations, among others. She noted that HHS is analyzing data to identify where the problems lie and to determine future directions, and SAMHSA has provided grant money to states and health information exchanges to ensure interoperability of PDMPs with health insurance exchanges (HIEs) and with PDMPs in neighboring states. The BHCC has undertaken to be a role model, and SAMHSA is conducting physician training for the Indian Health Service and federally qualified health centers.

Mr. Olson suggested targeting high school and college students with messages and tools about the dangers of misusing prescription medications. Dr. Wong stated that different messages are warranted for different target audiences with different patterns of use, misuse, sharing, and availability. Dr. Clark stated the need to transmit the information to all segments of the population because all are at risk. The aim is to treat pain appropriately, with awareness that one can become physiologically dependent or end up with abuse. Pain management may differ for different demographics, and the data are unclear. Logical approaches to pain treatment are needed, backed up by strategies for people who slip into addiction.

In response to a question from Dr. Rickman Jones, Dr. McCance-Katz stated that it is difficult to characterize overdose deaths as intentional. Ms. Price added that some Georgia data indicate whether a death was accidental or suicide and by which drug. Ms. Hyde stated that SAMHSA's suicide work indicates that guns are the method of first choice for suicide, followed by prescription medications. She noted that the Centers for Medicare and Medicaid Services (CMS) considers it important to ensure that people have access to pain medications. CMS has encouraged its Medicare pharmacy benefits managers to pay greater attention to and analyze data and closely manage to avoid overprescribing.

Ms. Gregory echoed the need to raise awareness in schools and suggested that a digital storytelling project may resonate with young people. Ms. Harding explained that SAMHSA's Strategic Prevention Framework guides the assessment of a situation and facilitates links to appropriate evidence-based programs. Schools have programs that promote awareness and education, intervention, referral, and treatment. Ms. Price noted that Georgia's alcohol initiative providers have engaged young leaders to create prevention-oriented skits now shown on YouTube.

Dr. Clark introduced Mr. Onaje Salim, the Center for Substance Abuse Treatment's new Acting Deputy Director.

Public Comment

To Mr. Ken Edgell's question about the status of SAMHSA's plan to add prescription opiates to the mandatory guidelines for its workplace testing program, Ms. Hyde responded that SAMHSA anticipates that the program will be implemented before too long, pending completion of the clearance process.

Ms. Ann Mahoney, past chair of the American Public Health Association's (APHA) Alcohol, Tobacco, and Other Drug Section, congratulated SAMHSA on its opioid overdose toolkit. She suggested that SAMHSA speak to the APHA at its 2014 annual meeting about behavioral health integration. She observed that the state agencies that operate means-tested programs may have a role to play in enrollment-outreach and eligibility-determination efforts under the ACA. Ms. Hyde responded that SAMHSA is engaged in significant developmental work on enrollment toolkits with a variety of organizations involved in the enrollment process, including behavioral health providers and organizations that serve people who are homeless or who reenter the community following incarceration. She noted that outreach and enrollment efforts are underway for veterans served by the VA as well as those who are not.

Adjournment

The meeting adjourned at 2:10 p.m.

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

April 4, 2014
Date

Administrator, SAMHSA

/s/
Pamela S. Hyde, J.D.
Chair, SAMHSA National Advisory Council

Minutes will be formally considered by the SAMHSA National Advisory Council at its next meeting, and any corrections or notations will be incorporated in the minutes of that meeting.

Attachments: Tab A – Roster of Members; Tab B – List of Attendees

**Substance Abuse and Mental Health Services Administration
National Advisory Council
Confidential Roster**

CHAIRPERSON

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SAMHSA NAC Teleconference Meeting – August 16, 2013

List of Attendees

Federal Attendees

Arturo Gonzales	NAC Member
Megan Gregory	NAC Member
Lorrie Jones	NAC Member
Charles Olson	NAC Member
Cassandra Price	NAC Member
Donald Rosen	NAC Member
Marleen Wong	NAC Member
Laurent Lehman	NAC/VAEx-Officio
Dee Roth	NAC Member
Ben Springgate	NAC Member

Steven Frey	CMHS Federal
Costella Green	CSAP Federal
Charlene Jenkins	CMHS Federal
Charles Ludlow	CSAP/DWP Federal
Leah McGee	CMHS Federal
Cathy Nugent	CMHS Federal
Claudia Richards	CSAP Federal
Onaje Salim	CSAT Federal
Daniell Tarino	CSAT Federal

Public Attendees

Nicholas Demos	Ret Federal Employee
Sandra Kay Fortay	National Center for State Courts
Ann Mahony	APHA
John Rosiak	EDC
Betsy Schwartz	National Council for Behavioral Health

By teleconference

Kareemah Abdullah
Ellen Awai
Erin Bagalman
Jean Bennett
Ellen Blackwell
Kim Blocker
Jonathan Brown
Sara Calvin
Jean Campbell
Sheila Cooper
Joy Cunningham
Deborah Demasse Snell
Mairead Desmond
Ken Edgell
James Ferguson

**Dave Freedman
Rachel Freeland
Theresa Hampton
Christina Hartman
Tia Haynes
Gail Held
Renata Henry
Cindy Ingraio
Margaret Jack
Alan Johnson
Eliza Jones
Patrice Kelly
Elizabeth Lopez
Gajef McNeill
Theresa Mitchell
Alan Moghul
Kimberly Morris
Mahak Nayyar
Lydia O'Donnell
Lynn Ormiston
Mellie Randall
Rae Reed
Claudia Richards
Onaje Salim
Debby Schmidt
Jill Anne Schulte
Denise Scott
Jeanette Stair
LaVencia Sugars
Elizabeth Sutton
Jim Swart
Pat Taylor
Laura Uttley
Carolyn Vanbrocklin
Bethanie Wang
Patrick Weld
Leslie Zun**