

65th Meeting of the
Substance Abuse and Mental Health Administration (SAMHSA)
National Advisory Council (NAC)
July 23, 2019
Meeting Summary

NAC Member:

Wilson Compton, M.D., National Institute on Drug Abuse (NIDA), on behalf of Nora Volkow, M.D., (ex-officio)
Karen Drexler, M.D., Veterans Administration, on behalf of Marsden McGuire, M.D., M.B.A., (ex-officio)
Jeffrey Geller, M.D., M.P.H.
Ellen Gerstein, M.A.
Joshua Gordon, M.D., Ph.D., National Institute of Mental Health (NIMH) (ex-officio)
George F. Koob, Ph.D. National Institute on Alcohol Abuse and Alcoholism (NIAAA) (ex-officio)
Kenneth J. Martinez, Psy.D.
Sally Satel, M.D.

Allan Tasman, M.D.
Gail Stuart, Ph.D.
Justin Luke Riley

SAMHSA Staff:

Elinore F. McCance-Katz, M.D., Ph.D.
CAPT Carlos Castillo, USPHS
Deepa Avula, M.P.H.
Thomas Clarke, Ph.D.
Johnnetta Davis-Joyce, M.A.
Paolo del Vecchio, M.S.W.
Anita Everett, M.D., DFAPA
Neeraj “Jim” Gandotra, M.D.
Daryl Kade, M.A.
Elizabeth Lopez, Ph.D.
Louis Trevisan, M.D.

Call to Order

CAPT Carlos Castillo, Designated Federal Official and Committee Management Officer called the meeting of SAMHSA’s NAC to order on July 23, 2019 at 9:01 a.m. The Advisory Committee was conducted virtually by webinar.

Welcome, Introductions, Opening Remarks

Dr. McCance-Katz welcomed NAC members. In her opening remarks, she shared the following:

- **Appreciation for Three Retiring NAC Members** – Dr. McCance-Katz thanked and recognized the contributions of Victor Joseph, Kenneth Martinez, and Gail Stuart who are retiring from the Council.
- **Approval of August 2018 minutes** – There were no edits to the August 2, 2018 NAC summary. It was motioned for approval and seconded.
- **SAMHSA’s Priorities** – While SAMHSA has made progress in addressing the opioid epidemic, work needs to continue. Other key SAMHSA priorities are the increase in suicide rates and mental health issues for children.

- **SAMHSA’s Strategic Plan** – SAMHSA has identified five key areas in its strategic plan: combat the opioid crisis; address severe mental illness (SMI) and serious emotional disturbances; advance prevention, treatment and recovery services for substance use; improve data and evaluation activities; and strengthen health practitioner and education.
- **Operational Changes** – SAMHSA has had a number of organizational and staff changes in an effort to be more efficient and responsive to public needs. Within the last week, two new SAMHSA leaders have come on board: Dr. Trevisan, Director for the Center for Substance Abuse Treatment and Neeraj “Jim” Gandotra as SAMHSA’s Chief Medical Officer.

Dr. Tasman requested that the Center Director updates for the NAC meetings be provided to members in advance, so they have time to review them before the meeting. Dr. McCance-Katz noted that, moving forward, SAMHSA will aim to provide these in writing at least one week prior to the meetings. Read-ahead materials were provided to the Council members in advance for their review and preparation for discussion.

SAMHSA and Center Directors Updates

SAMHSA leadership provided the following updates from SAMHSA’s Centers and Offices.

Center for Mental Health Services (CMHS)

Dr. Everett shared that CMHS has been engaged in efforts on “refocusing, refurbishing and refreshing.” This specific work includes:

- Revising their grant management process. This was started with the development of a data dashboard.
- Focusing on the Certified Community-based Health Clinics (CCBHC) model, which provides integrated care for mental health patients in one setting.
- Exploring the feasibility of an N11 phone number for mental health and suicide calls.
- Supporting suicide prevention programs including funding to 18 health systems in implementing the Zero Suicide initiative. She added that many other health systems are picking up Zero Suicide without funding.
- Continuing a partnership with the Veterans Administration (VA) on several suicide initiatives, particularly since many veterans seek services outside of the VA.
- Developing a report on early experiences related to civil commitment into assisted outpatient treatment (AOT). Findings show that AOT has lowered rates of incarceration and hospitalization as well as less homelessness. It also shows greater family satisfaction.

Center for Substance Abuse Treatment (CSAT)

Dr. Trevisan became CSAT’s Director last week, but has been continuing efforts to hire new staff, which will ease the burden of current staff and bring in new perspectives. CSAT is responsible for the STR/SOR grants related to addressing the opioid epidemic. The grants have entered a new management construct that will provide subject matter expertise in both treatment and prevention needs related to opioids.

Dr. Trevisan noted that States are engaged in a wide variety of innovative approaches including efforts related to the following concerns/needs: building partnerships (e.g., with criminal justice, hospitals, homeless or domestic violence centers, recovery programs, child welfare, etc.); providing school-based and family education; organizing media campaigns; and implementing the hub-and-spoke model for outpatient treatment in primary care settings. Some of the innovations have included the use of telehealth, peer outreach, mobile apps, and medical-legal partnerships. With regard to community distribution of naloxone, communities are providing them in nontraditional settings like senior living facilities, hair salons/barbers, and gas stations.

Dr. Trevisan also noted a few additional unique programs that CSAT has been engaged in:

- Native American-focused funding to provide culturally-appropriate programming and peer support.
- Support to 46 new drug courts.
- Expansion of DEA-waiver providers to serve OUD patients with MAT services.

Center for Substance Abuse Prevention (CSAP)

Ms. Davis-Joyce reported that CSAP manages the prevention set-aside of the block grant as well as Synar activities. CSAP also manages discretionary programs including Drug-Free Communities; Sober Truth (underage drinking program); the Minority Substance Abuse/HIV Prevention Initiative; Native Connections, which is focused on tribal communities, and other programs. She shared that 86% of CSAP's appropriations goes directly into grant programs.

Other non-grant activities that CSAP engages in include:

- The Talk They Hear You campaign, which equips parents/caregivers with resources on how to begin conversations with children about alcohol use.
- Activities during National Prevention week, which occurs every May.
- Town Hall meetings and other outreach to the public.

CSAP's NAC, which meets in August, will be exploring implementation strategies that will increase the number of individuals who pursue prevention careers.

Center for Behavioral Health Statistics and Quality (CBHSQ)

Dr. Lopez said that CBHSQ's mission is to increase SAMHSA's overall efficiency and operation. As an example, the Center has been engaged in modifying data collection tools to capture more information about diagnoses and medication assisted treatments (MAT). SAMHSA is also asking more program questions on key outcomes.

Dr. Lopez shared that CBHSQ works closely with SAMHSA's National Mental Health and Substance Abuse Policy Laboratory to ensure that findings are systematically shared with the field and general public. Dr. McCance-Katz also has reestablished the Drug Abuse Warning Network (DAWN), which collects real-time surveillance data from emergency departments on drug-related presentations.

SAMHSA's National Mental Health and Substance Abuse Policy Laboratory

Dr. Clarke stated that the Policy Lab is the newest SAMHSA entity and was developed through the 21st Century Cures Act. The Policy Lab's mission is to facilitate policy changes and provide leadership on policies, programs and evidence-based practices related to addressing mental health and substance abuse. It works closely with NIMH, NIAAA and NIDA to ensure that research informs practice and the delivery of services.

Some of the specific tasks of the Policy Lab include:

- Coordinating SAMHSA's Strategic Plan and activities across the SAMHSA Centers.
- Preparing Congressional Reports.
- Launching an evidence-based practice resource center.
- Developing guidebooks. They have already done guidebooks on topics such as MAT in the criminal justice and emergency department settings; marijuana; prevention; and co-occurring disorders.
- Supporting NIDA's HEALing communities study which will generate evidence from four States on tools used to prevent and treat opioid addiction at the local level.
- Contributing to the development of HHS' Healthy People 2030 measures for substance use, opioid use disorder (OUD), and mental health.
- Collaborating with partners such as the National Academy of Sciences, which is exploring the mental health landscape of undergraduate and graduate students.

Office of Management, Technology, and Operations

Mr. del Vecchio shared that his office supports SAMHSA's infrastructure, most specifically its IT and operations need. The Office also supports facility management, security, and cybersecurity activities. It also supports travel and purchasing activities, ethics requirement, and performance management. With regard to travel and purchasing, the Office now has an online system to better facilitate that process.

Office of Communications

Ms. Kade reported that the Office of Communications manages the SAMHSA Store, which provides products (toolkits, factsheets etc.) on a variety of topics including MAT inside correctional facilities; behavioral health for the American Indian community; suicide; and inappropriate use of antipsychotics in older adults and those individuals with developmental disabilities. One of the most popular items is the wallet card with the National Suicide Lifeline number.

The Office of Communications also manages SAMHSA's digital and social media activities, including the development of hashtags and the Agency's website. One recent improvement they have worked on is to improve the search function on the samhsa.gov website.

Office of Financial Resources

This Office is responsible for handling the grants and contracts process, as well as SAMHSA's internal human resources. According to Ms. Avula, SAMHSA has received a 35% budget increase which comes with additional responsibilities and accountability. This Office has worked to streamline the grants/contracts process by asking fewer questions on the applications. This has tripled the number of applications they have received. The Office has also strived to get the money out to awardees more expeditiously and is focused on getting more money out to the field and communities, rather than clustered in "local DC-based firms."

SAMHSA has modified its technical assistance (TA) approach to serve everyone rather than just SAMHSA grantees. They have also expanded these TA centers. Originally, the centers were focused on substance abuse treatment. However, there are now new regional TA centers for prevention and mental health. SAMHSA has intentionally designed the centers to provide cross collaboration and also to have specialized focuses.

Ms. Avula shared that some of the focuses of the TA centers were generated directly from requests in the field. Examples include:

- Support to grandparents who are raising their grandchildren as a result of the opioid epidemic.
- Expanding school-based mental health services in light of the shooting at Parklawn High School.
- How to develop a program tailored to the Orthodox Jewish community.

Discussion

The NAC representatives and SAMHSA staff made the following questions and comments.

How does SAMHSA define recovery? (Dr. Geller)

Dr. Clarke noted that recovery can mean different things. In many instances, it is broad and includes housing, employment/education.

How are "innovative practices" being identified? (Dr. Martinez)

Dr. Clarke responded that rather than having SAMHSA define that, SAMHSA wants to learn from the States and let them inform the Agency of what those practices are. Ms. Avula added that the Policy Lab does have a committee that will do a review from literature and that is a more formal process for identifying evidence-based practices.

How can we get more single-setting intervention centers (integrated care) which provide comprehensive services (e.g., mental health, physical health and substance use services)? SAMHSA has provided funding to 24 States already. But other States do not seem interested in pursuing this, even though there is evidence that this approach saves money and improves outcomes. (Dr. McCance-Katz)

Dr. Geller noted that some of these type of Centers may already exist but since they were not funded by SAMHSA, SAMHSA may be unaware of them.

Dr. Martinez said that there may be some funding barriers such as the Medicaid rule about multiple billings in one day. Dr. Everett noted that an integrated care code was added for use by primary care practices.

Dr. Tasman indicated it would be beneficial to educate senior administrators about what integrated care actually is and the options that are available (e.g., it isn't necessarily a complete revamp of an existing office).

Dr. Tasman also mentioned workforce limitations as an issue and SAMHSA may want to explore expanding capacity to educational institutions so that they can meet the workforce demand. This approach was used to successfully increase the number of psychiatrist nationally. This might be again done for other behavioral health professionals.

Open Dialogue with Chair/General Council Discussion

Dr. McCance-Katz facilitated this discussion, which focused on four key topics.

Civil Commitment

As background, Dr. McCance-Katz share that, in a previous role as Chief Medical Officer in Rhode Island, she had experienced personal cases with psychotic patients refusing treatment because they don't recognize that they are ill. Often, these individuals end up criminally-justice involved. This is an issue nationwide. The shooting at Parklawn High School brought this to the forefront. As a result of that tragedy, there is now a Federal Commission on School Safety.

Dr. McCance-Katz wanted NAC to explore conversations on what kind of interventions might be provided when someone with an SMI is not amenable to treatment. She recognizes that civil commitment is a sensitive subject because of issues of patient autonomy and rights. Other discussions have revolved around patients issuing psychological advanced directives should they become incapacitated (e.g., psychotic) in the future. The Assistant Secretary also acknowledged that this is a State rather than a Federal issue. However, SAMHSA, with the American Health Lawyers Association, has developed a white paper which was shared with NAC members prior to this meeting.

Ms. Gerstein said that she shared the white paper with a board member who oversees mental health. The board member commented that she thought the document was accurate in terms of background, however she was not in favor of more laws on involuntary civil commitments (e.g., Georgia's 1013s). She preferred more focus on earlier prevention and intervention services.

Dr. Tasman indicated he liked the psychiatric advanced directives option, noting that there is very little awareness about this. He shared that one obstacle to the directives would be the HIPAA concern, particularly when that individual becomes engaged with law enforcement (e.g., police arrive on the scene may not have access to this information).

Dr. Martinez shared a case that happened yesterday where a man with mental illness was fatally shot by police after family members called about a women's mental health crisis. She was under 5 feet tall and nude. This is an example of where law enforcement needs improved training.

Dr. McCance-Katz agreed that psychiatric advance directives need to become more well-known. She recently had a meeting with the leadership of the Joint Commission to help raise awareness about the directives and also to ask that the Joint Commission initiate a survey of providers.

Dr. Everett shared that SAMHSA has a resource document to provide guidance on directives. She also said that this can be encouraged as a parity issue as there are routine requirements on requesting directives for physical health needs.

Dr. Tasman echoed Dr. Martinez's comment about training law enforcement. He shared an experience in Louisville, which has had high police shootings. As a response, the city implemented universal training to law enforcement that resulted in reduced police shootings (though recently there has been an increase in the rate).

Dr. Tasman also suggested that, in addition to surveying hospitals, SAMHSA should consider a survey of federally-funded community mental health centers. Dr. McCance-Katz agreed to explore that. She noted that it is more compelling when the message (and requirement) relates directly to an entity's accreditation standards.

Dr. Gandotra suggested pursuing a "path of least resistance." He noted that there are psychological rehabilitation facilities (e.g., Cornerstone) that struggle with this issue. They might welcome serving as a pilot for expanding use of these directives.

Dr. McCance-Katz asked what NAC members felt about the public and stakeholder response to the white paper. Dr. Martinez indicated the paper was sound, reasonable and balanced. The mental health recovery community are resistant to involuntary civil commitments, but it is a conversation that needs to be pursued so that some compromise/common ground can be identified. Dr. Trevisan shared that he worked for the Veterans Administration where he encountered resistance from clinicians, but the veterans themselves were very supportive (e.g., a directive that says no Haldol).

Dr. McCance-Katz shared that at SAMHSA's Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) meeting in early July, public members (which includes NAMI) were asked for feedback. SAMHSA is committed to soliciting input from as many stakeholders as possible.

1115 Waivers for Lifting the IMD Exclusion for SMI

Dr. McCance-Katz explained that there is now an 1115 waiver to lift the IMD exclusion for SMI treatment, but States have not been applying for the waiver. She welcomed feedback from NAC members on how to increase awareness and implementation of this option. She noted that SAMHSA plays an ancillary role in this, because it is essentially a CMS effort.

Dr. Tasman suggested leveraging advocacy groups for this. However, he said that SAMHSA could help provide guidance that these groups could use. For example, there are some concerns about cost (e.g., this will increase utilization). So there is a need to provide data demonstrating that this is worth the risk and will reduce costs and improve health in the long run.

Methamphetamine and Opioids: Therapeutic Approaches

Dr. McCance Katz said that as SAMHSA engages in conversations about opioids, States and stakeholders are relaying two concerns:

- Resistance of some OUD users to seek treatment – While the service delivery systems and approaches have improved immensely in addressing OUD, many individuals still do not seek treatment (perhaps because of prior bad experiences).
- Methamphetamines – States and other partners are indicating that usage rates are increasing and in some geographical areas, methamphetamine usage may be higher than OUD.

She added that, unlike OUD, there are not MAT options for methamphetamines. However, SAMHSA has been exploring the benefits and allowability for contingency management approaches.

Dr. Tasman shared that Kentucky is one of those geographical areas with high methamphetamine rates. He added that in addition to a need for developing more effective treatment options, there is a need to increase the number of mental health professionals who have addiction training. While there are programs that provide subspecialties, many of the fellowship slots are not filled (up to 50%). Dr. McCance-Katz acknowledged the workforce issue, noting that CMS and HRSA maintain Federal responsibilities in this area. She added that she has worked with the Providers Clinic Support System (PCSS) to do some similar work in substance abuse, such as incorporating DEA waivers as part of classroom training. SAMHSA is also leveraging funding announcements to increase the demand for non-doctoral professionals.

Dr. Drexler shared that the VA has endorsed contingency management for stimulant use disorders and there are two papers about these efforts. Specifically, there is a study with 4,700 veterans that shows significant results to using this intervention related to cocaine, cannabis and methamphetamines use. She cautioned about its use with OUD treatment because of difficulties with fentanyl detection and positive screens related MAT. However, she said that contingency management has been used for individuals with OUD related to follow-up Vivitrol injections.

In terms of contingency services, the VA offers coupons for canteen services, which, unfortunately, may not be applicable in other settings. Canteen services received a \$100K for honoring these coupons.

Dr. McCance-Katz shared that some entities were concerned about the legality of “paying patients for treatment.” However, the Office of the Inspector General has ruled that small

incentives (\$15 maximum per event or \$75 per year) are allowable. CSAT will be convening a meeting next week to discuss further contingency management approaches.

With regard to CLIA labs doing the testing, Dr. Drexler said that point-of-care testing has been a challenge with CLIA lab chiefs. While the VA has worked to overcome resistance, community-based settings may not have the capacity for immediate testing/awards.

Dr. Compton appreciated all the efforts being done with contingency management and to improve the systematic behavioral management process. He said that NIDA is continuing to do research on effective treatments, including MAT for methamphetamine.

Marijuana

Currently 33 states allow medicinal marijuana with ten states and the District of Columbia legalizing recreational use. This has allowed for time-study research into the impact of marijuana use. Research show that use is increasing among younger Americans and there is burgeoning literature on the adverse health impact. Following are some comments/observations/concerns from NAC members.

- **Packaging as “good for you”** – Ms. Gerstein expressed concern with how the marijuana industry has been spending money to promote that message the marijuana has medicinal value even for young kids (e.g., as an anti-seizure medication). There are even claims that it is useful in addressing opioid use disorder (OUD). It is hard to combat that message.
- **Concerns that it could be an epidemic and the potency differential** – Marijuana today is more potent than in the past and is a gateway to other substance use disorders. Most parents are unaware of the increased potency and that psychosis is a consequence.
- **State Resources and Recommendations** – Ms. Gerstein indicated that resources such as the Stop Act Grants might be useful. Dr. Martinez recommended that SAMHSA develop a gold standard focusing on the impact for developing brains under 25 years old (including during pregnancy). He recommended that SAMHSA consider guidance for legislators who might be working on new laws about the impact on youth and children and approaches to incorporating language in legislation to protect this population. He also suggested that legislators be encouraged to earmark profits towards obtaining data and expanding treatment options.
- **Other Resources and Recommendations** – Dr. Drexler suggested that SAMHSA consider developing support tools for parents and social media messages that stakeholders can disseminate. Social media, in particular, is where many youth now get their information.
- **Dose-Response Concerns** – Dr. McCance-Katz shared that data is showing that there are dose-response relations with increase the onset of SMI, depression, suicide and OUD. Data has shown that there are also detrimental impacts to the overall social fabric since use is predominantly during the “prime of life.” Such issues include to impact on an individual’s career/education, on raising families and utero-exposure.

- **Awareness of Concerns** – Dr. McCance-Katz noted that SAMHSA is working hard to collect data about marijuana impacts but welcomed input on how to increase public awareness of this information. Dr. Satel agreed and said that parents need to be targeted. For example, parents are pushing back on vaping for underage youth, but less so with marijuana.

Public Comments

There were no public comment. The operator read a statement from Dr. Drexler: “As for marijuana, some patient decision support tools for primary care providers and social media messaging to combat the marijuana industry's ubiquitous social media presence.”

Closing Remarks/Adjourn

Dr. McCance-Katz thanked everyone for their participation and for their advice and assistance on very important issues, and looks forward to getting input from all members in the next meeting.

CAPT Castillo thanked the members and adjourned the meeting at 11:54 a.m.

Certification

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

SEP 13 2019



Date

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and
Substance Use

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