

**68th Meeting of the
Substance Abuse and Mental Health Administration (SAMHSA)
National Advisory Council (NAC)
September 3, 2020
Meeting Summary**

NAC Members:

Jeffrey Geller, M.D., M.P.H.
Ellen Gerstein, M.A.
Dave Gustafson, Ph.D.
Laura Howard, J.D.
Tracy Neal-Walden, Ph.D.
Francisco Rodriguez-Fraticelli
Sally Satel, M.D.
Allan Tasman, M.D.
Barbara Warren, Psy.D.

SAMHSA Staff:

Elinore F. McCance-Katz, M.D., Ph.D.
Valerie Kolick, M.A.
Deepa Avula, M.P.H.
Melinda Baldwin, Ph.D., LCSW
Mitchell Berger, M.P.H.
Joseph Bullock, Ed.D.
Richard Carmi
Tom Coderre
Roberto Coquis, M.D.
Humberto Carvalho, M.P.H.
Thomas Clarke, Ph.D.
Johnnetta Davis-Joyce, M.A.
Paolo del Vecchio, M.S.W.
Ashley Duffy, M.A.
Anita Everett, M.D., DFAPA
Ron Flegel, MT (ASCP), M.S.
Steven Fry, M.S.
Neeraj Gandotra, M.D.
Robert Grace
Lori Hayman, J.D.
Josefine Haynes-Battle, M.S.N, R.N.
Anne Herron, M.S.
Sean Lynch, Ph.D.
Maureen Madison Ph.D.
Anne Mathews-Younes, Ed.D, D.Min
Kim Nelson, LAC, M.P.A.

Christopher O'Connell, M.B.A.
Charissa Pallas, M.M.
Marion Pierce
Krishnan Radhakrishnan, M.D., Ph.D.,
M.P.H.
Kimberly Reynolds, M.P.A.
Jeanne Tuono
Tracy Weymouth, M.S.W.

Ex-Officio Representation:

Wilson Compton, M.D., National Institute
on Drug Abuse (NIDA), on behalf of Nora
Volkow, M.D.
Robert Heinszen, Ph.D., National Institute of
Mental Illness, on behalf of Joshua A.
Gordon, M.D., Ph.D.

Guest:

David Covington, LPC, M.B.A., RI
International

Public:

Michael Abrams. M.P.H., Ph.D., Public
Citizen
Asra Ahmad, M.P.H.
Sarah Calvin, M.A.
Kevin Cintorino, National Geospatial-
Intelligence Agency
Jennifer Colby
Jeffrey Geller, M.D., M.P.H., American
Psychiatric Association
Jack Goodman
Brian Hepburn, M.D., National Association
of State Mental Health Program Directors
Aaron Konopasky J.D., Equal Employment
Opportunity
Melodye Watson, LCSW-C

Call to Order

Valerie Kolick, Acting Designated Federal Official, called the meeting of SAMHSA's National Advisory Council (NAC) to order on September 3, 2020, at 1:02 p.m. The NAC was conducted as a hybrid in-person/virtual meeting. The members in attendance constituted a quorum.

Welcome, Introductions, Opening Remarks

Dr. Elinore McCance-Katz, the Assistant Secretary for Mental Health and Substance Use, welcomed NAC members. There were no edits to the January 28, 2020, NAC meeting minutes. It was motioned for approval and seconded.

Update on the Final 42 CFR Regulations

Neeraj Gandotra, M.D., Chief Medical Officer

Dr. Gandotra noted that the effective date for the Final Rule is August 14, 2020. The purpose of the updates are to provide for better coordination of care with non-Part 2 providers, particularly in the context of the opioid epidemic while still maintaining confidentiality adherences. It is important to note that disclosures still require written consent from the patient.

Following are the key modifications of the update:

- **Applicability and Re-Disclosure** – Once patient consent is provided, information can be disclosed by a covered entity related to treatment, payment, and healthcare operations. Re-disclosures are allowed in accordance with HIPAA standards.
- **Definition of Records** – The definition of “records” was revised to create an exception so that information communicated orally by a Part 2 program to a non-Part 2 provider for treatment purposes does not constitute a “record” subject to Part 2
- **Disposition of Records** – If a patient sends a message to a provider’s personal device, deleting the message fulfills the “sanitizing” requirement for the record.
- **Consent and Disclosure** – A patient may now indicate consent to an entity rather than a specific individual. This is to allow patients to apply for benefits (e.g., Social Security) more easily and improve care coordination activities. Patients can give consent once for the purpose of payment and healthcare operations.
- **Disclosures to Central Registries and PDMPs** – Opioid Treatment Providers (OTPs) will be able to enroll in a Prescription Drug Monitoring Program (PDMP) and report on their patients. Non-OTPs will be able to query the Central Registry for their patients. This will ensure there aren’t duplicate enrollments. This still requires prior written consent from the patient.
- **Medical Emergencies** – A Part 2 provider can disclose information on a patient without consent if their treatment becomes disrupted due to a “bone fide medical emergency,” or a national disaster.
- **Research** – The updates are intended to align with HIPAA and Common Rule provisions. The update allows for research disclosure by a HIPAA-covered entity to individual and organizations who are not covered entities if the data disclosed is in accordance with HIPAA privacy provisions.
- **Audit and Evaluation** – This was an ambiguous clause that was clarified regarding which services fall in and outside of the provision.

- **Confidential Communications** – Courts may order disclosures for the purpose of investigating “an extremely serious crime.” The clause “allegedly committed by the patient” was removed.
- **Undercover Agents and Informants** – DOJ has expressed concerns that the policy is overly restrictive for investigations of Part 2 programs. The new language allows for agents to be placed undercover with a court order for a period of 12 months and can be extended with an additional court order.

Dr. Gandotra noted that these details are also listed on the SAMHSA landing page.

Questions and Comments

Dr. McCance-Katz stated that the comments received most often about the proposed rule were about the value of being able to share Part 2 information for case management and coordination. She also referenced the “mini-rule” that supplements the regulation. In it there was a change that was requested by the DOJ to revert language that was inadvertently modified in a more recent promulgation. This is still being reviewed but it is expected that restoring the text back to the original language will be approved.

Dr. McCance-Katz also stated that the CARES Act has statutory language that requires that 42 CFR Part 2 be subsumed under HIPAA. This effort will need to be co-managed by the Office of Civil Rights which has oversight of HIPAA.

Update on SAMHSA’s National Crisis Guidelines

David Covington, LPC, M.B.A., CEO and President, RI International

Mr. Covington shared that RI International provides full crisis services across ten states. RI International also provides consulting services to ten other States. Released in March 2020, SAMHSA’s [National Action Plan for Behavioral Health Crisis Care](#) proposes a radical transformation in the delivery and implementation of crisis services.

The concept of the plan is that crisis services be available to “anyone, anytime and anywhere.” This is the process for individuals who have a heart attack or get in a car accident but is lacking for behavioral health emergencies. Rather, these individuals tend to be “touched” by law enforcement, 911 and emergency departments in lieu of behavioral health services providers. The current approach is fragmented; frustrates law enforcement and ER staff; and has exposed some states (e.g. Washington State’s practice of psychiatric onboarding) to lawsuits on constitutional grounds. International communities also tend to shunt behavioral health patients through an ER choke point. Mr. Covington also noted that the system failure has had tragic consequences. For example, the gunman at the Aurora Colorado movie theater made an unsuccessful call to crisis hotline immediately prior to his shooting rampage.

Mr. Covington noted that the shift proposed by SAMHSA is effective, saves money, and is compassionate. In fact, several communities and states have already begun implementation (e.g., providing a proof of concept). The proposed model has three fundamental building blocks:

- **Someone to Call** – Beyond a 911 dispatch service, a crisis hotline should operate more like an air traffic control system with hotline staff serving as case managers who can provide online assistance, set up appointments, and if needed, send out a mobile unit to the person (e.g., with precision like Uber). The national 988 hotline could serve in this role.
- **Someone to Come to You** – Mobile units with at least two-behavioral health providers will come out to the individual wherever they are to provide assistance.
- **Someplace to Go To** – This would be a facility that serves specifically behavioral health needs and has a quick intake process and no-waiting for bed availability. The first and last person seen is a peer provider and services are patient-centered. It might be a respite or residential setting. The building style is a living room design to make the space more welcoming.

Mr. Covington noted that the current system operates like an on/off switch where the person in crisis either stays at home or is transported to the ER/Jail. However, research using a system called level of care utilization (LOCUS) has shown that it is more stratified and that most of the need is in the interim outpatient dimensions between those two endpoints.

The SAMHSA guidelines provides minimum standards for each of the three building blocks along with best practices for each of the three components. He also noted that there are existing codes for these services, though they are misused to cover services within the existing system.

Crisis Models in Existence Today

Mr. Covington shared details used in the Arizona model. He noted that a prerequisite is a standard and sustained funding source. Arizona used the 1115 waiver which requires that a change be cost neutral. In addition to saving money, the new crisis model reduced police “wall” time, ER throughput, and availability of expensive acute beds. Actuaries have developed “crisis payment rates” to provide to health care providers.

Dr. Covington noted that the national 988 hotline would be operational by July 2022.

Questions and Comments

NAC members shared the following questions and comments:

- **New York City Implementation** – Dr. Warren noted that a similar program was attempted in New York City, but it faltered because it became a “lifeline to nowhere” and did not have the cascade of services to support the system. Mr. Covington responded that the NYC First Lady did come out to Arizona to learn about the crisis system and funding. But that Dr. Warren is correct - all three components need to be provided for the system to work.
- **Social Determinants of Health** – Dr. Warren also mentioned that, particularly when outpatient care is warranted, there is a need to also have resources to address other issues like housing and transportation. Mr. Covington agreed.
- **Police Receptivity** – Mr. Covington shared that police respond very positively to the system because it reduces their wait time, allows them to get back to the work they were trained for, and they can see positive outcomes.

- **Finding Resources** – In response to Dr. Gustafson’s question, Mr. Covington shared that resources can be found at crisisnow.com. It includes a community calculator and videos. However, individuals and organizations can also reach out to the communities and States that have already implemented the program.

Dr. McCance-Katz said that SAMHSA is committed to supporting this beyond merely publishing guidelines. For example, SAMHSA is looking at the Certified Behavioral Health Community Clinics (CCBHCs) as being a foundation for the system. The CCBHCs must be certified and provide 24-hour crisis care.

In terms of budget, the CCBHCs were a \$100 million program. It is now a \$450 million program. In addition, the Presidential budget for 2021 includes a request for funding crisis services through the mental health block grant as a supplemental increase for the grant. Lastly, SAMHSA is providing technical assistance (TA) to support implementation.

Update on the Activities of the Training and Technical Assistance Centers

Humberto Carvalho, M.P.H., Office of Management, Analysis and Coordination

Mr. Carvalho noted that for the past three years, SAMHSA has taken a more strategic approach for delivering training and TA. A major change is that it is now available to all providers as well as the public, rather than just grantees. The various components can be found on the Practitioner tab of the SAMHSA website. Some of the pivotal components of the training TA program are provided below.

Technology Transfer Centers (TTCs)

This consists of three networks: addiction, mental health and prevention. Each network has a regional Coordinating Center, regional centers and specialized centers for the Hispanic/Latino and American Indian/Alaska Native communities. Nearly 250K providers have accessed these trainings.

Each of the network Centers have developed a page dedicated to the unique concerns related to the pandemic. Combined they have delivered over 500 events. The Mental Health TTC is developing a 3.5-hour online program that serves educators and will be available later this year.

Clinical Support System for Serious Mental Illness (CSS-SMI)

This is also called the SMI-Advisor and is focused on supporting mental health clinicians in implementing evidence-based and person-centered care for individuals with SMI. The program provides training, technical assistance and one-on-one consultation. Over 58,000 professional have been trained through this program.

Center of Excellence for Protected Health Information (CoE-PHI)

The CoE-PHI supports training and TA to provide training on privacy laws and regulations, including FIRPA, HIPAA and 42 CFR Part 2. Recently they provided training for tribal members as well as trainings on the updates to the 42 CFR Part 2 regulations.

National Center of Excellence for Eating Disorders (NCEED)

Housed at the University of Carolina, Chapel Hill, NCEED's mission is to advance education on eating disorders and treatments, as well as to promote public awareness. Providers who have accessed the Center have been requesting that SAMHSA develop a tool comparable to SBIRT to support clinicians in addressing eating disorders.

Rural Opioids Technical Assistance (ROTA) Program

In collaboration with the US Department of Agriculture, ROTA is providing training to rural communities to address the opioid epidemic. There have been three cohorts with a total of 23 grantees. The program also provides support to tribes.

Expansion of Practitioner Education (Prac-Ed)

The purpose of this program is to integrate evidence-based SUD education into university curriculums. SAMHSA has funded two cohorts representing 30 institutions.

New Programs

Mr. Carvalho noted that the following new programs which began in August or will in September:

- The Homeless and Housing Resource Center
- The Family Support Technical Assistance Center (FAM-CoE)
- The National Peer-Run Training and TA for Addiction Recovery Peer Support (APR-CoE)
- Rural Emergency Medical Services Training (EMS Training)
- The Center of Excellence for Behavioral Health Disparities

Feedback from Providers

Mr. Carvalho noted that SAMHSA has received a lot of feedback from providers in the process of implementing these programs, particularly challenges with working amid the pandemic and implementing telehealth alternatives. There are also concerns related to increases in anxiety and depression related to isolation. Issues related to racial equity was another common theme.

Discussion

Dr. McCance-Katz stated that the purpose of the TA expansion is to provide parity for mental health and SUD services. She added that in addition to being provided without cost, some trainings also provide CMEs. SAMHSA strives to engage providers so they will come back these sites often.

Council Discussion: COVID-19: Existing Needs; Future of Substance Use Disorder and Mental Disorder Treatment

Council Members

Dr. McCance-Katz noted that the impact of COVID-19 across the county has been profound, touching everyone in some way or another. In addition to the face value physical health consequences, byproducts of the pandemic include educational interruptions; employment/business/financial stresses; and lack of access to health and social support,

particularly for vulnerable populations (e.g., the elderly, children, those with special needs or behavioral health disorders).

From a behavioral health perspective, the pandemic has increase isolation; disrupted daily routines and structures; and increased trauma, anxiety, and grief. While many of us recognize this anecdotally, the impacts are well-documented: Americans are at risk for developing behavioral health issues and those in recovery are at increased risk for relapse. There are also concerns about increased suicide ideation and attempts which are directly tied to unemployment increases. In addition, while emergency department visits have dropped (e.g., individuals are avoiding the ED because of COVID), the number of those presenting for suicide ideation/attempt have increased.

Dr. McCance-Katz also shared that before the pandemic, 58 million had a mental health disorder and/or an SUD. The majority are not receiving treatment. The cost of untreated mental illness is estimated at \$193 billion. while untreated SUDs is estimated at \$600 billion (for a total of \$800 billion).

Dr. McCance-Katz shared that SAMHSA has been convening calls with State officials regularly. Within the local communities, there have been significant increases in helplines; all States have been applying for crisis resources; and programs are at reduced coverage coupled with a lack of services bed. There have been increases in domestic violence reports as well as injury/death in infants and children. While telehealth has worked for many, those in rural locations have struggled with internet access. Research and data collection efforts like the Household and Monitoring the Future surveys have been disrupted.

Dr. McCance-Katz noted that data is showing that when the lockdown is lifted, there is a reversal in these adverse trends. She shared that the CDC recently published a report from a recent online survey. It revealed that 41 percent of those surveyed met criteria for a mental health and/or SUD. In addition, 21 percent of young adults had suicidal thinking.

Early in the pandemic, SAMHSA developed a National Action Plan which is based on a four-pronged approach:

- **Address the needs of the public** who may be experiencing behavioral health consequences due to COVID and the lockdown. This encompasses providing tips for social distancing; working with FEMA to increase crisis counseling programming; and enhancing crisis hotlines.
- **Address the needs of those at risk** who had existing behavioral health issues before the pandemic. SAMHSA advocated for increase access/coverage for telehealth services including telephone modalities.
- **Address the needs of practitioner and healthcare organizations.** Over 300K providers have taken trainings specific to using and billing for telehealth services.
- **Enhance communication** so that all stakeholders are aware of the resources available to them. SAMHSA has developed a webpage on their site specific to COVID-19 concerns.

With regard to telehealth, Dr. McCance-Katz note that she anticipates that telehealth will continue to be used moving forward even after lockdowns are lifted. SAMHSA has been working to identify best practices and ways to address limitations for this type of healthcare delivery. SAMHSA also has been working to ensure that individuals on Medicated Assisted Treatments do not have their services disrupted. This effort includes allowing flexibilities around prescribing; enabling coordination for the initial dose to be done through a telephone visit; and enhancing mid-level practitioner responsibilities (as clinicians were not able to provide the same level of support).

Moving forward, SAMHSA will be focusing on:

- Identifying flexibilities under COVID that will continue after the pandemic subsides.
- Maintaining continued focus of serving individuals with SMI.
- Continuing to support the expansion of CCBHCs.
- Supplementing TTC support services.
- Addressing safety considerations in behavioral health settings.

Questions and Comments

NAC members shared the following questions and comments:

- **Reimbursement for Telehealth Services** – Dr. Neal-Walden appreciated the work SAMHSA has done to allow for telehealth delivery of services. She noted some financial concerns, most specifically dealing with no-shows during group sessions. Dr. McCance-Katz appreciated the concern and said that these type of changes would require collaborative discussions with CMS.
- **Evidence-Based Practices (EVPs) for Telehealth** – Dr. Neal-Walden also asked if SAMHSA had any data about EVPs related to telehealth. Dr. Compton shared that NIDA has allocated funds to do some supplementary research projects and these include studies on the strengths and limitations of telehealth modalities. Dr. Tasman shared that he has used telehealth for over a decade. There are some populations (e.g., individuals with schizophrenia) who don't fare well in this approach. Dr. Walden noted improved engagement in her practice. She also noted that there are people who had access issues with in-person visits but are now able to participate via telehealth.
- **Impact of the Pandemic on the Opioid Supply** – Dr. Compton shared that NIDA has concern about the impact of the drug supply chain under the pandemic. Most specifically, are those with OUD increasingly seeking fentanyl-related compounds as a substitute?
- **TTCs Services as a Priority** – Ms. Avula stated that the pandemic has raised the bar on technical assistance and training. It has always been sought after but now providers and others are “hungering for” this information.
- **Research on Mental Health** – Dr. Heinssen noted that, like NIDA, NIMH has been doing supplemental studies on the impact of telehealth. They have also been looking at alternative approaches for psychotherapeutic procedures and addressing health disparities. NIMH is also working on a communication strategy related to public information about the potential COVID-19 vaccine,
- **The Mental Health Impact on Providers** – Dr. Warren shared that behavioral health providers have themselves experienced anxiety and need some self-care and wellness

support. Some in this field may face stigma in seeking services (i.e., shouldn't you be able to treat yourself). Dr. McCance-Katz said that the CARE Act provided specific funding for these services, but she understands there might be barriers for providers to access these services. She said she would have her staff take a deeper dive into this important concern.

- **The Role of Families** – Dr. Gustafson expressed appreciation for the video that was sent out before the meeting. He noted that families are desperate, and they are also a resource in supporting their loved ones needs. He referenced a personal physical health issue where his wife played an instrumental role working with the doctors on his recovery. Dr. McCance-Katz agreed and noted that while behavioral health has more privacy concerns, families are still critically important, so it is important to provide opportunities to include and engage them as much as allowable.

Public Comments

There were several public comments:

- **Aaron Konopasky** is an attorney with the Equal Employment Opportunity. He noted that individuals with depression and OUD are protected under the American Disabilities Act (ADA) and added that doctors should help their patients stay employed as part of recovery. This would entail writing a letter and the EEO is available to aid with that.
- **Michael Abrams** is a health researcher at Public Citizen as well as a board member for a family therapy center. He noted that is hard to work with children virtually and wanted SAMHSA to consider coverage of home visits for services. Dr. McCance-Katz noted that this was a CMS issue. If Dr. Abrams sends an email to SAMHSA, she would forward it to CMS.

Closing Remarks/Adjourn

The Assistant Secretary thanked everyone for their participation. She adjourned the meeting at 4:13 p.m.

Certification

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

November 12, 2020

Date



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

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.