

## **Substance Abuse and Mental Health Services Administration**

### **53rd Meeting of the SAMHSA National Advisory Council**

**April 12, 2013**

**Rockville, Maryland**

#### **Minutes**

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council convened in open session for its 53rd meeting on April 12, 2013, at SAMHSA headquarters in Rockville, Maryland. SAMHSA Administrator Pamela S. Hyde chaired the meeting.

Council Members Present: Megan Gregory; Stephanie Le Melle, M.D.; Charles Olson; Elizabeth Pattullo; Cassandra Price; Dee Davis Roth, M.A.; Benjamin Springgate, M.D.; Christopher Wilkins; Marleen Wong, Ph.D. (see Tab A, Council Roster)

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

SAMHSA Principal Deputy Administrator: Kana Enomoto, M.A. (by telephone)

Designated Federal Official: Geretta Wood

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

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

#### **Call to Order**

Ms. Geretta Wood, Designated Federal Official, called the meeting of the SAMHSA National Advisory Council to order at 9:00 a.m. and declared the presence of a quorum.

#### **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 presence of many new Council members, including two younger members, Ms. Megan Gregory and Mr. Charles Olson. She observed that the Affordable Care Act (ACA) has been in place for 3 years, enabling coverage for young people through age 26 under their parents' insurance policies and enrollment despite any preexisting conditions. SAMHSA has focused on eligibility and enrollment issues, particularly related to people reintegrating into the community from jails and prisons, and people who are homeless. Ms. Hyde noted that 62 million more people will gain access to behavioral health services in January 2014, posing many challenges to the systems that will serve them. SAMHSA has been planning for the launch of the National Dialogue on Mental Health as part of President Obama's Now Is the Time initiative. The next series of Council meetings will be held August 14–16, 2013.

#### **Reflections on the Joint Advisory Council Meeting**

Ms. Hyde asked Council members for their views on issues raised at the Joint Council meeting held the previous day. Ms. Dee Roth suggested that convergence of the National Dialogue on Mental Health and the legislative debate on who can possess firearms may result in unwanted conflict. Dr. H. Westley Clark, Director, Center for Substance Abuse Treatment (CSAT), stated that participants at the Joint Council meeting who attended a mini-session on pending legislation on gun control discussed the impacts of gun

control on people with behavioral health problems. He acknowledged the challenge to avoid stigmatizing people with behavioral health issues in the service of a larger gun control policy, while endorsing gun control as a necessary public health strategy. Mr. Paolo del Vecchio, Director, Center for Mental Health Services (CMHS), asserted the dual need for evidence- and data-driven gun control policy, and for collecting more data to support policy change. Ms. Hyde added that the Department of Health and Human Services (HHS) is working with the Department of Justice on this issue. Dr. Clark stated that SAMHSA, Centers for Disease Control and Prevention (CDC), and National Institute of Mental Health (NIMH) compiled and submitted a compendium of the literature on gun violence from a public health perspective.

Dr. Marleen Wong asserted that national service programs for transition-age young people may protect against isolation. Dr. Ben Springgate and Ms. Elizabeth Pattullo concurred. Dr. Springgate suggested disseminating the compendium of research on gun violence more broadly and looking into whether aspects of the compendium may have relevance for communities. Ms. Hyde responded that the research focuses less on solutions and more on the relationship between risk and protective factors and violence. Dr. Stephanie LeMelle called the Council's attention to Fred Osher's work on criminogenic risk factors (e.g., homelessness, trauma, family history of violence) and the possibility of clinicians addressing those risk factors in outpatient settings. Dr. Clark added that CSAT, in conjunction with the Council of State Governments and Justice Department, has supported this work within the criminal justice system in the context of tailored interventions. Dr. Wong highlighted the importance of early intervention in school mental health programs. She emphasized that risk factors are not predictive factors because of protective factors. Ms. Hyde commented that SAMHSA receives criticism for not focusing as much on the aging population, but in an environment of constrained resources, she asserted, the most good can be achieved by addressing issues of people under age 25. Dr. Peter Delaney, Director, Center for Behavioral Health Statistics and Quality (CBHSQ), noted the challenges associated with person-centered approaches.

In describing Georgia's drop-in recovery-support model, Ms. Cassandra Price urged engaging and supporting families with better community opportunities, not just mental health services. Mr. Christopher Wilkins described social impact bonds and urged SAMHSA to consider that in public/private partnerships, social impact bonds can enhance and leverage funding for innovative work. Dr. Le Melle stated that several such projects have succeeded in New York. Mr. Wilkins acknowledged the need to present SAMHSA with sufficient data with which to consider such an approach. Ms. Gregory urged SAMHSA to reach out and engage more youth in advocating for its objectives, for example, through YouthBuild USA and the Presidential Youth Council.

Ms. Pattullo highlighted the need to find a balance between what is believed to be effective in one's general experience or in a particular community, and what has been learned from science. She urged SAMHSA to examine effective strategies to reduce violence, noting that Georgia and Texas reinvest criminal justice dollars in community settings, and Los Angeles has implemented effective community interventions. Dr. Springgate added that though New Orleans has implemented practices that have worked elsewhere, violence there continues. Ms. Gregory concurred with Ms. Hyde's suggestion to highlight positive statistics and to encourage youth to live positive, happy, healthy lives. Ms. Frances Harding, Director, Center for Substance Abuse Prevention (CSAP), recommended focusing on the rollout of the evidence-based practice of prevention.

Dr. Le Melle pointed out that few evidence-based practices are used in clinical practice, and professional training programs typically do not teach implementation of evidence-based practices or supervision. Ms. Hyde stated that certain older evidence-based practices are linked to payment systems that now face dramatic changes. Mr. Wilkins stated that regulatory compliance, quality improvement, and supervision costs must be understood as components of delivery costs.

Mr. Wilkins observed that SAMHSA's mission and vision statements focus on the end state for consumers. He described SAMHSA as Archimedes's fulcrum, which, with a lever long enough, could move the world. Transformative practice, policy, regulation, financing, and consumer interest would converge to drive refinements of those areas and to generate synchronicity and uniformity of purpose in supporting the end state. With limited resources, SAMHSA would then set priorities and attainable goals and work to reach them. He urged a conversation shift to acknowledge that the end state must be the place where the dialogue leads—and then identify the priority inputs. Dr. Clark stated that SAMHSA devotes attention to how the federal government mediates health with CDC as a willing collaborator.

Dr. Le Melle suggested that SAMHSA mine and share data to elicit best advice from Council members. Dr. Delany responded that SAMHSA is strengthening its internal data capacity. Ms. Price urged SAMHSA to focus on whether people get better and move toward self-defined recovery and, if not, to determine missing ingredients. Mr. del Vecchio added that CMHS works with CBHSQ to develop a recovery measure. Ms. Roth endorsed the phrase "SAMHSA leads public health efforts to advance the behavioral health of the nation." Dr. Wong noted a Los Angeles trend to move away from implementing interventions and toward prevention and a focus on trauma-informed public-health approaches.

### **Consideration of Minutes**

Council members unanimously adopted the minutes of the SAMHSA National Advisory Council meeting held on August 10, 2012, as amended.

### **National Behavioral Health Quality Framework and Barometer**

RADM Peter J. Delany, Director, CBHSQ, explained to Council members that in working to create a world-class data center at SAMHSA and to reduce the data burden on grantees and the broader field, CBHSQ is creating a series of high-quality core measures for treatment, mental health, prevention, and infrastructure. The National Behavioral Health Quality Framework (NBHQF) builds on the National Quality Strategy's (NQS) focus on better care, healthy people and healthy communities, and affordable (accessible) care. The Framework's goals include evidence-based and effective interventions, person and family centered, coordinated care, promote healthy living, safe, and accessible/affordable. SAMHSA will track the impact of each goal across three domains with measures for each of three cells: public and private payers, provider/practitioner, and population.

Dr. Delany stated that the final measures must be endorsed by the National Quality Forum where possible, must be relevant to NQS priorities, address high-impact health conditions, promote alignment with program attributes across programs including health and social programs across HHS, reflect a mix of measurement types (outcome, process, cost-appropriateness, and structure), apply across patient-centered episodes of care, and account for disparities.

Dr. Lisa Patton, Acting Chief, Quality, Evaluation, and Performance Branch, CBHSQ, stated that SAMHSA has partnered with Health Resources and Services Administration (HRSA), Administration for Health Research and Quality (AHRQ), and other agencies to review the new measures. In addition, an HHS internal panel nominated measures, and SAMHSA extended the review to a large group of external stakeholders. Final measures will include core measures of key issues as well as supplemental measures relevant to populations. Routine monitoring will result in the retirement of some measures and the implementation of others to lead to improved care. Dr. Patton described examples of measure recommendations and gaps for each of the Framework's six goals. Recommendations for evidence-based practices, for example, included depression utilization and remission, initiation and engagement of alcohol and other drug dependence treatment (SBIRT), maternal depression screening, risky-behavior

assessment, and major depressive disorder/suicide risk assessment. She noted particular difficulty in developing measures of person-centered care.

Recommendations for coordinated care include medication reconciliation after discharge, timely transmission of the transition record to providers or agencies, follow-up after hospitalization for mental health disorders, co-occurring physical health problems for specialty populations, and use of health information technology to perform care management at the point of care. Ms. Price noted the need to distinguish among levels and loci of care for behavioral health treatment. Recommendations for the goal of healthy living for communities include measures for smoking cessation, risky behavior assessment or counseling by age 13, and assessment of comorbid health conditions. Recommendations for measures of progress toward the goal of reducing adverse care events involve patients discharged on multiple antipsychotic medications, major depressive disorders/suicide risk assessment for adults, and child and adolescent major depressive disorder, including suicide risk assessment. Recommendations for measures for reducing the cost of behavioral health care include numbers of rehospitalizations within 30 days of discharge from inpatient psychiatric care, rehospitalizations for medical conditions, and follow-up after hospitalization for substance use disorder.

Dr. Delany explained that SAMHSA has added to its own databases data from the Behavioral Risk Factor Surveillance Survey, Medical Expenditure Panel Survey, Monitoring the Future, and multiple other sources. In implementing the National Behavioral Health Barometer—a stand-alone component of SAMHSA’s quality agenda that will provide an annual snapshot of behavioral health on national, regional, and state levels, for youth, adults, and older adults—CBHSQ plans to develop reports that incorporate a broad range of prevalence and treatment data. Dr. Delany noted that SAMHSA is augmenting its economic analysis and services research units, and considering new models that make projections using the new datasets. He stated that states will use this Web-based data for their own purposes, including adding state data to block grant applications.

**Discussion.** Ms. Price urged a focus on key measures to avoid too many measures for states to be able to afford to adapt. In response to a comment by Dr. Springgate, Drs. Delany and Patton and Ms. Hyde noted SAMHSA’s difficult task of addressing data collection on special populations, such as individuals in prison or jail. In response to a question from Mr. Olson, Dr. Delany and Ms. Hyde explained the rationale for differing age groups for various surveys, which is based on such considerations as, for example, age of legal drinking.

Responding to Ms. Price’s query, Dr. Delany stated that CBHSQ is working to harmonize and tweak the National Quality Strategy by creating a core set of measures in treatment, prevention, and infrastructure. SAMHSA is beginning talks with the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to help SAMHSA coordinate creation of a behavioral health information network. Dr. Delany described the evolution of these efforts and noted that new measures will be developed and obsolete measures will be removed. Ms. Pattullo commended SAMHSA’s work on the Barometer, and Ms. Roth noted that its complexity will require explanations to stakeholders. Ms. Hyde explained that though the Barometer will reveal the state of the nation on behavioral health, it is not a report of the National Behavioral Health Quality Framework, for which measures are not yet available. Dr. Le Melle urged presenting the Barometer to stakeholders in a way that will be useful to them. Ms. Hyde acknowledged the value to states and localities of having good community data to enable prevention planning for underage drinking and prescription drug use. SAMHSA’s goal is to generate positive differences in grantee’s communities though nationwide prevalence data may remain unchanged.

Dr. Delany described the Community Early Warning Monitoring System under development whereby communities will identify their own data, post it on a dedicated website, and use the data to determine

how their community is faring on emerging trends in behavioral health. Ms. Frances Harding, Director, Center for Substance Abuse Prevention, stated that SAMHSA is trying to refine and define many of the measures communities collect, and to devise strategies to collect good measures universally. She stated that science dictates that a community must define its own community and that prevention efforts reflect data that shows highest risk. Ms. Hyde stated that Ms. Harding is organizing SAMHSA into a learning community to help the nation learn how to implement prevention more widely and effectively.

### **National Dialogue on Mental Health**

Ms. Hyde explained that SAMHSA is working with the White House to plan a launch event for the National Dialogue on Mental Health, which is composed of three segments: community conversations, stakeholders in public/private partnerships, and a public awareness/educational effort using electronic media on the meaning of mental health on a personal level.

**Discussion.** Ms. Price urged taking steps to work with local stakeholders to tailor the conversations to the localities' issues and suggested modeling the dialogues on SAMHSA's policy academy model. Dr. Wong observed that similar conversations following the Los Angeles riots had positive outcomes. SAMHSA Principal Deputy Administrator Kana Enomoto stated that a toolkit under development to support community conversations would provide factual information and guidance to enable debunking of myths at the intersection of mental illness and violence. She pointed out that contact with people with lived experience represents an important way of reducing negative attitudes and discrimination. Ms. Hyde described the anticipated participant mix, which would include ordinary citizens who are demographically representative of the community, people from government and behavioral health organizations, people with lived experience, and a healthy sampling of youth. Ms. Hyde responded to Dr. Le Melle's question that the event funders will provide support for community coalitions to implement the action plans they had begun to develop, and a learning community website will be created. Mayors have been asked to convene the conversations, but not to supply funding. Ms. Hyde emphasized that SAMHSA will work to disseminate facts, and trained, neutral facilitators would elicit feelings and views.

Several Council members advised SAMHSA to focus on multiple routes to well-being. Ms. Gregory stated that she plans to work for Alaskans' access to exercise facilities, fresh food, and gardening plots in Alaska, which are strategies with potential to improve health and create community. Dr. Wong described the Israeli program Talking and Walking, a type of psychological first aid by which people walk in their neighborhoods under siege and discuss the impact of the trauma. Mr. Olson identified several other alternatives, including acupuncture, art therapy, and meditation. Ms. Hyde added that SAMHSA has become active in the Million Hearts wellness campaign and other wellness programs.

### **Behavioral Health Workforce Report to Congress**

Ms. Hyde stated that SAMHSA has not yet decided on its role regarding workforce issues, on which HRSA has the lead. SAMHSA has authority and obligation to focus on workforce improvement.

Ms. Linda Kaplan, Senior Public Health Advisor, SAMHSA, explained that less than 11% of people who have substance use disorders get treatment and only about 38% who have psychological distress receive any care. She stated that about 9 million people have co-occurring disorders; increasing numbers of veterans report mental and substance use disorders; and many states are working to reduce prison populations. Against this backdrop, health reform and parity will increase access to behavioral health care significantly. Increasing research and advances are emerging in the field; many are pushing to accelerate adoption of evidence-based practices; and SAMHSA is leading the shift to person-centered, recovery-oriented care. The use of multidisciplinary teams is increasing, and teamwork in the workforce to understand and deliver recovery-oriented and person-centered care will be an important strategy. Though

behavioral health issues may be viewed using a chronic care model, emphasis is emerging on prevention and long-term recovery. The system is shaped increasingly by people with lived experience; reliance on Screening, Brief Intervention, and Referral to Treatment (SBIRT) will become more commonplace; and the impact of trauma is recognized more broadly.

Ms. Kaplan stated that demographic data on the workforce reveal that it is predominantly composed of women, except for psychiatrists. Minorities are underrepresented in all professional groups and among peers, and the workforce is aging. The workforce is subject to comparatively high staff turnover; many rural counties have no behavioral health practitioners; and more than 3,000 areas have shortages of mental health professionals. Ms. Price challenged the conventional wisdom about shortages of behavioral health workers, and Ms. Hyde responded that the nation has no data on the existing workforce compared to the need for them, though professional groups have made assessments. Ms. Kaplan added that some areas have an overabundance of workers in mental and substance use, resulting in maldistribution. Working in behavioral health is associated with lower status, discrimination, and lower earnings.

The Center for Integrated Health Solutions focuses on competencies in working in integrated care settings. Workforce needs include training and education on recovery-oriented care and recovery principles, use of technology including electronic health records, competencies in co-occurring disorders, dissemination and adoption of evidence-based practices, recruitment of a more diverse workforce, standardized workforce data collection, and increased role of peers and other community service workers. SAMHSA's workforce programs include technology transfer and training on evidence-based practices; manuals, publications, and other resources; support for knowledge transfer; recruiting a more diverse workforce; integrating primary and behavioral health care; peers and recovery; and preparing for health reform. HRSA behavioral health workforce programs include 5,000 behavioral health practitioners who work in federally qualified health centers; 10,000 National Health Service Corps awardees, of whom 2,809 are behavioral health practitioners; and a graduate psychology education program. SAMHSA and HRSA have engaged in training and technical assistance collaborations for a variety of settings, populations, and programs. Ms. Hyde referred Council members to SAMHSA's report to Congress.

**Discussion.** Dr. Le Melle suggested that telepsychiatry can increase access to behavioral health workers, and Dr. Clark stated that SAMHSA and HRSA collaborate on technology to leverage limited resources, for example, in geographical or population-sensitive situations where face-to-face meetings may be impossible or undesirable. In addition, smartphones can enable texting and urgent communications between therapists and clients. Dr. Wong noted her positive experiences with telehealth in her School of Social Work clinic, particularly in cognitive behavioral therapy. She noted that younger people and military personnel may prefer remote therapy, but that structural issues pose a challenge, particularly alignment with Medicaid-providing agencies. She also raised the issue of a provider licensed in one state but working with an individual from another. Ms. Hyde pointed out also that practitioner consultation and billing represents an outstanding question. Dr. Le Melle stated that New York's criminal justice system enables electronic consultations in prisons, a unique way to conduct supervision. Dr. Delany added that teletraining of clinicians poses issues related to developing interpersonal skills, an area where SAMHSA may help in setting standards. Ms. Hyde noted that though some practitioner groups consider telehealth unethical, it is essential to develop good practices. Ms. Harding stated that electronic media plays a strong role in prevention efforts, especially in educational settings, and that much prevention training takes place using electronic technology. She added that the cutting edge in prevention is messaging to parents.

Dr. Springgate expressed concern that the aging and retiring workforce, coupled with increasing numbers of people receiving behavioral health services, may result in services delivered by people with more limited training or lower-level credentials. Competition may drive segments of the workforce to higher-paying positions where SAMHSA's populations are not necessarily served. Ms. Price suggested the value of creating efficiencies and increasing productivity, multiple payer sources, and more efficient business

models. Ms. Pattullo predicted that new provider models will emerge and asserted that veteran service providers should make room for newly minted providers and to facilitate career ladders that will afford providers with a sustainable living.

Ms. Hyde clarified data on the workforce. Though 11 million is the best estimate for the number of people with behavioral health issues who will obtain new insurance coverage, some already will have received services. Among the remainder of the 62 million people newly eligible for coverage are individuals whose needs will yet to have been identified. Ms. Hyde clarified that the data that show that 90% of people with substance abuse who do not receive treatment refers to *specialty* treatment; some may receive treatment elsewhere or engage in mutual aid activities. Dr. Delany asserted that the essential treatment gap refers to the 1–2 million individuals who say they need help but could not obtain help or tried and gave up. Only 1.9 million treatment slots have been identified in the public sector, which probably would double when the private sector is added. Ms. Hyde pointed out that though the field still counts slots, they may not reflect new methods of service delivery.

Mr. del Vecchio asserted that the peer workforce promotes the triple aim of healthcare reform—efficiency, effectiveness, and customer satisfaction—and that data support their effectiveness. He noted that SAMHSA is concerned with standardizing skills and competencies of family peer support providers, financing in this context, training for incorporating peer services providers into integrated healthcare teams, and augmenting data development around peer specialists and recovery coaches.

In response to Ms. Hyde’s request for input regarding SAMHSA’s role, Mr. Wilkins urged the agency to lead a bold advocacy and policy initiative to jump start the legitimacy and strength of the behavioral health workforce, and to ensure the availability of the needed providers. Ms. Hyde responded that the shift in the workforce will extend beyond behavioral health into primary care, where providers increasingly address mental health issues. Because HRSA and the Department of Veterans Affairs have the lead in workforce development and because the Centers for Medicare and Medicaid Services have the lead as payers, SAMHSA’s leadership role is under development.

Dr. Wong stated the need to consider standards, roles, and training programs for the peer workforce. Dr. Le Melle urged SAMHSA to conceptualize training programs for serving effectively on multidisciplinary teams and for systems-based practices. She also pointed to the existence of good studies on the working relationship between clinicians and peer service providers. Ms. Price concurred, citing the need for a recovery-oriented service-delivery system where all stakeholders understand the role of peers. Ms. Harding observed that multidisciplinary prevention teams have much to teach clinician teams. Dr. Clark pointed out that the many people with a behavioral health problem who do not perceive the need for help represent a population that would benefit from early intervention in risky situations and before problems worsen. This offers an opportunity to promote a full continuum of “associated interveners.” Dr. Springgate stated that as ACA implementation moves forward, more opportunities are needed for reimbursement for peer-delivered mental health services. He suggested that peers help to develop standards that reflect community norms.

Ms. Price urged SAMHSA to focus on efficiency, effectiveness, and consumer satisfaction, looking at the policies and evidence-based practices that make behavioral health effective across the system, how SAMHSA uses its grant portfolio to promote efficiencies and effectiveness across the behavioral health system, how to measure customer satisfaction using the Barometer and quality framework. Mr. Wilkins urged SAMHSA to establish a memorandum of understanding with HRSA regarding rate setting; define short-term tactics to diversify the workforce; define longer-term tactics to build the workforce with more robust training, standardized competencies, and an interdisciplinary focus; and become the content expert on the characteristics of a newly developed workforce.

## **Prescription Drug Misuse and Abuse: Prevention and Treatment**

Ms. Hyde explained to Council members that SAMHSA works on the issue of prescription drug abuse with CMS, HRSA, Indian Health Service, Food and Drug Administration, National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIMH, and the Surgeon General. CSAP Director Fran Harding presented an overview of SAMHSA's work from prevention through treatment to address prescription drug misuse, as part of SAMHSA's first strategic initiative, Prevention of Substance Abuse and Mental Illness. Data show that over the last decade 22 million Americans began to use prescription drugs for nonmedical reasons, and though SAMHSA sees this as a growing and pervasive problem, CDC has declared prescription drug use an epidemic.

SAMHSA has targeted parents to educate them about prescription drug misuse; they can achieve outcomes in their role as parents and as a role model for prescription use by young people. The need is evident in that survey data show that only one third of parents are "very concerned" about misuse of prescribed narcotics by their children and teens.

Ms. Harding stated that the National Prescription Drug Abuse Prevention Strategy uses a multifaceted approach to prevention: prescriber and consumer education and awareness efforts; expanded and enhanced use of prescription drug monitoring programs, and education and awareness raising about safe disposal of unused medications to avoid unprescribed use, potentially by others in the home. Ms. Harding enumerated SAMHSA's partners, including HHS's Behavioral Health Coordinating Committee, Office of National Drug Control Policy (ONDCP), Drug Enforcement Administration (DEA), Departments of Education and Justice, Indian Health Services, communities, and states. SAMHSA's prevention efforts to curb prescription drug use emphasize prescriber and consumer education, and prevention of prescription drug abuse in the workplace. For Partnerships for Success grants states were asked to address prescription drug misuse. Safe disposal of pharmaceuticals is another SAMHSA priority, highlighted by DEA's annual take-back days for proper drug disposal. SAMHSA has worked with its state partners, primarily NASADAD and more recently NASMHPD. Among data for 34 states, for 11 states prescription drug misuse is the most important issue they face. Ms. Harding stated that SAMHSA planned to host its second annual National Prevention Week in May 2013, devoting one day to prescription drug misuse.

CSAT Director H. Westley Clark stated that CSAT, which supports, certifies, and accredits approximately 1,250 opioid treatment programs nationwide, became aware of widespread prescription opioids misuse that was confirmed by survey data. Together with DEA, CSAT implements the Drug Addiction Treatment Act, which allows physicians to prescribe medications for opioid treatment in outpatient centers outside traditional programs. SAMHSA also supports training of medical and substance abuse professionals on treatment issues, particularly buprenorphine.

Since 2000 SAMHSA has had the authority to regulate use of methadone, which together with medical and psychosocial services, has been demonstrated to be an effective treatment for opioid addiction. Physicians who meet legal requirements for certification or training to administer buprenorphine may prescribe the drug in their offices. Though many primary care physicians freely prescribe Dilaudid or codeine, most are reluctant to prescribe buprenorphine. Dr. Clark stated that the majority of the 90% of opioid treatment programs are private for profit and need not disclose the identities of clients who pay out of pocket. People with resources can go to a private provider and not disclose who they are, while individuals who access Medicaid must disclose.

With the recent advent of electronic health records and prescription drug monitoring programs (PDMP), practitioners can access scheduled drug prescriptions records online. CSAT has collaborated with the Office of the National Coordinated Health Information Technology on pilot programs that collect databases to electronic health record systems and crosswalk them to PDMPs. The Springfield (Ohio)

Center for Family Medicine is testing the effectiveness of sending a drug-risk indicator via electronic health records to primary care physicians if a risk is identified. PDMP standards and an interoperability framework have been established. SAMHSA is facilitating multidisciplinary medical education on prescribing controlled substances and is collaborating with state medical boards. SAMHSA also has developed multi-module training programs, a grant program that promotes safe use of opioids, and Treatment Improvement Protocols on detoxification, medication-assisted therapy, and chronic pain management in adults in recovery from substance use disorder.

Ms. Hyde noted that HHS Secretary Sebelius asked SAMHSA and other agencies for recommendations for a Department-wide approach. An extensive data review of Medicare, Medicaid, and private-sector on prescribing practices has revealed the complexity of the issue. Suggested approaches include improving prescribing practices and preventing both intentional and inadvertent diversion and misuse.

**Discussion.** In response to Ms. Price's question, Dr. Clark stated that Kentucky, Indiana, and Ohio have established good PDMPs. Some PDMPs are lodged in criminal justice systems, while he prefers the public health approach. Mr. Wilkins expressed interest in HRSA data on surgeries unable to be performed due to opiate dependency. He suggested training allied health professionals to do bedside post-operative prevention counseling on opiate use. He also urged SAMHSA to raise the limit on physicians' first-year buprenorphine patients. Dr. Clark stated that he will look into accreditation guidelines in light of Mr. Wilkins's report that accreditation bodies require two visits to an opioid treatment program—and two fees—for accreditation for methadone and for alcohol detoxification.

Ms. Price noted that healthcare integration offers opportunities to educate on pain management options. Dr. Springgate stated that although more well-run pain management options are emerging, many refuse Medicaid. He suggested strategies to disseminate [opioidprescribing.com](http://opioidprescribing.com) or educational programs more widely, and he suggested integration of continuing education on pain management with licensure programs. Ms. Hyde noted the need to balance constraints to prevent overprescribing with the consequences of underprescribing. Ms. Price stated the importance of attending to physicians' responsibilities and asserted the need also to educate the public about responsible drinking and taking prescription medications as prescribed. Ms. Harding concurred with the need for public education, especially to curb inappropriate medication use by all segments of the community. Mr. Olson suggested wider dissemination of guidelines for proper prescription storage, perhaps in the statement that patients sign in pharmacies about understanding dosage and side effects. Dr. Clark asserted the need for a comprehensive prevention strategy. Mr. Olson responded to a question from Ms. Hyde that stealing prescription drugs is easier than stealing illicit drugs, fueled in part by the perception that if were prescribed for my friend, it is fine for me to take it.

Ms. Gregory urged SAMHSA to partner with the National Council of Young Leaders and the new Presidential Youth Council. She advised that messages go further when peers reach out to each other

### **Public Comment**

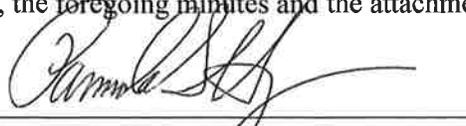
Mr. Sean Bennett urged protection of informed consent and expressed concern that SAMHSA may favor forcing people to take hazardous pharmaceuticals. Ms. Hyde responded that other individuals hold the opposite view, and that SAMHSA believes people ought to get the right treatment at the right time with consents that are appropriate in law.

### **Adjournment**

Ms. Hyde thanked Council members for their time and input, and she adjourned the meeting at 3:10 p.m.

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

JUL 15 2013  
Date



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

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 Council Roster**

**National Advisory Council**

**Public Roster**

***CHAIRPERSON***

**Pamela S. Hyde, J.D.**

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Washington, DC

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Associate Chief Consultant

Mental Health Disaster Response

Post-Deployment Activities/PTSD

U.S. Department of Veterans Affairs

810 Vermont Avenue, NW

Washington, DC

**NAC Meeting – April 11, 2013**

**List of Attendees**

*0 Non-SAMHSA Federal Attendees*

*24 Public Attendees representing 19 Constituent Organizations*

Julio Abreu	MHA
John Bennett	N/A
Sean Bennett	Self Employed
Sara Calvin	RTI International
Marylyn Clarke	IL Hospital Association
Laura Colson	CA DOAD
Barbara Draley	MayaTech
Angel Johnson	Mayatech Corporation
Jim Jones	Private Investor
Dawn Lambert-Wacey	NY State OASAS
Katie Levit	Truven Health Analytics
Tami Mark	Proven Health Analytics
Alan Moghul	Abt Associates Inc
Marceline Murawski	RTI International
Lola Oguncomilade	Afya Inc
Sharon Ohlhaber	MD Mental Hygiene Admin
Stephen Orme	RTI International
Alex Ross	HRSA
Sam Schildhaus	Truven Health Analytics
Edward Singleton	MayaTech
Kristopher Vilama	AL Dept of Mental Health
Meredith Williams	Abt Associates
Ping Yu	Belle
Mark Zehner	University of WI