

**67th Meeting of the
Substance Abuse and Mental Health Administration (SAMHSA)
National Advisory Council (NAC)
January 28, 2020
Meeting Minutes**

NAC Members:

Jeffrey Geller, M.D., M.P.H.
Ellen Gerstein, M.A.
Laura Howard, J.D.
Tracy Neal-Walden, Ph.D.
Allan Tasman, M.D. (by phone)
Barbara Warren, Psy.D.

SAMHSA Staff:

Elinore F. McCance-Katz, M.D., Ph.D.
CAPT Carlos Castillo, M.S.W.
Thomas Clarke, Ph.D.
Johnnetta Davis-Joyce, M.A.
Paolo del Vecchio, M.S.W.
Anita Everett, M.D., DFAPA
Ron Flegel, MT (ASCP), M.S.
Neeraj Gandotra, M.D.
Anne Herron, M.S.
Sean Lynch, Ph.D.
Krishnan Radhakrishnan, M.D., Ph.D.,
M.P.H.

Tracy Weymouth, M.S.W.
Daryl Kade, M.A.

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.
Marsden H. McGuire, M.D., M.B.A.,
Department of Veterans Affairs
Aaron White, Ph.D., National Institute on
Alcohol Abuse and Alcoholism, on behalf
of George F. Koob, Ph.D.

Guest:

Michael Greenberg, J.D., Ph.D., MITRE
Corporation

Call to Order

CAPT Carlos Castillo, Designated Federal Official and Committee Management Officer, called the meeting of SAMHSA's NAC to order on January 28, 2020, at 1:06 p.m. The NAC was conducted in-person with one member participating by phone. 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. Since there are several new NAC members, the Assistant Secretary asked that each new member provide brief introductions:

- **Dr. Barbara Warren** is a clinical psychologist and Director for LGBT Programs and Policies in Mount Sinai's Office for Diversity and Inclusion. She also is an Assistant Professor of Medical Education at Mount Sinai Health System, where she leads its implementation of LGBT competent health care.

- **Dr. Tracy Neal-Walden** is a licensed clinical psychologist and a retired Air Force Colonel who currently serves as the Clinic Director for Easter Seals. She has a specific interest in evidence-based care for military populations.
- **Secretary Laura Howard** leads the Kansas Department of Disability and Aging, which houses the state's Behavioral Health Services. The Department is in the process of merging with the Department for Children and Families and the juvenile services within the Department of Corrections. Secretary Howard will lead this new agency. She previously served as Kansas' Deputy Secretary for Healthcare Policy and was a SAMHSA Regional Administrator.

Consideration and Approval of the September 26, 2019 Minutes

There were no edits to the September 26, 2019, NAC summary. It was motioned for approval and seconded.

Update on SAMHSA Budget

The Assistant Secretary noted that Congress allocated \$5.6 billion to SAMHSA in 2019 which is a substantial increase from 2018. Much of this funding is focused on addressing the opioid crisis. The increase is also a recognition of the national importance to address serious mental health and other substance use disorders. Overall, there are nearly 58 million Americans living with mental health and/or substance use disorders.

Dr. McCance-Katz began with an overview of funding related to SAMHSA's programmatic areas focused on substance use disorders:

- **The State Opioid Response (SOR) Grants** – Nearly \$1.5 billion is dedicated to SOR, which are funds given directly to states, who in turn, disseminate them to agencies as sub-grantees. The focus of these funds is to fund evidence-based practices (EBPs), such as Medication Assisted Treatment (MAT). The funds are allocated on a formula basis based on treatment gaps and overdose rates. There is an additional 15 percent set-aside to the ten states that have been heaviest hit by the epidemic. There are also set-aside funds dedicated to tribes. Recently, SAMHSA opened a grant funding to be used for treatment of stimulant-use disorders as this is a more critical issue in some states. Specifically, the funds can be used for Contingency Management which is the only EBP recognized for stimulant-use disorders.
- **Technical Assistance (TA) and Training for Opioids** – SAMHSA has developed clinical teams to support MAT providers in every state; a TA program on data waiver topics (PCSSMAT); a new grant program to embed data waiver training within universities (PCSS University); and a naloxone training for first responders.
- **Opioid Programs for Vulnerable Populations** – The MAT-PDOA program focuses on individuals who are criminally-justice involved. SAMHSA also funds a grant program for pregnant and post-partum women; along with a *Building Communities into Recovery* program which aims to expand the peer and recovery coach workforce.
- **The Drug Abuse Warning Network (DAWN)** – This is a sentinel surveillance program which tracks drug-related emergencies. It is being used to inform SAMHSA on where to direct its resources.

- **Block Grant Funding to States** – SAMHSA manages the Substance Abuse Prevention and Treatment Block Grant for states and Territories/Jurisdictions.
- **Resource Materials** – SAMHSA provides resource materials that are free to states, organizations and individuals. As an example, the Assistant Secretary referenced TIP 63: Medications for Opioid Use Disorder, which is one of the more widely-used resources.
- **Data Waiver Expansion** – The SUPPORT Act has expanded the specialties that are able to get the data waiver, therefore, SAMHSA has reduced the reporting burden and implemented other initiatives to increase the number of practitioners who are trained and become data waived.
- **The STOP Act** – SAMHSA received increased funding for these grants which are designed to prevent alcohol use among underage youth.
- **New Programming** – SAMHSA will be issuing funding announcements for the following four new programs:
 - *Comprehensive Opioid Recovery Centers Funding* – This will be awarded to opioid treatment entities that provide innovation in serving high-risk populations (e.g., in non-traditional settings).
 - *Emergency Department Alternatives to Opioids* – This funding will be used to provide multidisciplinary support for non-opioid-based pain management.
 - *Treatment Recovery and Workforce Support* – This will support people in recovery on obtaining employment.
 - *Peer Recovery Support TA Center* – The Center will be added to the existing Technology Transfer Center (TTC) network.

The Assistant Secretary then provided an overview of SAMHSA’s programmatic areas related to Mental Health Services:

- **Block Grant Funding to States** – SAMHSA manages the Community Mental Health Services Block Grant for states and Territories/Jurisdictions.
- **Children’s Mental Health** – SAMHSA funds a number of programs under this initiative including an infant and early childhood screening focused on children exposed to substances during in utero development; Project Aware which provides training to school-based staff on mental health issues; and the National Childhood Traumatic Stress Initiative.
- **Transitional Youth** – SAMHSA administers the *Youth and Family TREE* program to support treatment, intervention and recovery services for adolescents and transitional-age youth.
- **Suicide Prevention** – SAMHSA operates Lifeline, a hotline providing access to crisis centers which served two million Americans in 2019. The agency manages a Suicide Prevention Resource Center and provides funding for the *Zero Suicide* program which trains healthcare professionals in screening patients for suicide ideation.
- **Certified Community Behavioral Health Clinics (CCBHCs)** – This is a program of integrated care (primary and behavioral health) that is focused primarily on individuals with serious mental illness. The CCBHC program is a set-aside for organizations located within the 24 states that received planning grants.

- **Other Mental Health Service Programming** – SAMHSA funds are also being used towards a criminal justice diversion program; the Assertive Community Treatment initiative; the *Assisted Outpatient Treatment* program; and a *Minority Fellowship Program* to increase diversity in the mental health provider workforce.
- **Resources** – Among the products, SAMHSA has just developed a summary of best practices on crisis intervention services that will be available later this month.

Lastly, the Assistant Secretary provided an overview of SAMHSA’s programmatic areas related to Prevention:

- **Strategic Prevention Framework** – This planning grant program supports community-based needs assessment and program/services implementation.
- **Minority AIDS Prevention** – These programs integrate culturally competent mental health and substance use disorder treatments into HIV services and settings.
- **Tribal Behavioral Health Grants** – Also called Native Connections, the grants fund Native American communities in developing culturally-appropriate prevention services.
- **Tobacco Prevention** – SAMHSA has been using this funding for Policy Academies and public education. The increase in vaping use and injury has been elevated within these educational discussions.
- **Prevention TTCs** – SAMHSA’s Prevention TTCs manage a portfolio of prevention needs ranging from substance use disorders to mental health and suicide prevention. These resources are available free to the public. SAMHSA has developed several public service announcements to broaden awareness of the Prevention TTC and the resources that it provides.

Following are comments/questions by NAC members about SAMHSA’s budget and programs:

- **Methamphetamine** – Secretary Howard expressed appreciation for SAMHSA’s flexibility in allowing State Opioid Response (SOR) funds to be used for stimulant-use disorders.
- **CCBHCs** – Secretary Howard is in Kansas, one of the 24 states with planning grants. She shared that the CCBHC has been a “game changer” to providing services and hoped that other states would have an opportunity to incorporate other states.
- **Treatment.gov** – Dr. Warren appreciated that the site provided programs that were specific to LBGTQI+ populations.

Expansion of Data Waiver

Tracy Weymouth, Director of SAMHSA’s Division of Pharmacologic Therapies, provided an overview of the expansion of data waivers both in terms of training and data-waiver approvals. She noted that there have been several recent changes to the data waiver eligibilities that have addressed barriers and will increase capacities for treatment. Specifically, the changes include:

- **Expansion of Data-Waivered Prescriber Types** – There are three new Advanced Practice Registered Nurse practitioner specialties that are now authorized to prescribe under the SUPPORT Act.

- **Easing of Data Waiver Limits** – If they meet either Board Certification or certified setting conditions, M.D.s and D.O.s are now allowed to practice up to the 100-patient limit in their initial application (e.g., without a one-year waiting period). Mid-level professionals also have been given eased restrictions on their patient limits.

Ms. Weymouth then shared that, due to the eligibility changes, SAMHSA has seen an increase in the attendance of both online and in-person trainings. She added that there were even increases in training professions (e.g., M.D.s) who were not impacted by the SUPPORT Act, which indicated that outreach efforts impacted ancillary professionals. As expected, there were more applications for the 100-limit waiver initially, rather than the 30-patient limit.

Ms. Weymouth noted that some state legislators are more restrictive in terms of specialties that have prescriptive authority. It will require state legislative changes to eliminate these barriers.

Following are comments/questions by NAC members about the data waiver changes:

- **30-Patient Limit** – Dr. Geller encouraged SAMHSA to focus on a broader outreach by highlighting the 30-patient limit option. Many prescribers will never reach the 30-patient limit but virtually all providers will encounter at least a few patients with OUD. By encouraging the 30-patient option, these providers might be motivated to obtain the training and not feel that the data waiver as applicable only to specialized providers.
- **Cost** – Dr. Geller added that many providers still do not know that the training is free. He feels that this needs to be publicized more. Ms. Weymouth agreed and shared that SAMHSA is trying to leverage their partners in getting the word out.

Drug Abuse Warning Network Update (DAWN)

As background, Sean Lynch shared that DAWN was started in 1972 by the Drug Enforcement Agency (DEA) and then assumed by SAMHSA from 1992 to 2011. The system was reestablished in 2018 through the 21st Century Cures Act.

DAWN is an early-warning surveillance system which captures data from emergency department (ED) visits related to substance misuse.

Dr. Lynch stated that the hospitals sampled include ten “sentinel” facilities, along with probability-sampled hospitals. The sample list was honed using data from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Disease Control and Prevention (CDC). The sample was then stratified by patient volume and geographical location (e.g., urban, suburban and rural). There are currently arrangements with 37 hospitals.

The collected data is protected through HIPAA, so all data is de-identified before submission. However, SAMHSA is working to develop a system so that hospitals can have access to their specific data results.

Following are comments/questions by NAC members about DAWN:

- **Linkages Between Visit and Route of Administration** – Dr. Compton asked if there will be linkages across different data points. Dr. Lynch said that the data is quite rich and will allow for tracking linked details. He added that mortality data is captured.
- **Inclusion of Bath Salts** – Dr. Lynch confirmed that bath salts and other non-pharmaceutical substances like inhalants are included in the DAWN data set.
- **Granularity of Data** – Dr. Warren wanted to know how the data will be used, and if it is granular enough to identify emerging trends (e.g., rise in methamphetamines in urban areas). Dr. McCance-Katz stated that SAMHSA is striving to ensure that the data is detailed enough to be able to brief Congress, HHS stakeholders, and states on trends expeditiously. Information will also be shared with the TTCs, so that they can quickly respond by providing outreach and training.
- **Limitations in Alcohol Data Collection** – DAWN does not collect alcohol-only related ED visits for those over 21 because it would result in a significant increase in the number of cases which would impact data collection capacities.

HEALing Communities Study

Thomas Clarke, Director of SAMHSA’s National Mental Health and Substance Use Policy Laboratory, explained that the HEALing Communities Study (HCS) is a cooperative agreement between NIDA and four states (Ohio, Kentucky, New York and Massachusetts) heavily impacted by the opioid epidemic. The study will examine the impact of integrated evidence-based practices in reducing opioid-related overdose. There are 67 communities enrolled and the objective is to reduce opioid overdoses by 40 percent within three years. SAMHSA is a partner and will be monitoring how the research can inform service delivery, which can be shared for implementation nationally.

HCS will be a randomized study conducted in two waves for comparison. The counties include rural and urban communities. The program will focus on three interventions:

- Community Engagement
- A Communication Campaign
- Opioid-Overdose Reduction Continuum of Care Approach

The study will include a strong community coalition (e.g., Advisory Boards) component and the development of data dashboards. Health communications will include reducing stigma as an overarching theme. The Coordinating Center has been tasked with investigating associated costs (e.g. feasibility).

Following are comments/questions by NAC members and SAMHSA staff about the HEALing Communities Initiative:

- **Definition of Community** – Dr. Everett asked about how a community is defined. Dr. Clarke noted that it varies but is usually by either zip code or county.

- **Data Dashboard** – Dr. Compton asked if the data dashboard will eventually be used for other initiatives. Dr. Clarke noted that many communities will be using existing dashboards. He noted that for dashboards, “less is more,” because stakeholders can get overwhelmed with too much data. It also makes the upkeep more sustainable.

42 CFR Notice of Public Rulemaking: Public comment summary

From August to October 2019, there was a public comment period on the changes to 42 CFR Notice of Public Rulemaking. SAMHSA received over 2,100 comments encompassing 1,800 pages. The major changes to 42 CFR aimed to reduce the communication barriers between Part 2 treatment facilities and other providers, most notably primary care providers.

In synthesizing the data, Michael Greenberg, with MITRE, noted that his staff focused on cherry-picking comments from the largest and most impacted stakeholder groups to identify overall comment trends. These included provider associations, payees and medical facilities. It was also important to include consumers and their advocates.

Below are some general themes Mr. Greenberg’s team gleaned from the comments:

- **Definition of Records (Communications)** – The proposed rulemaking provides more clarity about oral communications, specifically that it does not become part of the Part 2 protected record. Six primary stakeholders supported with one stakeholder in opposition. A salient comment from the Betty Ford clinic expressed concern that the policy might create a “perverse incentive” to circumvent the protection by favoring oral communications over written modes.
- **Applicability** – The proposed rule included information on the downstream impact of sharing data created by a non-part 2 provider. Ten organizations supported the change with five entities expressing opposition. Concerns were primarily technical related to EMR implementation (e.g., being able to tag and track separately). However, there were also comments about the risks to providers and potential negative impact on patients.
- **Disclosure to PDMPs** – Changes to the proposed rule would allow OTPS (with the consent of the patient) to disclose information to PDMPs. Nine major stakeholders supported the change with five opposing it. Opposing commenters expressed concerns about privacy and law enforcement access to the PDMP data.
- **Disclosures Permitted with Written Consent** – This proposed change expanded on the already existing preamble by provided some illustrative examples. There was little opposition to this proposed change, but many prominent organizations urged SAMHSA to add care coordination and case management in the case examples.
- **Medical Emergencies** – The proposed change would allow the disclosure of records without patient consent during a natural disaster. All prominent commenters supported this change.

Publication of Oral Fluid Mandatory Guidelines: Toxicology Screening

Ron Flegel is the Director of SAMHSA’s Division of Workplace Drug Services which oversees the Federal Drug-free Workplace program as well as the HHS-certified laboratories that perform

drug testing for federal agencies and federally regulated industries. His division also provides guidance materials to workplaces outside of the federal government.

Mr. Flegel provided background related to the three primary sampling methods for drug testing:

- **Urine** – This is the most common collection method and now can detect synthetic opioids. It detects recent past use.
- **Oral** – This can detect current use and is good following accidents or suspicious activity. It also is more reliable than urine, because there are less subversion products for avoiding detection and a bathroom is not needed (where a person submits a sample outside of viewing).
- **Hair Samples** – This can detect patterns of use and is good for pre-employment purposes.

The alternative matrix used for drug testing has not been updated for quite some time. One concern relates to false positives from passive-exposure, particularly with marijuana. There are several subversion products related to urine testing, having the option to issue either urine or oral drug tests has demonstrated truer results. For example, a random review where both urine and oral specimens were tested, 2.2 percent of urine samples detected marijuana. However, 7.9 percent of oral samples from the same individuals tested positive for marijuana.

With regard to marijuana, federal employees are not allowed to use the substance, even if it is legalized by their state. Mr. Flegel added that CBD (which is the non-psychoactive component of marijuana) has been problematic. Specifically, these products vary considerably with some having high THC levels. Federal employees should be cautioned to avoid all products that might potentially be contaminated.

The cost for oral testing is higher than urine, predominantly because the providers must purchase the testing kit (rather than just a container which is done for urine).

Council Discussion

The Assistant Secretary then solicited comments and updates from the Council. NAC members shared the following:

- **Presentation and Meeting Materials** – Dr. Geller found the presentations informative and impressive. Dr. Tasman requested the presentation materials in advance of the meeting.
- **Technical Transfer Centers (TTCs)** – Dr. McCance-Katz noted that she had asked the TTCs to provide links on a variety of topics which are included in the folders. This was just to give NAC members a sample of the kind of resources that the TTCs can provide.
- **Children of Individuals with Substance Use Disorder** – Dr. White recently attended a prevention conference at Johns Hopkins University which was focused on homes with addiction. Dr. Tasman also asked if there are any preventive interventions for children who live in homes which have a family member experiencing addiction. Dr. McCance-Katz shared that data analysis in this area is nascent. With regard to programs, the United

Way in Louisville has some and there is a TTC which is focused on research in this area. Dr. Compton shared that NIDA has a few family interventions and Dr. Everett noted that the National Academy of Sciences website recently published information in this area.

- **SAMHSA's Interaction with Other Government Agencies** – Dr. Warren asked how SAMHSA interacts with other government agencies. The Assistant Secretary shared that SAMHSA participates in regular discussions with other agencies on several cross-cutting issues, especially the opioids crisis. Examples of agencies that SAMHSA has regular communications with include AHRQ, the Indian Health Service, the Agency for Children and Families, CDC, and DEA. There are several interagency coordinating committees that meet regularly to foster cross-communication.

Public Comments

There were no public comments.

Closing Remarks/Adjourn

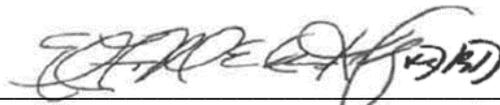
CAPT Carlos Castillo thanked everyone for their participation. He adjourned the meeting at 4:13 p.m.

Certification

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

03/18/2020

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.