

**U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
Center for Mental Health Services (CMHS)  
National Advisory Council (NAC) Meeting  
5600 Fishers Lane  
5th Floor, Conference Room 5N76  
Rockville, MD**

**February 14, 2018**

**Chairperson**

Paolo del Vecchio, M.S.W., Director

**Designated Federal Official**

Pamela Foote

**Council Members Present**

Michael Biasotti, M.A.  
Dennis D. Embry, Ph.D.  
Wenli Jen, Ed.D.  
Jeffrey W. Patton, M.S.W.  
Juanita Price, M.Ed.  
Stacy M. Rasmus, Ph.D.  
Jeremiah Simmons, M.P.H., M.S.  
Jürgen Unützer, M.D., M.P.H., M.A.

**Council Member Absent**

Katia Reinhart, Ph.D., R.N., CRNP, FNP-BC, PHCNS-BC

**Ex Officio Members Present**

Elinore F. McCance-Katz, M.D., Ph.D., SAMHSA  
Robert Heinssen, Ph.D., National Institute of Mental Health  
Wendy Tenhula, Ph.D., Veterans Affairs

**Subcommittee Members Present**

Lacy Kendrick Dicharry, M.S., M.B.A.  
Gilberto Romero, B.A.

**CMHS Staff Present**

Cyntrice Bellamy, M.S., M.Ed., Director, Division of State and Community Systems  
Development  
Nikki Bellamy, Ph.D., Emergency Mental Health & Traumatic Stress Services Branch  
(EMHTSSB), Division of Prevention, Traumatic Stress, and Special Programs (DPTSSP)  
CAPT Wanda Finch, Senior Public Health Analyst, Office of Consumer Affairs (OCA)  
Stephen Fry, Public Health Analyst, OCA  
Patricia Gratton, Director, Office of Program Analysis and Coordination  
CAPT Eric Hierholzer, Lead Public Health Advisor, EMHTSSB, DPTSSP

Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, Office of the Director  
Richard McKeon, Ph.D., Chief, Suicide Prevention Branch, DPTSSP  
Keris Jän Myrick, M.B.A., MS, Director, OCA  
CAPT Maryann E. Robinson, Ph.D., R.N., Chief, EMHTSSB, DPTSSP  
Nainan Thomas, Ph.D., Acting Director, DPTSSP  
Luis Vasquez, L.I.C.S.W., Division Director, Division of Service and Systems Improvement

**Other SAMHSA Attendees**

CDR Carlos Castillo, ACSW, LCSW, BCD, Committee Management Officer, Office of Policy, Planning and Innovation  
CAPT Christopher M. Jones, Pharm.D., M.P.H., Director, National Mental Health and Substance Use Policy Laboratory  
CAPT David Morrissette, Ph.D., L.C.S.W., Office of the Chief Medical Officer, SAMHSA

**Other Attendees**

Michelle Durst  
Stuart Gordon, Director of Policy, National Association of State Mental Health Program Directors

**OPEN SESSION**

**WELCOME**

Mr. del Vecchio welcomed the CMHS NAC members and guests to the open session of the meeting. He stated that Pamela Foote, Designated Federal Official, would conduct a roll call to ensure a quorum before the meeting was called to order.

**CALL TO ORDER AND ROLL CALL**

Pamela Foote conducted the roll call and called the meeting to order at 10:03 a.m. Executive leadership introduced themselves.

**OPENING REMARKS**

Mr. del Vecchio asked for a motion to accept the August 10-11, 2017 meeting minutes. The motion was made by Mr. Patton and seconded by Dr. Jen.

Mr. del Vecchio reviewed the day's agenda, which started with the Director's Report and a review of the current budget and key program activities. He stated that the Assistant Secretary for Mental Health and Substance Use, Elinore F. McCance-Katz, M.D., Ph.D., would join the CMHS NAC for a conversation. After a working lunch, the CMHS NAC would hear presentations on the Subcommittee on Consumer Issues, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), SAMHSA's new Mental Health and Substance Use Policy Lab, and SAMHSA's disaster and behavioral health response efforts.

## CMHS DIRECTOR'S REPORT

Mr. del Vecchio reviewed the CMHS budget, noting that the government is on its fifth continuing resolution, which will last until Congress passes a budget for fiscal year (FY) 2018. The current short-term spending bill is effective through March 22 when Congress must determine specific appropriations for the different budget lines. He also noted that we may be subject to a third potential shutdown come March 23 if Congress is not able to come up with a resolution and we certainly hope that is not the case. He noted the challenges to budgetary planning and execution during the uncertain waiting period. The President's FY 2019 budget was just released yesterday. The budget request for SAMHSA is approximately \$3.5 billion, a \$688 million reduction from the FY 2018 budget, assuming an annualized continuing resolution. The FY 2019 budget request provides \$1.2 billion for a variety of new and expanded efforts to fight the opioid crisis, which is a total increase of \$4.8 billion for SAMHSA. The budget request seeks to advance our mission of reducing the impact of substance abuse and mental illness on America's communities. Mr. del Vecchio noted that the budget request prioritizes funding to address serious mental illness (SMI), including a full restoration of the Mental Health Block Grant, the Healthy Transitions Grant Program, and the National Strategy for Suicide Prevention. Congress, as the appropriating authority, could revise the requested budget numbers. Mr. del Vecchio also reported that the President and SAMHSA is proposing to eliminate the Minority Fellowship Program. It was felt that this program was duplicative of other federal programs currently being administered.

Announcing personnel updates, Mr. del Vecchio stated that David DeVoursney is the new Branch Chief in the Community Support Program. Departing Branch Chief Cindy Kemp has moved to the SAMHSA Office of Chief Medical Officer (OCMO). CMHS Deputy Director, Dr. Priscilla Clark has departed and is on a detail to assist with HHS efforts around ReImagine HHS. Recruitment efforts are under way to find a new Deputy Director.

Mr. del Vecchio highlighted information from the *In Focus* publication that was shared with CMHS NAC members, focusing on recent ISMICC developments. The ISMICC is a Federal Advisory Council body mandated by the 21st Century Cures Act. Its public and private members represent SAMHSA, the Social Security Administration (SSA), the Centers for Medicare & Medicaid Services (CMS) and the Departments of Veterans Affairs (VA), Defense, Justice, Education, Housing and Urban Development (HUD), and Labor, as well as non-federal subject-matter experts from a variety of disciplines. The ISMICC held its first meeting on August 31, 2017, and submitted its first report and recommendations to Congress on December 14, 2017. CAPT Morrissette, a former CMHS staff member, is now serving as the ISMICC Implementation Coordinator.

Next, Mr. del Vecchio shared program updates in several areas:

1. First is our work around First Episode Psychosis in strong partnership with states through our block grant 10 percent set-aside. Over the last three years, we have established a partnership with the National Institute of Mental Health (NIMH) and close to 200 specialty care programs for First Episode Psychosis have been established across the country. As a result, for the first time, families and young people in most states can get help for a first episode (of psychosis). The 21st Century Cures Act add a new provision to the Children's Mental Health Initiative to not only serve children and youth with serious emotional disturbance, but also those at risk for these conditions as well. Dr.

Heinssen of NIMH noted that an NIMH-SAMHSA team is exploring opportunities for implementing evidence-based treatments for people at clinical high risk for psychosis, a “science to service” concept that the NIMH National Advisory Mental Health Council approved in January. Funding for this prodromal initiative is contingent on the final FY 2018 budget.

2. In the area of Certified Community Behavioral Health Clinics, close to 70 clinics in eight states are now certified to provide comprehensive care. This joint effort with CMS to improve the quality of services delivered uses metrics and the CMS value-based purchasing model.
3. Exciting new work is also occurring in recovery-oriented cognitive therapy. The Beck Institute and others are applying cognitive behavioral approaches to treat people with SMI, and CMHS is working with the National Association of State Mental Health Program Directors in six states to roll out these evidence-based practices (EBPs). A series of training webinars for these types of approaches is in high demand.
4. The National Suicide Prevention Lifeline recently hit a yearly milestone, responding to 2 million calls, and the numbers continue to increase. Following rap artist Logic’s performance of the song “1-800-273-8255 (TALK)” during the 2018 Grammy Awards ceremony, calls to the Lifeline tripled. SAMHSA continues to ensure that the capacity of Lifeline can meet this growing call volume.
5. SAMHSA’s annual Voice Awards help to recognize positive television and film productions that address mental health and addiction. Americans receive much of their mental health information through the entertainment industry, and over the past few years the number of nominations for the Voice Awards has increased.
6. Children and trauma will be focus of the Children’s Mental Health Awareness Day on May 10, 2018. Also in May, the first Older Adult Mental Health Awareness Day will focus on providing insights about this end of the age spectrum. CMHS and SAMHSA staff are collaborating on this event with staff from the National Coalition on Mental Health and Aging and colleagues at the HHS Administration for Community Living.

Mr. del Vecchio also noted that CMHS is studying how historically black colleges and universities can help to increase the mental health workforce through the training of students on campus.

Mr. del Vecchio encouraged CMHS NAC members and the public to watch [SAMHSA.gov/grants](http://SAMHSA.gov/grants) for the latest information about current SAMHSA funding opportunities. He then opened the meeting for discussion.

## **Discussion**

Ms. Price stated that the director’s report was very encouraging. However, she is concerned about the potential lack of funding for the Minority Fellowship grant program, which may lead to a lack of qualified, credentialed, and licensed people of color—who are indigenous to the communities they serve—to provide services.

Dr. Rasmus noted that NIMH has funded three collaborative hubs aimed at suicide prevention in Alaskan and American Indian communities and that Alaska is interested in extending its partnership. She also expressed a concern about this year’s lack of tribal-specific grant

opportunities. Mr. del Vecchio responded that some tribal-specific set asides may be available and that significant work around suicide prevention is being done through the Native Connections/Tribal Behavioral Health Grants. CMHS manages more than 110 tribal grantees.

Ms. Dicharry asked about SAMHSA-specific key words that might enhance the SAMHSA Lifeline. Dr. McKeon explained that the Lifeline operates a phone and a chat service but not a text service because the Crisis Text Line is available. Dr. McKeon noted that James Wright, the Lifeline project officer, and John Draper, the director for the National Suicide Prevention Lifeline, have had contact with the Crisis Text Line, and the Suicide Prevention Branch is open to collaboration. The VA Veterans Crisis Line has its own text service.

Mr. Biassotti asked whether any metrics or correlations exist between the increased number of calls to the suicide prevention lifeline and the current suicide rate. Mr. del Vecchio replied that the most recent data from the Centers for Disease Control and Prevention (CDC) show increases in suicide across virtually every age group. The number of people in crisis has also increased. These numbers could be higher absent resources such as the Lifeline.

Dr. McKeon said that evaluation data from the Garrett Lee Smith Youth Suicide Prevention grants show that counties that have implemented grant-supported youth suicide prevention programs have lower rates of youth suicide deaths and attempts compared with matched counties that have not received grants. Dr. Embry added that analysis of how and why the Good Behavior Game prevents suicide, produced a ridiculously simple finding that suicide decreases when peers become more reinforcing of peers.

## **SAMHSA UPDATES**

Dr. McCance-Katz noted that this was her first time attending the CMHS NAC as Assistant Secretary. Her position was created by the 21st Century Cures Act. Congress emphasized one area of her responsibility as the development and maintenance of a system to disseminate research findings and EBPs, and she confirmed that SAMHSA takes this responsibility very seriously.

Dr. McCance-Katz reviewed several of SAMHSA's priorities.

1. The 21st Century Cures Act instituted the National Mental Health and Substance Use Policy Laboratory, which will oversee EBPs and implementation across the nation, not only among SAMHSA grantees.
2. The broad ISMICC partnership, also created under the 21st Century Cures Act, can help to address Congress' concerns about collaboration among federal government departments in providing services to persons with SMI or SED. The ISMICC's first report offered 45 recommendations in a wide range of areas, such as crisis intervention, the need for hospital beds and their advantageous location, the justice system, and increased access to treatment and recovery services.
3. The President's budget proposes a large funding increase for SAMHSA to tackle the opioid epidemic.

Dr. McCance-Katz expanded on the Policy Laboratory's approach to implementation of EBPs. She believes that the National Registry of Evidence-based Programs and Practices (NREPP) is problematic, partially because there is significant duplication of efforts among SAMHSA, CDC,

NIDA, and DOJ. In addition, SAMHSA has spent significant funds to maintain the NREPP, but data show that most practitioners do not use EBPs because their implementation is expensive. The Policy Laboratory will examine accepted EBP models and will seek ways to make local training in their use available to communities at no cost.

Dr. Embry discussed the National Institute of Drug Abuse's work on contingency management especially that of Nancy Petry, which he considers to be the best, though not a widely used strategy to treat addiction. The contingency management protocol is very effective for opiates and can be administered by lay people. Dr. McCance-Katz responded that she is very familiar with the contingency management work of Nancy Petry and Maxine Stitzer but noted that these strategies raise issues, such as costs to third-party payers, objections to outright gifts to treatment patients, and concerns that unwanted behaviors return once contingency management measures stop. Dr. Embry then offered possible solutions to each issue.

Mr. Biassotti applauded the new focus on the most seriously ill from a family member perspective but added that families and law enforcement officials fear that current advances to help such individuals might lose traction as attention is focused on battling the opioid crisis. Dr. McCance-Katz acknowledged this concern as well-founded: the opioid crisis affects Americans and their communities in very dramatic ways, and sometimes the seriously mentally ill seem invisible. She stated that she will work diligently to secure needed resources such as diversion, crisis centers, and re-entry programs for people with SMI. One reason for tasking Dr. Morrissette to focus full-time on the ISMICC implementation is to ensure that the public ISMICC members' recommendations receive appropriate attention. Diversionary programs are needed to keep people with SMI out of the justice system. Also needed are re-entry programs that provide appropriate services to afflicted people. Partnerships must be established within communities to provide the medical and recovery services required by people with SMI.

Dr. Unützer mentioned the lack of psychiatrists, especially those trained in addiction psychiatry, and the need to work with primary-care providers. He asked what can be done to support current addiction specialists and to increase the pool of providers. Dr. McCance-Katz responded that SAMHSA is developing a comprehensive plan to increase the workforce, particularly in addiction medicine. In addition, allied health providers, registered nurses, nurse practitioners, and others should receive training about addiction and SMI and SAMHSA is trying to bring together these stakeholder groups to participate in discussions about expanding the workforce trained in serving people with addictions.

Ms. Price mentioned the scarcity of mental health professionals, particularly child psychiatrists, in many areas, including Washington, DC, adding that small nonprofits like hers can barely afford the professionals' expensive fees. She asked what organizations can do to combat behavioral health challenges when the numbers of mental health and addiction professionals are insufficient. Dr. McCance-Katz declared her intention to advocate for what is needed to address this issue.

Dr. Tenhula inquired about ways to recruit young professionals who are interested and willing to treat persons with addictions or SMI. Dr. McCance-Katz suggested that trainees might become interested in the field if they are sent into the community to experience successful programs firsthand. She acknowledged that it is often difficult to find psychiatrists interested in treating

people with substance abuse disorders in part because they often only see them in the hospitals whereas persons who are treated in the community are often doing very well.

In response to a question, Dr. McCance-Katz acknowledged the need to develop a national peer workforce. Although she will work with Ms. Myrick to address this issue, SAMHSA will not be involved in certifying this workforce. However, SAMHSA can encourage states to conduct standardized trainings and to accept certifications from other states. Peers should be brought into medical education, (the broad spectrum of health care practitioners) so that they can understand and be more valuable to those in need of services and support. She added that people do not get everything they need to recover if they are not getting both medical and community recovery support. Those recovery supports are a function of what peers bring to the table.

Mr. Patton explained that Michigan professionals have struggled with some of the newer definitions for people in recovery, particularly for peers who have or wish to have jobs. Some people are losing their jobs because they are defined as being in recovery. Dr. McCance-Katz recognizes that it is challenging for a person who is a felon and in recovery to become involved in their community and to find a job. The Administration is considering this challenge, and she is advocating to block the records of people with minor offenses. She added that HUD is involved in the ISMICC because housing discrimination remains an issue for people in recovery.

Mr. Simmons asked about SAMHSA's current research agenda and efforts to improve behavioral health equity. Dr. McCance-Katz responded that some improvements have occurred in the grant programs but disparities remain. She added that SAMHSA is not a research agency but does have the Policy Lab.

## **SUBCOMMITTEE ON CONSUMER ISSUES**

*Speaker: Lacy Kendrick Dicharry, M.S., M.B.A., Chair*

Ms. Dicharry explained that the Subcommittee was charged with reviewing the ISMICC report to Congress and making recommendations about implementation of the report's findings. During a recent meeting, the members highlighted critical implementation areas such as reducing incarceration, the delivery of care, and disparities experienced by those with the most critical mental health needs. The recommendations from the report are as follows:

- **Recommendation One:** Encourage the meaningful inclusion of people living with SMI, youth, family, and caregivers in the implementation of the ISMICC recommendations.

Although some people with lived experience and/or family members serve on the ISMICC, no young adults serve on the ISMICC. We encourage the meaningful inclusion of people living with SMI, youth and family and care givers be included in the implementation process of the recommendations.

- **Recommendation Two:** Explore and encourage standardized continuity of care.

The exploration of the continuity of care relevant on chronological age must consider the following factors: service eligibility, transition and income services across treatments, support and benefits, and other programs for people living with SMI and serious emotional disturbance (SED) and their families. The subcommittee identified enhanced awareness of attitudes and behaviors of people experiencing suicidal thoughts as a catalyst to increasing collaborative efforts across federal agencies. Eligibility to participate in housing programs and to access mental health services differs by state,

which can be a confusing process for someone with no family support to assist them navigate the systems. The subcommittee hopes to move toward a more appropriate needs-based framework across systems to help people access services and transition in a more functional and efficient way.

- **Recommendation Three:** Expand support, specifically around financial support and public-private partnerships, through research efforts that continue to build the evidence base on the care actually delivered.

Although there is significant interagency collaboration at the federal level, there is little guidance on how states can replicate that collaboration, especially from the financial perspective. There have been some efforts to build the capacity of grantees to sustain their work through blended funding. Perhaps these efforts could be expanded and enhanced to include public-private partnerships. Another model is the cross-agency work of the Bringing Recovery Supports to Scale Technical Assistance Center Strategy.

Ms. Dicharry concluded her update by noting that the last Congressional continuing resolution included Families First Act Title 4E funding for foster care, which is a significant provision because it redefines state eligibility to receive reimbursement for those services. Title 4E now includes adults and family members who experience substance abuse or mental health challenges and are at imminent risk, and other children entering the foster care system. She emphasized the importance of not only sharing information at the federal level, but providing guidance at the state level which could help prevent the entry of families into foster care and potentially avoid some trauma.

### **Discussion**

Dr. Embry offered some comments from his perspective as a member of the scientific advisory board for the Children's Mental Health Network. He suggested that practical examples of successful efforts, such as the PAX Good Behavior Game, should be compiled and documented. Additionally, the transfer of Drug-Free Communities (DFC) grants to SAMHSA's supervision provides a vehicle to mobilize strategies targeted at not only the sale of tobacco and alcohol to minors, but also in opiate prescribing.

The group discussed the inconsistent implementation of procedures to follow when a person who is facing certain felony charges and is taken to an emergency room for evaluation. Ms. Dicharry suggested that the ISMICC be made aware of this issue, so that it can disseminate the remedy procedures broadly and consider ways to hold hospitals accountable.

Ms. Dicharry requested that the NAC vote on the three recommendations. Mr. del Vecchio entered a motion to accept the recommendations. The motion was received and seconded by Mr. Simmons. All votes were in favor, with one abstention by Dr. Jen who was not present during the full briefing on the recommendations.

### **ISMICC OVERVIEW**

*Speaker: CAPT David Morrisette, Ph.D., L.C.S.W., ISMICC Coordinator*

Dr. Morrisette reviewed the federal response to the ISMICC recommendations, noting that the committee is chaired by Dr. McCance-Katz. The ISMICC's report to Congress focused on gaps in services and advances in SMI, SED, and treatment, and offered 45 recommendations. A

second (and final) report is due to Congress in 2022. Dr. Morrisette envisions using the recommendations as a foundation, creating implementation workgroups across federal agencies, building on existing programs such as the HUD-VA Supportive Housing program, and developing a research agenda as well as reporting on advances in services.

Various SAMHSA staff (stewards) will lead the implementation workgroups and seek ways to collaborate. The implementation work groups are really a collaboration effort across the 10 federal agencies involved in the ISMICC. Other considerations include engagement of government organizations, developing an inventory of federal activities and evaluating this federal effort. More information about the ISMICC can be found on the SAMHSA website, including the full report and the executive summary.

### **Discussion**

Ms. Dicharry explained that the NAC approved a recommendation that calls for engaging people who experience each of the services represented in the ISMICC. Dr. Unützer added that another recommendation addresses improving the national linkage of data.

Mr. Biassotti expressed his concern that the most seriously ill and their families often have limited or no funding and therefore have few options about the location or the type of care they receive.

Dr. Unützer remarked that, if a three- or four-fold variation in the likelihood that a person will reach their 50th birthday could be shown, depending on the state and even factoring in state facilities, professionals might be motivated to explore why one location is better or worse.

Dr. Embry observed that the behavioral risk factor survey has been used as a dependent variable for some of the population of interest and the Youth Risk Behavior Surveillance System as a dependent variable for state-level strategies.

Dr. Embry explained that the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act's block grant authorizes the levying of penalties against states that violate the Synar Amendment provisions. He wondered whether this penalty could be used as leverage, because often the legislation on moving people under care is enacted at the state level.

Ms. Dicharry commented that the Consumer Subcommittee recently discussed every recommendation in the report. She asked about the process to evaluate and report on all of the programs and to address all of the questions posed in the report. Dr. Morrisette explained that the statute requires evaluation of federal programs in terms of outcomes, including mortality, homelessness, and hospitalizations. The process will depend on what data are available to analyze and what resources are available to conduct evaluations.

Dr. Embry mentioned that the ISMICC report addresses SED, and he would like to understand some of the report's numbers in context. A new Institute of Medicine (IOM) committee has been convened to study the scaling of prevention science, and deeply embedded in a 2009 IOM report is detailed epidemiological evidence to suggest that the levels of mental, emotional, and behavioral disorders are much higher among children than currently believed. This report provides extensive evidence on multiple randomized parity of effectiveness trials, with

longitudinal follow-up. These are largely ecological interventions, rather than normal treatment interventions, because peer activities maintain a lot of the interventions.

## **MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY**

*Speaker: Christopher M. Jones, Pharm.D., M.P.H., Director, National Mental Health and Substance Use Policy Laboratory*

*Discussant: Stacy Rasmus, Ph.D., Member, CMHS NAC*

Dr. Jones explained that he is currently staffing the Policy Lab, attending advisory committees and councils, prioritizing the Lab's work, and soliciting feedback from stakeholders. Dr. Jones talked about language in the 21st Century Cures Act that supports innovation and the dissemination of EBPs. The focus on service delivery models is embedded within the charge to the ISMICC. The mandate for the Policy Lab broadly includes any effort to advance the implementation, identification, and coordination of policies likely to improve mental health and reduce substance abuse. More specifically, the Lab has been charged with improving data collection activities to inform programmatic efforts. The Center for Behavioral Health Statistics and Quality (CBHSQ) has historically managed Government Performance and Results Act (GPRA) measures. Dr. Jones commented that the mental health system is fragmented, and often people cannot access all of the services they need in one place. Certified Community Behavioral Health Clinics provide a model and a type of payment structure for how services can be provided in one place. Opportunities exist to consider how that model looks in different areas and how it can be sustained.

The Policy Lab is authorized to issue grants supporting research into service delivery models, and priorities include refocusing on opioids and SMI. The Lab will play a role in the implementation of EBPs. SAMHSA is refocusing on ways to provide technical assistance, which is directly tied to the successful adoption and dissemination of EBPs.

The Policy Lab and CBHSQ will work together to determine what information is disseminated and how it drives policy. Dr. Jones is interested in the convergence of mental health and substance use. The ISMICC report drew upon data from the National Survey on Drug Use and Health, which show that the treatment a person with a co-occurring disorder receives depends on which door they enter—the “mental health door” or the “substance use door.” The point of entry may determine whether their mental health issues, or their substance use issues, or both, are addressed. This situation could be an artifact of how we think about the populations being served. Dr. Jones has studied the prevalence of Any Mental Illness (AMI) and SMI among people with an opioid use disorder in the past year: 64.0 percent had AMI, and 24.5 percent had SMI. These complex people need different modalities to address their issues, which must be considered when deploying resources on the addiction side and expanding access to medication-assisted treatment.

Turning to data linkages, Dr. Jones described an ongoing effort by the Assistant Secretary for Planning and Evaluation to link the National Death Index data to claims data to gain insight into a person's condition before his or her death. Similarly, datasets from SSA and HUD might provide information about social supports that are important to a person's well-being. Dr. Jones acknowledged the many technical challenges to this effort, for example, how claims data are coded and validated.

In addition, there is a disconnect between the patient receiving interventions and retaining people in treatment. The innovation must be directed at building a system that comprehensively provides a continuum of care services. Dr. Jones concluded with several questions to the group: What areas lack good guidance? What should we be doing based on what we know about specific issues? What are the top policy issues in the mental health space? What are the research gaps? What are the challenges for implementing EBPs? If we are putting a strategic shift in place, we want to make sure that what we are building is useful.

#### Discussion

Dr. Rasmus briefly described ongoing research projects that collect data among Alaskan Native youth and the Yup'ik community regions. As a tribal person and a tribal researcher, she stated that tribes have unique issues, struggles, and challenges, particularly with EBPs. Ninety-eight percent of EBPs are normed and validated on non-tribal people. In terms of policy recommendations, she welcomes the emphasis on collaboration, particularly between the larger agencies, CDC, and NIH. As a mostly NIH-funded researcher, she has found it difficult to communicate with NREPP staff who have their own priorities around gold standards of research, how research should be conducted, and methodologies and practices.

Dr. Jones observed that one of the challenges of a registry-based system is that some populations will likely never be studied. Moving away from the registry-type system takes some of the pressure off of believing that we must have randomized control trials, or some other bar, and lets us affirm that science changes, like here is what we know now, and here is our best thinking.

Dr. Rasmus said that often people appear as though they are not performing based on the GPR performance measures. She favors several reforms, including those related to changing the evaluation component of FOA grant announcements and advancing our knowledge of an evidence base on multi-level interventions. Most EBPs are individual-based and clinical. However, some innovative measures around social networks are extraordinarily useful at producing data and highlighting the points and mechanisms to effect change, particularly around suicide prevention or reduction of risk in tribal youth.

Dr. Unützer commented that implementation of some of the NREPP interventions has resulted in a wide range of outcomes and it is important to look at that variation in a systematic way.

Dr. Embry added that interventions contain both good and bad elements, and the good should not be thrown out with the bad. Building in proximal measures of outcomes could improve this situation. Dr. Jones noted the importance of mixed methods. Studies sometimes report that a state made policy changes and then saw certain results, but without evidence that the policy changes were actually implemented. A comprehensive understanding of individual- and community-level interventions is necessary to identify where the successes and breakdowns occur. Dr. Jen added that some of these issues can be addressed through providing proper training on the tools, developing a common language and glossary, and building relationships between researchers and practitioners.

Dr. Heinssen stated that proper examination of variations requires systematic collection of data. Exploration of how to balance rigor, practicality, and assessment is an essential part of the effort

to define an approach that allows for implementation of broad measurement strategies in real-world clinical settings without requiring research-level data quality.

Ms. Dicharry and Dr. Jones stressed the importance of engaging end users in project design, outreach strategies, and evaluation.

### **INTRODUCING SENIOR MEDICAL ADVISOR**

*Speaker:* Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS

Dr. Larson plays an active role in the ISMICC, helping with planning and prioritization and offering her perspective as a child psychiatrist. She also acts as a liaison between OCMO and CMHS. She works to build relationships with stakeholders, especially the medical community. She is the lead on several projects, including oversight of programs, psychotropic prescribing for kids, and developmental outcomes of maternal opiate use. She is writing papers on long-acting injectables and on the use of technology-based interventions for people with SMI.

Mr. Patton asked for Dr. Larson's insight into the shortage of child psychiatrists. She explained that many psychiatrists do not want to work in community-based service because of time constraints and other limitations that create structural problems. Ms. Price added that lower reimbursement rates for psychologists compared to doctors may be contributing to this problem. Dr. Larson observed that, where care can be provided by pediatricians or other providers in less serious cases, there is potential to broaden care models to improve capacity.

Mr. Patton elaborated on the reimbursement problem, noting that under Michigan's managed care capitation model the cost of psychiatric services is very high. He advocated for eliminating the fee-for-service model and instead adopting a value-based model, although a shortage of child psychiatrists will persist.

Dr. Embry made the case for focusing on the ecology of psychiatric disorders, noting that the entire environment (e.g., the school context) must be considered, not just particular behaviors that are treated with a targeted pill. Dr. Larson remarked on the broad interest among child psychiatrists in social determinants of behavioral health and how they can intervene.

Responding to a question about perinatal approaches, Dr. Larson described an expert panel that is studying the issue of child developmental outcomes with maternal opiate use. Experts are cautious about discussing the negative effects of in utero exposure out of concern that women could be pressured to detox from medications. The science around this issue must be explored. In general, the recommendation is for medically assisted treatment because the relapse rates are high, although some women might be good candidates for stopping medication.

### **BEHAVIORAL HEALTH DISASTER RESPONSE**

*Speaker:* CAPT Maryann E. Robinson, Ph.D., RN Chief, EMHTSSB, DPTSSP, CMHS

*Discussant:* Wenli Jen, Ed.D., Member, CMHS NAC

Dr. Robinson explained that much of the work by the Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB) is anonymous, so the outcomes are not as easily captured. Embraced by SAMHSA leadership, disaster behavioral health is a public mental health model

that looks at mental health, including substance abuse and includes stress management. EMHTSSB looks at support interventions for survivors of both natural and, more recently, human-caused disasters. It is important to incorporate disaster behavioral health into disaster preparedness and response plans. Most survivors of a disaster will experience some level of trauma that, left unaddressed, can compromise their physical, mental, social, and emotional health. Therefore, crisis counselors must have a clear understanding of trauma-informed care. These counselors train providers from the impacted community, who go door-to-door to provide behavioral health support and education that reflects community-based resources. This work is funded by a short-term disaster relief grant in partnership with the Federal Emergency Management Agency (FEMA).

A typical disaster response timeline begins the day of the disaster and extends approximately 12 to 18 months or more, during which time the crisis counseling grant program is in place. SAMHSA's services primarily fall into two categories. The primary service is of high intensity and involves direct contact with a disaster survivor. The secondary service encompasses media and advertising activities. Once the program is established within a community, the crisis counselors create a brand of services that target the community's particular needs. SAMHSA employs an approach that considers the population, service types, and the community needs rather than simply offering a generic response. SAMHSA also pays attention to the long-term recovery needs of persons and communities and utilizes many modalities of providing care and services including hotlines, first responder resources and materials for the impacted community.

Dr. Jen remarked that most people do not talk about stress management. She has focused on the disillusionment phase, stress management, and anxiety and has worked with educators to incorporate meditation and mindfulness into school systems. In California there has been a disconnect between educators and emergency preparedness professionals. Community Emergency Response Team (CERT) programs can require too much time to complete, and therefore downloadable non-CERT "crash" courses would be helpful. Better emergency preparedness for children and mental health emergency "tip sheets" in multiple languages are also needed.

Dr. Embry commented that given the pace of events now, planned variations might be required. Dr. Robinson stated that, after responding to disasters, emergent events, and human-caused incidents for 40 years, she is confident that emergency professionals know what to expect and how to respond. Although some lessons can be generalized, the resources deployed are tailored to fit the community's situation. Psychological first aid is provided during the early stages of a disaster and has been found to be a very helpful intervention.

Dr. Tenhula asked whether disaster responders partner with community organizations, nonprofits, and community-based organizations as a critical way to leverage or expand the program's reach. CDR Seligman explained that crisis counselors come from the neighborhoods or counties affected by the disaster. Every state has a disaster state coordinator, who coordinates with EMHTSSB and directs all resources received to the local authorities. At his or her discretion, the state coordinator also provides information to the local emergency shelter, which then shares that information with nonprofits, such as the American Red Cross, and other nongovernmental organizations that will be in the disaster space.

Mr. Simmons asked whether Facebook's safety check feature, which enables people in a disaster area to post about their safety, provides links to SAMHSA resources and services. Dr. Robinson replied that the disaster distress helpline directs people to frequently used and local resources.

#### **PUBLIC COMMENT**

There was one public comment. A caller from Michigan discussed the insufficient community response to the legal needs of the children in his care, because divorce increases the risk of suicide within the family by 100 percent. When these children and their parents are separated and the parents are divorced, the caller's organization identifies the children's legal rights and provides them with what the court ordered, as required by the Developmental Disabilities Act of 2000. While the states are supposed to fulfill these obligations, Michigan does not do so at this time. He requested that the CMHS NAC place on its agenda the issue of identifying children's legal rights upon their registration at school and the services available through the Developmental Disabilities Act.

#### **CLOSING COMMENTS**

Mr. Patton said that he would like to see the issue of offenders on the next agenda, particularly peers.

#### **ADJOURNMENT**

Ms. Foote thanked all the participants and adjourned the meeting at 4:25 p.m.