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 Pavilion A
Rockville, MD 20857

February 20, 2020

Chairperson
Anita Everett, M.D., DFAPA

Designated Federal Official
Pamela Foote

Council Members Present
Steven Adelsheim, M.D., Ph.D.
Sergio Aguilar-Gaxiola, M.D., Ph.D.
Michael Biasotti, M.A.
Leonard Bickman, Ph.D., M.A., B.S.
Dennis Embry, Ph.D.
Wenli Jen, Ed.D.
Jeffrey Patton, M.S.W.
Lori Raney, M.D.
Stacy Rasmus, Ph.D.
Sampat Shivangi, M.D.
Khatera Tamplen, B.S.

Council Members Absent
Jane Adams, Ph.D.

Ex Officio Members Present
Elinore F. McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, SAMHSA
Christopher Loftis, Ph.D., PMP, National Director, Veterans Administration/Department of Defense, Mental Health Collaboration, Office of Mental Health and Suicide Prevention
Joel Sherrill, Ph.D., Deputy Director, National Institute of Mental Health (NIMH), Division of Services and Intervention Research

Ex Officio Members Not Present
Joshua A. Gordon, M.D., Ph.D., Director, NIMH
Robert K. Heinssen, Ph.D., Director, Division of Services & Intervention Research

CMHS Staff Present
Tison Thomas, M.S.W., L.M.S.W., Director, Division of State and Community

Systems Development (DSCSD)
CDR David Barry, Psy.D., Branch Chief, Community Support Programs Branch
Melinda J. Baldwin, Ph.D., LCSW, Special Assistant, Office of the Director (OD)
Anne Mathews-Younes, Ed.D., D.Min., Deputy Director, OD
Shadia Garrison, M.P.H., Director, Office of Program Analysis and Coordination
Emily Lichvar, Ph.D., Government Project Officer, Child, Adolescent and Family Branch, Division of Systems and Services Improvement, (DSSI)
LCDR Katie Hagar, B.S., BSN, RN, Government Project Officer, Homeless Programs Branch, DSSI
Mary Blake, B.A., Government Project Officer, Community Support Programs Branch, DSSI
Eric Weakly, Branch Chief, DSCSD
Savannah Kidd, MFT, Public Health Advisor, Suicide Prevention Branch, Division of Prevention, Traumatic Stress and Special Programs (DPTSSP)
Brandon Johnson, M.H.S., Public Health Advisor, SPB, DPTSSP
Justine Larson, M.D., M.P.H., MHS, Senior Medical Advisor, CMHS
CAPT Maryann Robinson, Ph.D., RN, Chief, Emergency Mental Health and Traumatic Stress Services Branch
Esther Ureña, Intern, OD
Lana Pohlmann, M.P.A, Intern, OD
Lora Fleetwood, Public Health Advisor, DPTSSP
Steven Fry, M.S., Public Health Analyst, Office of Consumer Affairs
Steve Dettwyler, Ph.D., Public Health Advisor, DSCSD

CALL TO ORDER AND ROLL CALL
Pamela Foote, the Designated Federal Official called the CMHS NAC meeting to order at 9:00 a.m. After conducting roll call and verifying a quorum, the meeting was turned over to Dr. Anita Everett, Director, CMHS.

WELCOME AND OPENING REMARKS
Dr. Everett welcomed Council members, noting that there are some new members in attendance and other members who were joining for their last meeting as their terms on the CMHS NAC is ending. She mentioned those members attending their last meeting: Dr. Wenli Jen, Mr. Jeff Patton, and Dr. Stacy Rasmus.

CMHS DIRECTOR'S REPORT
The Director's Report covered several programs; results from the National Survey on Drug Use and Health (NSDUH), focusing on results related to African Americans; current budget information; and the organizational structure of SAMHSA and CMHS.

NSDUH Information
The NSDUH is primarily focused on substance use disorders (SUD) but over the last ten years has added elements that address the prevalence of mental illness. According to NSDUH findings from 2018, approximately 19 percent of Americans aged 18 or older have a mental illness. Of those, approximately 20 percent have been diagnosed with any mental illness and five percent have been diagnosed with a serious mental illness (SMI).

NSDUH revealed areas where we need to focus resources, particularly for African Americans. There has been a significant increase in major depressive episodes among young adults aged 18 to 25. Substance use and mental disorders among African Americans are closely linked. NSDUH data indicates that illicit substance use is associated with increased risk for other substance misuse and mental illness.

Although the prevalence of major depressive episodes is lower among African Americans than the general population, there is concern regarding the rise in suicidal thoughts, plans, and attempts among African American youth. CMHS is working with the Centers for Disease Control and Prevention (CDC) to understand and address these troubling statistics.

CMHS Budget Information

Dr. Everett reviewed the CMHS budget for FY2020. There are significant increases in programs in CMHS:

- A $70 million increase in funding for the Certified Community Behavioral Health Clinics (CCBHCs) program.

- The National Strategy for Suicide Prevention budget increased by $7 million
  The Suicide Prevention Resource Center budget increased by $2 million. Funding for other suicide prevention programs remained as funded in 2019.

The program receiving the largest increase is Project AWARE, which introduces prevention and intervention services in school systems.

Other programs receiving funding increases include Mental Health First Aid, Healthy Transitions, and the National Child Traumatic Stress Initiative, Criminal and Juvenile Justice Programs, Assertive Community Treatment Programs, Assisted Outpatient Treatment, and Outpatient Civil Commitment Programs.

There was no change in funding for Children's Mental Health Services, Projects for Assistance in Transition from Homelessness (PATH), Protection and Advocacy, or the Mental Health Block Grant.

Discussion

Dr. Shivangi asked about programs on suicide prevention and postpartum depression. He wondered if there could be a committee at the national level to look at the issue and conduct outreach. Savannah Kidd of the SPB responded that two programs mentioned during the budget overview—the National Strategy for Suicide Prevention and the Zero Suicide Awards—conduct work or activities which address the relationship between postpartum depression and risk for suicide.

Dr. Embry discussed his involvement in the long-term research on the Good Behavior Game at Johns Hopkins University. The Good Behavior Game (GBG) has scaled up to involve more than 50,000 teachers in schools across the country. Dr. Embry noted that African-American youth

who have participated in the GBG show reduction in suicide as well as in behavioral health disorders.

Dr. Aguilar-Gaxiola discussed the troubling increase in suicide rates among African Americans and asked if there are specific projects addressing this population and whether similar information could be presented on suicide rates among Latinos. Brandon Johnson stated that the Congressional Black Caucus has developed an emergency task force to address the increase in young African American suicides and has released a report on the issue. In addition, CMHS is working with other federal agencies doing work in this area and the SPRC is developing new resources to disseminate.

Dr. Raney asked if there is additional information on the SAMHSA website on evidence-based suicide prevention programs, including programs funded under the 21st Century Cures Act. Dr. Everett replied that CMHS is aware of many programs that are effective and Brandon Johnson, of the SPB noted that the Suicide Prevention Resource Center (SPRC) includes grantee success stories.

CONSIDERATION OF THE AUGUST 21, 2019 MINUTES

Dr. Everett closed the discussion and then asked for a motion to approve the minutes of the August 21, 2019, CMHS NAC meeting. Dr. Adelsheim so moved and Mr. Patton seconded the motion. Dr. Everett called for a vote to accept the minutes; all were in favor. Dr. Everett turned the meeting over to Pamela Foote for a period of public comment.

PUBLIC COMMENT

There were no public comments.

PROGRAM UPDATES

Division of Services and Systems Improvement (DSSI)

Dr. Mathews-Younes introduced the DSSI program update, which included information from three grant programs.

LT CDR Katie Hagar described the Minority AIDS Initiative - Service Integration Grant Program within the Homeless Programs Branch. This program is designed to provide individuals with SMI and co-occurring disorders living with or at risk for HIV and hepatitis with integrated mental health and SUD treatment along with HIV primary care and prevention services. Her success story was about the Tarzana Treatment Centers' in California. The "Whole Health Integration Project against HIV" has accomplished high client retention and connection to services. One client left the transitional housing program and outpatient services after suffering a severe relapse, subsequently stopping adherence to their HIV medication and returning to selling drugs. Program staff continued to remain in touch with the client, keeping lines of communication open, and the client reached out after becoming ill. Program staff were able to help him find medical treatment and bring the client back to the transitional housing program and outpatient services. The client is now adherent to all HIV and psychiatric medications, has an undetectable viral load, is sober, and working on obtaining permanent housing.

Dr. Lichvar described a case example from the Clinical High Risk for Psychosis grant program. This program works to provide evidence-based assessment and intervention to improve the functioning and resilience of young people at high risk for psychosis and to foster achievement of their academic and vocational goals. It also aims to delay or prevent the onset of psychosis and minimize the duration of untreated psychosis.

Her example was drawn from a program named "Prospect" in New York at Columbia University. The program received a referral for a 21-year-old woman referred by her psychiatric provider and community therapist due to significant functional decline. She was severely socially withdrawn and reported having paranoid thoughts along with agitation, anxiety, depression, feelings of hopelessness and helplessness, and numerous other symptoms. Upon enrollment in Prospect, she participated in psychoeducation about the clinical high risk for psychosis and was introduced to cognitive behavioral therapy skills. At reassessment, she reported being more socially engaged and no longer met criteria for clinical high risk for psychosis.

Mary Blake described an example from the Assertive Community Treatment (ACT) program, a tribal organization establishing a new ACT in a part of New Mexico that is much underserved, impoverished and with a high rate of violence.

Division of State and Community Systems Development (DSCSD)
Tison Thomas, Director of DSCSD, described activities related to the Mental Health Block Grant (MHBG), the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, and the Programs for Assistance in Transition from Homelessness (PATH) program.

The MHBG is the largest portfolio within CMHS, with approximately $722 million going to 50 states, six territories, and three associated countries. The block grant is a formula grant programs and state grantees can use funds for treatment services, supports, training, implementation of new evidence-based practices, and other purposes.

Around 7.8 million individuals are served through the MHBG, of whom 27 percent are aged 0 to 17, 32 percent are aged 25 to 44, and 25 percent are aged 45 to 64. Since 2008, the number of clients with SMI and serious emotional disturbance (SED) has increased by 30 percent to more than 5.5 million individuals. Around 7.5 million individuals are being served in community mental health programs, 130,000 are served in state psychiatric hospitals, and 450,000 are served in other inpatient psychiatric settings. Ten percent of funds are set aside for first episode psychosis. The number of first episode psychosis programs has increased from 37 in 2014 to 294 in 2020.

The PATH program is a $64 million, nationwide grant program to create additional resources for individuals with SMI who are experiencing homelessness or who are at risk of homelessness. States give the money to approximately 450 providers who provide PATH-related services. States also work closely with local Continuums of Care, the Veterans Administration homeless assistance programs, as well as state and local housing authorities. Approximately 150,000 people receive resources and services each year.

The PAIMI program is another formula grant that goes to governor-designated protection and advocacy programs in 50 states, six territories, and one American Indian consortium. These 57 grantees provide services to individuals in state institutions and in community-based systems of care and investigate abuse, neglect and can litigate violations of individuals' rights. PAIMI served approximately 10,000 individuals in FY2018.

Discussion
Dr. Adelsheim acknowledged SAMHSA's efforts around early psychosis interventions and requested clarification on future funding of the protection and advocacy work. Mr. Thomas confirmed that the President's 2021 budget proposes to reduce funding of this program from $36.1 million to $14 million.

Dr. Jen expressed her concern about the funding reduction proposal for PAIMI and asked what the reduction would mean in terms of programmatic changes. The PAIMI program has regulations attached to the statutes which require that protection and advocacy programs must only serve patients within the state hospital system should funding fall below $25 million.

Mr. Patton asked about a letter from the Assistant Secretary to state mental health commissioners stating that MHBG dollars may be used for jail services. This is a new ruling on the use of MHBG funds. Mr. Thomas explained that the letter was just sent on February 11, 2020 and it includes the provision that services must be provided through a recognized community mental health program. This clarified that the MHBG funds could not be given to Correctional programs directly to provide treatment for incarcerated persons.

Division of Prevention, Traumatic Stress, and Special Programs
Dr. Maryann Robinson described two programs within the Division: the Mental Health Awareness Training Grants (MHAT) and the Crisis Counseling Program (CCP).

The MHAT program serves and trains school personnel, emergency first responders, law enforcement, veterans, armed service members, and families to recognize and signs and symptoms related to mental disorders, particularly those related to SMI/SED. There are currently 156 grantees and an additional 16 grants will be awarded in Fiscal Year (FY) 2020. Typically several thousand persons are trained through MHAT grants each quarter of the year and the training results in referrals to treatment.

The CCP provides disaster behavioral health services such as basic support and education about post-disaster reactions, coping mechanisms, and linkages to resources and professional services for disaster survivors. In 2019, the team managed or awarded 36 crisis counseling grants to 19 states, territories, and tribes. The program supported more than 1,500 crisis counselors and provided direct referrals to more than 30,600 individuals to mental health services.

Dr. Robinson reintroduced Savannah Kidd, who discussed the National Hotline Improvement Act. This 2018 legislation directed the Federal Communications Commission (FCC), SAMHSA, and the VA to discuss the feasibility of implementing a three-digit number to support mental health and suicide crisis communications. In December 2019, the FCC submitted its report to Congress and initiated proposed rulemaking, which begins the process of designating 988 as the

new nationwide three-digit number as a suicide prevention and mental health crisis hotline. This easy numeric designation will facilitate access to crisis call line services, reduce stigma, and save lives.

Calls made to 988 would be directed to the existing National Suicide Prevention Lifeline (1-800-273-TALK or 8255). It also proposes that all telecommunication carriers and Voice Over Internet Protocol service providers be required to make within 18 months any network changes necessary to ensure that users can dial 988 to reach the Lifeline. The FCC took public comments until February 14, 2020. In 2018, trained Lifeline counselors answered more than 2.2 million calls and provided 100,000 online chats.

Discussion
Dr. Aguilar-Gaxiola asked if studies exist on the societal costs of suicide. Ms. Kidd pointed to the National Violent Death Reporting System, operated by the CDC, which includes the cost of years of life lost to suicide.

Dr. Bickman asked about research on the effectiveness of hotlines. Dr. Everett replied that Columbia University and SAMHSA conducted research on the effect of calls to the Lifeline. In many cases, the cases were described by callers as being lifesaving.

Mr. Patton inquired how local Lifeline crisis centers get information on available services. Ms. Kidd responded that it varies by locality but that the Lifeline headquarters conducts the network certification and education of the 163 crisis centers that are a part of the network. Some local centers partner with their local state mental health authorities.

Dr. Adelsheim remarked on the media guidelines and support of suicide awareness and partnerships around suicide prevention. He noted that the media rarely follows guidelines for reporting on instances of suicide which may increase the risk of contagion. In his experience, local media has no idea that they may increase or decrease risk of suicide among young people by how they report a suicide. Dr. Everett mentioned work by the National Institute of Mental Health (NIMH) to demonstrate an increase in suicide attempts when the show **13 Reasons Why** was broadcast.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHCs)
CDR Barry of the United States Public Health Service (PHS) began his presentation by talking briefly about the PHS Commissioned Corps. The Commissioned Corps is a cadre of officers that serve medical missions and belong to the Department of Health and Human Services (HHS). The Commissioned Corps is currently providing support to Puerto Rico, coronavirus efforts, and a variety of issues related to suicide clusters in Indian Country.

CDR Barry then described the CCBHC-Es, noting that the Centers for Medicare and Medicaid Services (CMS) also has a CCBHC program. One key difference between the two programs is that CMHS provides funding directly to the clinics. CCBHC-Es are required to provide 24/7 crisis services as well as treatment planning, screening and monitoring, veterans' services, peer support, and psychiatric rehabilitation services. The most recent CCBHC-E request for

applications closed on March 10, 2020. Up to 98 awards are expected and all states are eligible to apply.

The CCBHC-E program is a discretionary grant program. There are currently 64 grants, each lasting two years, and with funding levels of up to $2 million per year. CCBHC-Es allow for co-location of services which leads to increased availability and access as well as reduction in wait times. CCBHC-Es served more than 30,000 individuals in FY 2019 and more than 35,000 to date in FY 2020. In addition, more than 210,000 individuals have been screened and approximately 150,000 individuals contacted through outreach services.

Collected outcome measures indicate that there are increases in overall health and everyday functioning among CCBHC-E clients, decreases in psychological distress, and increased school attendance. The co-location of services has also led to more appropriate use of emergency department resources and linkages between emergency services and the CCBHCs.

CDR Barry shared that an individual with SMI who had found it difficult to get services prior to the CCBHC-E because he had to spend a lot of time getting to different treatment centers. Being able to access co-located services within the CCBHC-E was important to him.

Mr. Patton gave a presentation on the SAMHSA funded CCBHC-E, Integrated Services of Kalamazoo, Michigan, formerly known as Kalamazoo Community Mental Health and Substance Abuse Services. This CCBHC is a municipal corporation created by Kalamazoo County. In FY2018, Integrated Services of Kalamazoo provided 24/7 services to 8,000 individuals, either in-house or via a network of provider agencies. A total of 6,973 clients received psychiatric services and emergency mental health. An additional 1,000 clients receive outpatient services and access intake through the network of external providers.

Their CCBHC-E program grant has allowed Integrated Services of Kalamazoo to offer care coordination and disease management services to more than 4,900 individuals and outpatient and targeted case management services to more than 600 individuals. In addition, more than 200 youth and adults receive intensive crisis stabilization services, which have reduced the need for inpatient services. Additional services provided include 2,401 individuals screened for tobacco use and 2,098 individuals screened for alcohol and other drug use. Of these, 992 individuals with SUD received follow-up education and referral.

Being part of the CCBHC program has allowed Integrated Services of Kalamazoo to collect, report, and act on data. Suicide risk was identified in 37 percent of adults and 31 percent of youth with 2,000 clients received follow-up care or suicide prevention services.

In the future, Integrated Services of Kalamazoo plans to increase access to behavioral health services for their population of focus, deliver comprehensive and coordinated care that provides access to evidence-based interventions for individuals with complex needs, and deliver integrated care for behavioral health and physical health risks and needs.

Discussion

Dr. Everett asked Mr. Patton about how the CCBHC-E program has impacted children's

services. Mr. Patton said that the organization has a history of working with parents and families. Integrated Services of Kalamazoo is also a system of care and has collaborated with all school systems in the area. Current staff are co-located in the schools and in a juvenile home. The CCBHC-E program has allowed the organization to expand services for children and families, including families with complex needs.

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE PRESENTATION on recent work on Youth

Following the lunch break, Dr. Everett introduced Dr. Thomas Boat who was the chair of the recently published National Academies report, **Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda**. Dr. Boat, is Director of the Division of Pulmonary Medicine at the Cincinnati Children's Hospital and a professor of pediatrics with the University of Cincinnati College of Medicine. He is a member of the Board of Children, Youth, and Families of the Institute of Medicine (IOM) and has been the author of five Institute Of Medicine (now called National Academy of Sciences, Medicine and Engineering) reports addressing physical, emotional, and behavioral dimensions of child health. In these roles, he has been a champion for the characterization of safe and nurturing family environments as important early contributors to lifetime health and wellness for all children. Dr. Boat began his presentation by introducing two colleagues: Natacha Blain, JD, PhD, Director of the Board on Children, Youth, and Families; and Erin Kellogg, MPA, MPH, a staff member on the Board. He also acknowledged the study sponsors: CMHS (the major sponsor), CDC, and the NIMH.

The committee was tasked with (1) conducting a consensus study to review key research and strategy advances as well as the challenges that have arisen since the publication of a previous report in 2009; (2) describing recent progress in understanding what is necessary to implement strategies effectively; and (3) identifying program, policy, and research gaps that might be used or addressed to promote healthy mental, emotional, and behavioral (MEB) development. Dr. Boat reported that mental, emotional and behavioral (MEB) disorders affect individuals and families, and communities and schools creating an economic burden throughout the country.

Specific IOM task considerations included:

- Trends in the prevalence of specific MEB conditions.
- The current context for health promotion strategies and use of a population-based and public health approach.
- A multigenerational perspective.
- The current status for the biology of neurobehavioral and environmental influences.
- Health equity and attention to cultural differences.
- Complementary and integrative approaches to helping children deal with stress.

- The types of research approaches and methods that can move the learning process ahead more quickly.

The report begins by describing the influences on mental, emotional, and behavioral health and provides an overview on the biology of neurobehavioral development. Researchers are beginning to understand how environmental influences change biological processes, particularly in the neurodevelopmental area. However, it remains to be discovered whether there might be biomarkers that can be used to predict resilience or vulnerability. There are also chapters on families and intergenerational effects, the education system, and health care, as well as emphasis on the community. The report includes a discussion of policies and what opportunities there are in the policy arena to support families and children to have healthier MEB development.

Finally, there is a discussion of research needs and how best to move from research to implementation.

One important conclusion was around the cost of implementation and how costs may be reduced. It was determined that the cost for many intervention programs has to do with the expense of infrastructure to support the programs. How can existing systems and infrastructure be used to reduce these costs? The education system and health care system are two opportunities to use existing infrastructure and go where children are already being served.

The committee made four major recommendations, noting that HHS should be the lead on these efforts. The recommendations are:

1. HHS should lead and collaborate with agencies at the state and local levels, as well as with private partners, to coordinate a highly visible national effort to make the promotion of MEB health a national priority.

2. Use program creation, regulatory, and other policy capabilities to promote healthy MEB development and mitigate risks to MEB health.

3. Support implementation by providing funding and other resources, e.g., to support research and demonstration projects, cross-sector partnerships, innovative funding mechanisms, economic analyses, and sustainability.

4. Assess existing data sources and develop a plan to use existing and new sources to track the status of MEB development, exposure to risk and protective factors, access to effective interventions, and implementation of programs and policies and their impact.

The report also set out a research agenda to move from recommendations to action, stressing that a huge, multipronged effort will be required, including coordinating and pooling resources.

Discussion

Ms. Kellogg remarked that the Forum on Children's Well-Being, formed by the committee members who worked on the previous report, will host a workshop in May on flourishing and adolescents that builds on the content of this report.

Dr. Aguilar-Gaxiola thanked Dr. Boat, remarking that the report is very timely given the troubling data and trends on MEBs among children and adolescents. It aligns with a recent report from the National Academy of Medicine on children which discusses adverse childhood experiences (ACEs). Research suggests that ACEs are the strongest predictor of early onset mental illness and physical conditions. Dr. Aguilar-Gaxiola also stressed that the economic costs of MEBs are borne not just by individuals and families, but also by communities and society at large. Dr. Boat responded that there is more and more surveillance and screening for social determinants and early childhood adversities. There is evidence of an intergenerational effect.

Dr. Adelsheim agreed that implementation of the report recommendations is a key issue. He is pondering how to conduct implementation in different ways, including aside from depending on the federal government. He mentioned that the World Economic Forum has taken on mental health as a primary issue around integrated youth mental health. This may be an avenue to amplify the recommendations.

Dr. Bickman also discussed the importance of implementation and the issues involved in effectively translating recommendations into action at the federal level. Dr. Boat responded that messaging to the public and to policymakers is crucial.

Dr. Embry commented that he would like to have a time to describe to the National Academy of Medicine and SAMHSA how population-level implementation of the Good Behavior Game and the Triple P Positive Parenting Program has been achieved using business, manufacturing, and distribution models and data monitoring systems. Dr. Boat agreed that the school system provides a great opportunity for reaching children and youth but that the health care system should also be an avenue.

Dr. Jen discussed her experience with community participatory research and getting buy-in for communities. It was helpful in data collection and in getting feedback into program assessment. She also explained how helpful it is to involve the school systems through a description of the School Attendance Review Boards in her area, which gathered private sector and nonprofit representatives to discuss students with MEBs. She suggested that SAMHSA may be able to look at some of the programs that are already working across the nation to see if they can be funded and provided technical assistance.

PRESENTATION BY SAMHSA LEADERSHIP
ELINORE F. McCANCE-KATZ, M.D., Ph.D.

Following brief introductions from attendees, Dr. Everett introduced Dr. Elinore F. McCance-Katz, Assistant Secretary for Mental Health and Substance Use, who discussed SAMHSA projects and priorities for 2020 and beyond.

SAMHSA received a number of budget increases, mainly in CMHS (which received a $118 million increase). One program receiving an increase is Project AWARE, which works with states and school districts to help build infrastructure to address children's mental health needs and to train teachers and school staff on the science and symptoms of mental health problems. Funding in this grant program may now be used for direct service delivery in school-based mental health clinics.

SAMHSA also received an increase for the Infant and Early Childhood Mental Health Consultation program. Funds may be used for children who were exposed to substances during fetal development. From discussion with programs such as the National Head Start Program, Dr. McCance-Katz knows that they are seeing more and more children who were substance exposed in utero and who are exhibiting indicators that they are going to have mental issues as they get older.

Other programs receiving budget increases include:

- A program to assist transitional-age youth that bridges adolescents who have developed mental disorders into adult services.
- The CCBHC program. The initial evaluation of these programs indicates that they are very beneficial.
- Suicide prevention and mental health awareness training programs.
- Criminal justice diversion programs.
- The Assertive Treatment Program.
- The Minority Fellowship Program, which trains individuals who will provide mental health services in minority communities.

Dr. McCance-Katz drew attendees' attention to a grant awarded to the American Psychiatric Association to develop training for providing assisted outpatient treatment in communities as part of wraparound services.

SAMHSA's special areas of emphasis include helping school systems be able to put mental health clinics into schools. As part of the Federal Commission on School Safety, in FY 2018 SAMHSA provided funding supplements to the Mental Health Technology Transfer Centers to address school-based mental health needs. SAMHSA has also been involved in launching SchoolSafety.gov and recently published best practices in crisis intervention services.

Other activities include working with CMS on the 1115 waivers to lift the IMD exclusion for SMI and advocating for use of psychiatric advanced directives. SAMHSA is working now to develop a phone app that can be used by individuals to keep their advanced directives with them. SAMHSA also recently implemented the pilot prevalence study for mental disorders. The statistical analysis will look at the prevalence of mental and SUD in selected urban, suburban, and rural areas that can be used to extrapolate to the nation and generate interest in a larger study.

SAMHSA has submitted several reports to Congress: the potential use of a three-digit number for mental health crisis/suicide prevention: the Assisted Outreach Program; and the CCBHC Expansion Program.

Dr. McCance-Katz completed her presentation by updating attendees on the use of the MHBG funding in jails and prisons. Historically, SAMHSA's policy has been that these funds could not be used for incarcerated individuals. Upon review, it was decided that funds may be used for that purpose as long as services are provided by community providers in the prisons and jails. Dr. McCance-Katz sent a letter to all states to let them know how they can use their MHBG funds to provide care and treatment to individuals with SMI who are incarcerated.

Discussion
Mr. Patton commented that he applauds SAMHSA for making the block grant funds available for services in jails and prisons.

Dr. Aguilar-Gaxiola mentioned that he appreciated the increased funding for Project AWARE and asked if Dr. McCance-Katz could comment on resiliency in the wellness aspects of the program. Dr. McCance-Katz replied that one of the components of Project AWARE is the placement in school systems of positive environments.

Mr. Biasotti asked if the MHBG funds can be focused at the local level where the problem exists to a greater extent than it does at the state prison level. Dr. McCance-Katz's expectation is that there will be significant funding used to support community mental health providers to deliver treatment services in local jails.

Dr. Adelsheim commented that he has long been involved with school mental health. In California, Project AWARE grants continue to expand school mental health services. He said that the Mental Health Technology Transfer Centers (MHTTCs) are starting to have discussions about what role they could play to support early psychosis-related work. How can the CMHS NAC support SAMHSA's leadership role and help with awareness so that efforts are happening in a more coordinated and connected way? Ms. Avula, Chief of Staff stressed that the intention with the MHTTCs and other technology transfer centers is that they be very field driven and yet remain consistent with federal efforts.

INTERAGENCY TASK FORCE ON TRAUMA-INFORMED CARE
Dr. Everett introduced Dr. Melinda Baldwin, Special Assistant to the CMHS Director, who gave a presentation on the Interagency Task Force on Trauma-Informed Care (ITFTIC) and the national strategy for trauma-informed care. SAMHSA was tasked with developing a national strategy to look at trauma-informed care across the federal government through the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act.

The task force decided to use the idea of using the four pillars of best practices, research, data, and federal coordination to frame the strategy.

Pillar 1 (Best Practices) is intended to support the provision of best practice in the area of trauma-informed care, trauma identification, referral, and treatment and to support the promotion of wellness and resilience. Goals related to Pillar 1 are: (1) support the dissemination and implementation of best practices across multiple settings; (2) expand the workforce available to address the needs of children and families impacted by, or at risk for, trauma; and (3)

recommend opportunities to leverage local- and state-level partnerships to prevent and mitigate trauma, accurately identify and refer children and families, and build resilience and coping.

Pillar 2 (Research) is intended to further the research base in the area of trauma identification, treatment, and trauma-informed systems for families and individuals impacted by or at risk for trauma. The goals related to Pillar 2, are (1) promote the development of an evidence base, and (2) enhance research in the area of implementation of approaches and systems to address trauma.

Pillar 3 (Data) is focused on coordination of data gathering, measurement, and tools to better assess the needs of children and families impacted by trauma, streamline services, and enhance care. Goals related to Pillar 3 are: (1) promote systems and technology to enhance data sharing, communication and collaboration across federal agencies, and (2) develop common definitions, measures, and tools in this area.

Pillar 4 (Federal Coordination) focuses on promoting communication and collaboration in the area of trauma, trauma risk, and trauma informed care across the federal government. Goals within this pillar are: (1) develop systems to coordinate across the government for the benefit of children and families impacted by or at risk for trauma (with a sub-goal of identifying options for coordinating existing grants); (2) coordinate workforce development efforts in the area of trauma and trauma-informed systems; and (3) align priorities and standardize concepts of trauma and trauma-informed care across federal agencies.

The ITFTIC seeks input on what is missing, what the cross-cutting issues are, and anticipated stakeholder concerns. The U.S. Digital Service, part of the Office of Management and Budget, is helping to gather that information before rolling out the strategy.

With that, Dr. Baldwin solicited feedback and comments from the attendees. They include the following:

- Ms. Tamplen asked if the project addresses policies that are supported for trauma-informed care and in terms of stakeholders' concerns, noting that an emphasis on voluntary services is a strength in her community. Dr. Baldwin replied that the task force will include any policy recommendations that it feels are important to advance the work across multiple agencies. The task force is not broaching the subject of voluntary/involuntary services but rather thinking about how trauma-informed care can be incorporated into service delivery systems across communities.

- Dr. Aguilar-Gaxiola asked if the definitions of trauma-informed care and trauma risk are consistent across agencies. Dr. Baldwin said that the task force started with the SAMHSA definition and found that other parts of government think very differently about trauma-informed care. The task force is coming up with definitions that will undergird the national strategy and hopes that a common and accepted definition will lead to better evaluation and better research.

SAMHSA POLICY LAB UPDATES

Dr. Everett introduced Dr. Thomas Clarke, Director, SAMHSA's Policy Laboratory, who provided an overview and description of activities.

In December 2016 the 21st Century Cures Act was enacted. The Cures Act created SAMHSA's Assistant Secretary position, the National Policy Laboratory, and the Office of the Chief Medical Officer. The focus of the National Policy Laboratory has been on identifying evidence-based practices that are relevant to the field and feasible to be implemented. The Lab also consults with agencies and offices such as the Office of the Chief Medical Officer at SAMHSA, NIMH, National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA) at the National Institutes of Health. At the start of the 21st Century Cures Act, much attention was focused on looking at individuals with SMI/SED and the opioid crisis, but activities have not been limited to those subject areas.

Dr. Clarke introduced several specific projects of the Policy Lab. They include:

- Oversight of SAMHSA's Strategic Plan—The strategic plan was developed in 2018 and is divided into five priority areas:
    - Combating the Opioid Crisis Through the Expansion of Prevention, Treatment, and Recovery Support Services
    - Addressing Serious Mental Illness and Serious Emotional Disturbances
    - Advancing Prevention, Treatment, and Recovery Support Services for Substance Use
    - Improving Data Collection, Analysis, Dissemination, and Program and Policy Evaluation
    - Strengthening Health Practitioner Training and Education

- Evidence-Based Practice Resource Center—This is a repository of evidence-based practices that focus on prevention, treatment, recovery, and mental health. A committee of experts reviews existing programs for inclusion. The resource center also develops guidebooks.

- Mental Disorder Prevalence Study—The study is a three-year cooperative agreement to determine the prevalence of severe health disorders such as schizophrenia, bipolar disorder, and psychotic disorders in the US. The study is looking at both household and non-household populations. Research Triangle Institute is conducting the study in partnership with several universities.

- Mental Health Consensus Study—For this consensus study, SAMHSA is working with the National Academy of Sciences, NIDA, NIAAA, and NIMH to look at the degree to which support systems for mental health concerns exist on college campuses. The panel is investigating what is known about evidence-based approaches to improving mental health for students, how institutions measure and evaluate mental health and well-being, the research base that underpins approaches to students' mental health services, and barriers for students who seek mental health treatment.

- Behavioral Health Workforce Initiative—This project funded the George Washington University School of Public Health to develop a database to enumerate behavioral health occupations including psychiatrists, substance use and mental health counselors, social workers, psychologists, marriage and family therapists, and others. In addition to demographic information, the study is looking at salaries and practice locations (including urban versus rural areas). There are several challenges with this project including limitations with the data sources.

Attendees' questions and comments included the following:

- Dr. Loftis stressed the importance of updating provider data annually to document salary disparities between government providers and community mental health providers. Having this data could help establish parity and assist in recruitment.

- Dr. Aguilar-Gaxiola asked about the sample size in the prevalence study. It is anticipated that around 40,000 individuals will be screened but the total completing the clinical interview will be around 7,200. He also ascertained that interviews will be conducted face to face and that the core instrument is the SCID DSM-5.

- Dr. Embry was concerned about the products on children's issues available through the SAMHSA store noting that they were mostly informational in nature and unlikely to move readers to take action. He suggested that publications and guides be tested in randomized control group trials. Dr. Clarke recommended that Dr. Embry review the materials available through the Evidence Based Resource Center, which are more science based. Dr. Everett said that SAMHSA would be happy to receive feedback from Dr. Embry and other NAC members on the materials available through the SAMHSA store.

CLOSING REMARKS

Dr. Everett thanked attendees for their participation and noted that CMHS NAC members preferred in-person meetings to the virtual meeting held previously. The next meeting is scheduled for August and members will receive information prior to the date. She also thanked Ms. Foote for her coordination of the meeting and committee activities.

ADJOURNMENT

The meeting was adjourned at 3:25 p.m.