

**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  
Conference Room 14SEH02  
Rockville, MD 20857**

**April 22, 2019**

**Chair**

Anita Everett, M.D., DFAPA

**Designated Federal Official**

Pamela Foote

**Council Members Present**

Jane Adams, Ph.D.  
Steven Adelsheim, M.D., Ph.D.  
Sergio Aguilar-Gaxiola, M.D., Ph.D.  
Khatera Tamplen, B.S.  
Mike Biasotti, M.A.  
Leonard Bickman, Ph.D., M.A., B.S.  
Dennis Embry, Ph.D.  
Jeff Patton, M.S.W.  
Lori Raney, M.D.  
Jürgen Unützer, M.D., M.P.H., M.A.

**Council Members Absent**

Wenli Jen, Ed.D.  
Stacy Rasmus, Ph.D.

**Ex Officio Members Not Present**

Elinore F. McCance-Katz, M.D., Ph.D., SAMHSA  
Joshua Gordon, M.D., Ph.D., Director National Institute of Mental Health, (NIMH)  
Robert K. Heinssen, Ph.D., Director, Division of Services & Intervention Research,  
National Institute of Mental Health  
Chris Loftis, Ph.D., National Director, Veterans Administration/Department of Defense,  
Integrated Mental Health, Mental Health Services

**CMHS Staff Present**

Anne Mathews-Younes, Ed.D., D.Min., Deputy Director, CMHS  
Patricia Gratton, Director, Office of Program Analysis and Coordination  
CAPT Maryann E. Robinson, Ph.D., RN, Acting Director, Division of Prevention,  
Traumatic Stress & Special Programs (DPTSSP) and Branch Chief, Emergency Mental  
Health & Traumatic Stress Services Branch (EMHTSSB)

Nainan Thomas, Ph.D., L.L.B., M.S.W., Acting Branch Chief, Mental Health Promotion Branch, DPTSSP

Tison Thomas, M.S.W., L.M.S.W., Acting Director, Division of State and Community Systems Development and Chief, State Grants Eastern Branch, DSCSD

Gary Blau, Branch Chief, Child, Adolescent and Family Branch, Division of Service and Systems Improvement (DSSI)

David de Voursney, M.P.P., Chief, Community Supports Programs Branch, DSSI

Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, Office of the Chief Medical Officer, SAMHSA

Richard McKeon, Ph.D., Chief, Suicide Prevention Branch, DPTSSP

Crystal Wunder, Special Assistant to the Director

Michelle Cornette, Ph.D., M.S., Team Lead/Public Health Analyst, Suicide Prevention Branch, DPTSSP

Lora Fleetwood, Public Health Advisor, DPTSSP

### **CALL TO ORDER AND ROLL CALL**

Pamela Foote called the meeting of the CMHS NAC to order at 11:00 a.m., conducted roll call, and established a quorum. The meeting was turned over to Dr. Anita Everett, Chair of the CMHS NAC and Director of CMHS.

### **WELCOME AND OPENING REMARKS**

Dr. Everett welcomed Council members and asked the in-person attendees to introduce themselves and provide a context for their participation. She then provided an overview of the agenda and explained its three main components: 1) the Director's Report on recent activities and updates within CMHS; 2) a special report on suicide; and 3) a discussion of the current meeting format as well as input for future meetings.

Dr. Everett asked if there were any questions, concerns, or comments about the August 1, 2018 CMHS NAC meeting minutes circulated by Ms. Foote. Seeing none, she asked for a motion to accept the August 1, 2018 meeting minutes. The motion was made by Mr. Biasotti then moved and seconded by Dr. Embry. The Council voted to accept the minutes with one abstention from Ms. Tamplen who stated she was not at the August 2018 meeting.

### **CMHS DIRECTOR'S REPORT**

Dr. Everett referenced the new branding for SAMHSA and noted that its mission is to reduce the impact of substance abuse and mental illness on America's communities. In accordance with congressional requirements to establish a strategic plan every four years, SAMHSA has outlined five strategic priorities for 2019 to 2023:

1. Combating the opioid crisis.
2. Focusing on serious mental illness (SMI) and serious emotional disturbance (SED).

3. Advancing prevention, treatment, and recovery support services for substance use disorders.
4. Improving data collection, analysis, dissemination, and program and policy evaluation.
5. Strengthening health professional training and education.

Dr. Everett described how SAMHSA has created and greatly expanded its technical assistance (TA) centers. A brief overview was provided for the following newly awarded TA Centers: the SMI Adviser; the Mental Health Technology Transfer Centers (MHTTCs); and the Prevention Technology Transfer Centers (PTTCs). The MHTTCs and PTTCs are a network of centers established within the 10 HHS regions with one Regional Center for each network. These centers mirror the Addiction Treatment Transfer Centers (ATTCs). The Assistant Secretary, Dr. Elinore McCance-Katz created the MHTTCs and PTTCs, preserving the ATTCs and rearranging them slightly to align the territories directly within the HHS regional areas. Members were encouraged to familiarize themselves with the Centers within their area and SMI Adviser. They are intended to be valuable resources that advance knowledge and implementation to the field.

Dr. Everett provided an overview of SAMHSA's current structure and organization. CMHS being one of four centers, with a core of offices, the Policy Lab, the Office of the Assistant Secretary, and the Office of the Chief Medical Officer. In the past two years, Dr. McCance-Katz has focused SAMHSA's efforts on SMI and SED. According to the National Survey on Drug Use and Health, of the 320 million people in America, 46.6 million have had "any mental illness," (AMI) over the last year, and of those about 11 million have a SMI. Dr. Everett noted, since 2008 there has been a rise in the number of 18 to 25-year-olds that have SMI. SAMHSA has been focused on addressing the treatment gap for several years. For those with AMI, the treatment gap for receiving services is about 60 percent, whereas for those with SMI, 33 percent are not in treatment.

Though progress is being made with the two largest causes of death in the United States, namely heart disease and cancer, suicide rates are on the rise, with men being twice as likely to die by suicide. Further, research shows that between the years of 2008 and 2017 there has been an increase of young people having more serious thoughts of suicide, having made a plan, and having attempted suicide. Therefore, there is an increased demand for suicide prevention and intervention services for young people.

Dr. Everett noted that CMHS grant activities align with SAMHSA's Strategic Priority 2, attending to the needs of adults with SMI and children with SED in our nation.

An update of the FY 2020 President's Budget was provided noting the following increases and decreases:

- \$10 million increase in Project AWARE
- \$5 million increase in Healthy Transitions to address the needs experienced by children with, or at risk of SMI or SED in rural trade schools, colleges, community colleges, and universities.

- \$10 million increase in Criminal and Juvenile Justice Programs that will fund a new cohort of approximately 28 grantees, focused on diverting those with SMI who are at risk for criminal justice involvement.
- \$10 million increase in Assertive Community Treatment to fund a new cohort of approximately 13 grants to advance this approach and address the needs of those living with SMI.
- \$51.8 million decrease in Primary and Behavioral Health Care Integration
- \$5 million decrease in Infant and Early Childhood Mental Health
- \$8 million decrease in the Minority Fellowship program.

Dr. Everett noted the following three products that are currently in development:

1. A report on Continuity of Care is forthcoming with regards to child services. The report is going through the clearance process.
2. Posters and booklets are being developed for state and local entities to increase disaster awareness, offer tips for survivors of a disaster or other traumatic events, provide information on coping with anger during a disaster, address “Psychosocial Issues for Older Adults in the Context of Disasters,” and understand risk communication.
3. A psychoeducational toolkit for families who have had a family member die by suicide is under development.

## **HOTLINE IMPROVEMENT ACT**

Richard McKeon, Ph.D., MPH, Branch Chief, Suicide Prevention Branch, CMHS

Dr. McKeon provided an overview to the members on the report that SAMHSA submitted to the Federal Communications Commission (FCC), as part of the National Suicide Prevention Hotline Improvement Act. The Act was passed by Congress and signed into law in August 2018. The Act charges the FCC, SAMHSA, and the Veterans Administration (VA) to work together to identify the feasibility and advisability of having a national three-digit, N11 type number for suicide prevention.

Dr. McKeon noted suicide rates are rising nationally. The Center for Disease Control released a report last year, indicating over the last 12 years suicide has risen in 49 of the 50 states, and in half of those states, the increases have been greater than 30 percent. The number of suicides in the United States is equivalent to the number of fatalities due to opioids, both at 47,000 deaths in 2017, which is the last year for which data are available.

Within that context and under the requirements of the law, SAMHSA’s report – a full copy of which is available on the FCC website – summarizes the effectiveness of the National Suicide Prevention Lifeline. The report also summarizes the history of SAMHSA-sponsored evaluations of the National Suicide Prevention Lifeline, as well as one research study conducted by the National Institute of Mental Health. The studies showed people who called the hotline in significant numbers felt better at the end of the call, that their hopelessness decreased, and that their suicidal ideation decreased. However, these studies also revealed that follow-up was poor after the call, which prompted SAMHSA to promote crisis centers following up with people after they had

called the Lifeline. This effort resulted in 60 percent of suicidal callers not experiencing a recurrence of their suicidal thinking four to six weeks later. However, 42 percent reported they did experience suicidal ideation and only about 20 percent of them had made contact with mental health services. Further, studies on imminent risk callers found that 25 percent of the 2.2 million callers are actively suicidal at the time of the call with about 2 percent at imminent risk for suicide.

SAMHSA's report also outlined some of the major challenges related to increases in call volume to the Lifeline and the capacity challenges to answer all calls rapidly. For example, in 2018, there were 2.2 million calls answered by the 165 crisis centers within the Lifeline network, a number that has been increasing at a rate of about 15 percent per year.

One of the advantages of the Lifeline is, unlike 911 or 211, there are national backup centers that can answer a call if a local crisis center cannot. However, the more calls going to the backup centers, the longer it takes to answer calls. The local center's average time to answer a call is 44 seconds. For the national backup center's it is almost two minutes, 116 seconds. There are some states where many of the calls are not answered locally and go directly to the backup centers.

Regarding call volume, there are a number of factors to consider. First, the Lifeline number is ubiquitous on the internet. Second, call volume tends to spike and hold after increased media attention to suicide. After Robin Williams' death, suicides rose dramatically, and Lifeline calls increased 300 percent, creating a profound struggle to answer the increased call volume. On a positive note, the rapper, Logic, produced a song using the Lifeline number as its title and was nominated for a Grammy, garnering much attention for the Lifeline. Funding for the Lifeline increased in 2019 from \$7 million to \$12 million.

The report informed the FCC on the advisability of having a standalone N11 or whether it should be merged with 911 or 211. The FCC is responsible for considering and reporting on either extending or repurposing all of the numbers from 211 to 911, to analyze, and make recommendations, taking into account SAMHSA and VA recommendations.

After the VA and SAMHSA filed their reports with the FCC in February, the FCC asked for an additional report due in early May from the North American Numbering Council (NANC), which is a Federal Advisory Committee. NANC will weigh in on the cost implications, disruption, as well as advantages and disadvantages of making a change to numbers 211 to 911. Once the FCC honors its congressional deadline of August 2019, Congress will decide how they will handle this issue, which has tremendous implications for the National Suicide Prevention Lifeline.

In conclusion, SAMHSA reported that an N11 number for suicide prevention has the potential for being a transformative step for crisis services in the United States.

## **DISCUSSION**

The steep increases of suicidal ideation among elementary school-aged children and suicidal attempts in indigenous communities is alarming and of great importance to the Council. Dr. McKeon stated that though there is not much data on children, the Lifeline runs a chat service used by a population younger than those using the Lifeline. The proportion of people who are trying to access the Lifeline by chat report greater frequency of suicidal ideation than the callers, (i.e., 25 percent of Lifeline callers are actively suicidal at the time of the call). There is some data on children provided by a few of the backup centers, which could be given to the Council.

Dr. McKeon also explained that SAMHSA's Garrett Lee Smith Youth Suicide Prevention grants have gone to all 50 states. Data show the rates of youth suicide in counties that implement activities, supported through these grants, have leveled out while matched counties without the activities report a significant rise. That effect continues for about a two-year period after the activities and appears to be directly connected to years of continued funding. The Native Connections program has been rapidly growing as well, with over 170 tribal grants now addressing suicide in tribal communities.

Dr. Embry, reported that the Good Behavior Game (GBG) reduces suicidality. GBG is not related to bullying but rather an increase in prosocial interactions between the young people. Further, it significantly reduces violence in schools. He suggested that the Council might want to explore promoting the GBG.

Dr. Adelsheim stated that the CDC's most recent report on suicides in indigenous communities made a primary recommendation for expanded school mental health-related services. He suggested that when SAMHSA considers additional Project AWARE funding, it should specifically consider a telehealth expansion for rural schools with an indigenous focus. He also requested that the Council be shown the expanded data around children and adolescents.

Dr. Adelsheim commented that the Director reported on the difficulties surrounding access to care, yet did not mention the 92 percent treatment gap for the teen/adolescent substance abuse the almost 59 percent treatment gap for youth ages 12 to 18 experiencing major depression.

Dr. Aguilar-Gaxiola stated a recent NIH report revealed that one-third of children ages 10 to 12 who were screened for suicidal thoughts and behaviors in emergency rooms had suicide risks. Further, there is evidence that between 2008-2017, there has been a substantial rise in the suicide rate for this age group. Dr. Adelsheim added that there is increasing data on the benefits of follow-up calls for anyone with suicidal ideation who is discharged from an emergency department. He suggested that beyond a crisis line, there could be crisis follow-up lines or some other vehicle to effectively build in protocols over time.

Dr. McKeon stated that SAMHSA strongly agrees and referred to ED-SAFE and SAFE-ED, two recent studies showing that post-emergency department follow-up calls played a significant role in reducing suicide attempts over the months following discharge.

Further, SAMHSA has a requirement in all suicide prevention grants that follow-up be provided and is considering how this can best be promoted and sustained over time. Dr. McKeon noted the praise-worthy commitment of some crisis centers to incorporate follow-up into their process even though they receive no funding to do so. He assured the Council that the report to the FCC included the critical nature of follow-up after people leave emergency rooms and in-patient units.

Dr. Unutzer added that there is a strong emerging evidence base about what kind of follow-up measures are helpful, such as caring letters and caring texts and the accompanying ongoing studies. He stated that just as there is much variation across communities regarding call capacity, there is likely much variation in follow-up.

Dr. Embry suggested the Council study these issues and report back to SAMHSA with recommendations rather than reflecting on issues “after the fact.” He personally volunteered to conduct such a study. Dr. Everett mentioned the idea of a workgroup made up of NAC members that works with CMHS on such projects.

Dr. Everett added that she has met with Dr. McKeon to strategize on increasing national attention on suicide, improving the crisis response system, and funding things that are outside the normal protocol. She asked the Council to weigh in on the potential for primary care to be a part of the follow-up process since half of the people that die by suicide have had interface with their primary doctor in the weeks prior.

Dr. Unutzer stated that though the primary care setting is suitable for most people, especially those in rural areas, there are other places that are important to consider such as the school setting. However, the access to the right kind of specialty care can be very challenging. Further, primary care physicians need support and backup before they will be willing to get involved. For example, a few states provide backup from a child psychiatrist for pediatricians or family doctors when they see a child who has thoughts of suicide or some other serious mental health or substance use problem. Currently the backup is available during business hours, but state legislative funding is moving to 24/7 backup this year. Thanks to the affordability of telehealth, they are working towards having the capacity for the psychiatrist to see the child presenting to the primary physician immediately.

Dr. Raney concurred, noting the 20 grants from HRSA for child psychiatry access programs and suggested that perhaps they could be coordinated with a child access line. She also commented on her frustration that though primary care uses the PHQ-2, which is the abbreviated depression screen, it is question nine on the PHQ-9 that screens for suicide. Dr. McKeon supported this assessment and referred to the research findings on the use of this screening tool, noting although suicide risk is most frequent among those with depression, there is an increased risk of suicide across virtually all mental health conditions.

Dr. Aguilar-Gaxiola asked Dr. Everett to elaborate on the Family and Suicide part of her presentation and on settings beyond schools for screening preteens. Dr. Everett deferred to Dr. McKeon who stated that the purpose of the toolkit was to provide family members with information on what to do when a loved one is thinking about suicide, has made a

suicide attempt, or has died by suicide; however, it does not address hospitalization and discharge. The product should be finished by the end of the fiscal year and will then go through the clearance process. Dr. Everett noted that SAMHSA is looking into the possibility of leveraging the mental health block grant, which goes to every state, to interface with crisis services.

Dr. Larson explained that SAMHSA is partnering with the American Academy of Pediatrics to develop a guide for pediatricians and other pediatric primary care providers, (e.g., nurse practitioners and physician assistants), on screening for suicide in pediatric primary care settings and how to handle a positive screen.

Dr. Agilar-Gaxiola commented that the strongest predictor of premature aging, development of current health conditions, and early onset mental illness is any kind of abuse, domestic violence, neglect, as well as suicide in the family or attempted suicide. Therefore, detecting these problems as early as possible and bringing awareness is key. Dr. Adams concurred and asked for consideration of direct training for parents to know the power they have to keep kids safe. For example, the Statewide Family Network in Kansas is planning a three-day retreat for families entitled, “Family and Culture Matters in the Prevention of Youth Suicide” to be held during Children’s Mental Health Awareness Week. The retreat will provide suicide prevention information to parents and highlight the power of the family. In addition, a guide for parents on the power of the family, traditions, and culture is being developed.

Ms. Tamplen supported a national three-digit number for suicide prevention and suggested involving attempt survivors in the toolkit, the training, and the follow-up outreach, including the calls. For instance, California call centers train and engage people with lived experience, which is incredibly valuable in connecting with someone in a profound state of hopelessness. Further, the California Mental Health Services Oversight and Accountability Commission is focused on creating a statewide strategic plan on suicide prevention that involves peer support. Regardless of the setting, when a peer specialist is given meaningful roles to reach out and support someone, positive results are achieved.

### **Public Comment**

.Ms. Foote noted there were no public comments submitted.

### **Future Meetings**

Dr. Everett asked for feedback about the style of the meeting, future activity around how the Council members prefer to interact and provided the function of the SAMHSA NAC.

Dr. Everett noted the CMHS NAC has a similar broad scope of approving grant funding and providing some oversight for the grant process as well as input on major problems facing the nation with regards to mental health and the mental health service needs of adults and children. She reiterated that members had expressed interest in an ongoing workgroup focused on suicide and the emerging problem of young children suffering

from suicidal ideation and encouraged members to share their ideas after commenting on the structure of the meetings.

Drs. Adelsheim, Patton, and Embry expressed disappointment over the cancellation of the in-person meeting planned for February noting the loss of multiple opportunities to interact with each other and to have greater coordination on projects that are taking place within CMHS as well as those happening nationally. Members confirmed that meeting in-person twice a year is not too much of a burden.

With a broad representation of skills and talent, the Council's purpose is to support CMHS "with the maximum amount of useful knowledge that could be easily applied to leverage change," according to Dr. Embry. Further, it would be very valuable for those with interest and expertise to develop working papers for CMHS via workgroups and phone calls between meetings.

Ms. Tamplen noted that before joining the CMHS NAC, she was on the Consumer Subcommittee, which allowed for a pre-meeting and the input of consumers and family members from across the country.

Dr. Aguilar-Gaxiola asked Dr. Everett to speak to how things were done in the past and what support is needed from the Council. Dr. Everett stated that the tradition has been to have bi-annual in-person meetings, lasting one to one and one-half days. Each center meets with its own NAC and then members could also attend the SAMHSA NAC meeting. However, the government shutdown, though not directly affecting SAMHSA, did affect some of the departments that support the work, (e.g., the Federal Registry), and caused a delay in the meeting schedule. Further, SAMHSA has been experimenting with virtual meetings and trying to discern the value of meeting in person versus virtual. Dr. Everett acknowledged the strong input from the members that in-person meetings are preferable, which was punctuated by input of more members who added that in-person meetings also allow for individual meetings with key staff that are working in their area of expertise.

Dr. Everett asked the Council to weigh in on the format of the meeting, noting the goal was to receive their valuable input as well as give them something of value in return. For example, she selected Dr. McKeon to speak because suicide is an area of interest to each member and the current work has the potential to change the national landscape. She wants her senior staff to be actively engaged in NAC meetings because of their experience. Council members were asked for their input on shaping future agendas and the following questions posed to the Council were:

- What content would be helpful and beneficial;
- Are members interested in more presentations like Dr. McKeon's;
- If so, would they like the content to be categorized and presented by population, by grant programs, etc.; and
- Would conducting a gap analysis on what is and what is not being done and what is not proven to be helpful?

Mr. Patton noted all would be helpful, adding that the input from people with lived experience is very important and should always be represented at NAC meetings. Dr. Embry suggested posing questions to the NAC in advance of the meeting, which would allow the Council to be more effective in supporting CMHS. Mr. Patton concurred.

Dr. Adelsheim pointed out that decreasing the six-hour meeting to two hours limits the exchange of information. For example, he would have liked to hear more from Dr. Larson on implementation regarding mental health in schools. Further, if attending the broader SAMHSA NAC is no longer an option, there needs to be another way of understanding how CMHS activities and funding may overlap with the activities of the other Centers or with the efforts of the Assistant Secretary's Office and how budget cuts might impact CMHS.

### **CLOSING REMARKS**

Dr. Everett closed the meeting, thanking Council Members for their expertise and her hopes for a successful and long-standing future that will be beneficial to all, but most especially to the patients, consumers, and clients that are served. Dr. Everett noted the next CMHS NAC meeting will be held in August and invitations are forthcoming.

### **ADJOURNMENT**

Pamela Foote thanked everyone and the CMHS NAC meeting adjourned at 12:55 p.m.