
**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 5W11
Rockville, MD

August 1, 2018**

Chairperson

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

Designated Federal Official

Pamela Foote, CMHS

Council Members Present

Steven Adelsheim, M.D.

Michael Biasotti, M.A.

Dennis Embry, Ph.D.

Jeffrey Patton, M.S.W.

Wenli Jen, Ed.D.

Stacy Rasmus, Ph.D.

Jeremiah Simmons, M.P.H., M.S.

Jürgen Unützer, M.D., M.P.H.

Ex-Officio Council Members Present

Wendy Tenhula, Ph.D., Veterans Affairs (VA)

Ex-Officio Members Not Present

Elinore F. McCance-Katz, M.D., Ph.D., SAMHSA

Joshua Gordon, M.D., Ph.D., National Institute of Mental Health, (NIMH)

Robert K. Heinssen, Ph.D., NIMH

Alfred Ozanian, Ph.D., VA

CMHS Staff Present

Cyntrice Bellamy, M.S., M.Ed., Director, Division of State and Community Systems Development (DSCSD)

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

LT. CMDR. Alexia Blyther, Public Health Advisor, State Grants Western Branch, DSCSD, CMHS

CDR Carlos Castillo, ACSW, LCSW, BCD, Committee Management Officer, Office of Policy, Planning and Innovation

David de Voursney, Branch Chief, DSSI, Community Support Programs Branch, CMHS

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, CMHS
Dorrine Gross, Public Health Advisor, DSSI, Homeless Programs Branch, CMHS
CAPT David Morrissette, Ph.D., L.C.S.W., Office of the Chief Medical Officer (OCMO), SAMHSA
Arne Owens, M.S., Principal Deputy Assistant Secretary for Mental Health and Substance Use, SAMHSA
Tanya Gunn, Public Health Advisor, State Grants Western Branch, DSCSD, CMHS
Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS, SAMHSA
Anne Mathews-Younes, Ed.D., D.Min., Acting Deputy Director, CMHS
Richard McKeon, Ph.D., Chief, Suicide Prevention Branch, CMHS
Ilze Ruditis, M.S.W., CAPT, U.S. Public Health Service, Senior Project Officer, DSSI, CMHS
Tison Thomas, Branch Chief, DSCSD, State Grants Eastern Branch, CMHS
Luis Vasquez, L.I.C.S.W., Division Director, DSSI, CMHS

Other Attendees

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

Open Session

WELCOME

Paolo del Vecchio, MSW, Director, CMHS; Chair, CMHS NAC

Mr. del Vecchio welcomed the CMHS NAC members and guests to the open session of the meeting.

CMHS Director's Report

Paolo del Vecchio, M.S.W., Director, CMHS; Chair, CMHS NAC

Mr. del Vecchio began by asking for a motion to accept the February 2018 meeting minutes. The motion was made by Mr. Patton and seconded by Dr. Embry.

SAMHSA's top three ongoing priorities, in accordance with the 21st Century Cures Act, are to address serious mental illness (SMI), opioid overdose and misuse, and rising suicide rates. SAMHSA is currently exploring the possibility of establishing a nationwide three-digit suicide hotline number and is also focused on addressing school mental health (especially regarding school shootings) and traumas resulting from family separations at the border. SAMHSA continues to help provide mental health services to people who have experienced natural disasters such as the hurricanes in Puerto Rico and U.S. Virgin Islands.

Compared to the enacted CMHS budget for fiscal year (FY) 2018 the proposed President's Budget for FY19 has been reduced by \$422,089,000, including one million for Certified Community Behavioral Health Clinics (CCBHCs). The FY19 Presidents Budget would expand the Criminal and Juvenile Justice Programs and Assertive Community Treatment (ACT) for

Individuals with SMI. The following programs are eliminated from the FY 19 President's budget- Project AWARE, Mental Health First Aid for Veterans' Families, Primary and Behavioral Health Care Integration, the Minority Fellowship Program, Minority Aids, and Infant and Early Childhood Mental Health.

CMHS has undergone several personnel changes. Mariel Lifshitz has joined the staff as Mr. del Vecchio's Special Assistant. The following staff have left CMHS, Gilbert Thompson, Keris Myrick, and Ingrid Donato..

The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), which consists of representatives from 10 federal departments along with 14 subject matter experts, is helping to shape SAMHSA's work on SMI and serious emotional disturbance (SED). The ISMICC identified 45 recommendations across five priority areas: Data, Access, Treatment and Recovery, Justice, and Finance. Implementation workgroups were established for these areas, each of which has selected a subset of the 45 ISMICC recommendations for SAMHSA and other federal agencies to prioritize.

In addition to CCBHCS and ACT grants, CMHS has issued a call for up to nine grants to improve infant and early childhood mental health and these grants will focus on children from birth to age 12. New work also focuses on providing psychosocial supports to children at risk for psychosis. Closely related is CMHS's work on first episode psychosis, which now includes 250 programs across the country. CMHS is conducting research on referral and recruitment of individuals with first episode psychosis and is comparing them with incidence statistics to help assess what proportion of affected individuals are being served by current programs.

CMHS is currently managing a total portfolio of 551 grants and anticipates awarding 415 new grants in 2018. Among these are the development of Mental Health Technology Transfer Centers, including 10 regionally based grantees, Tribal and a Hispanic and Latino Centers and a national coordinating center. These centers are successfully adapting the model of Addiction Technology Transfer Networks to support technical assistance in mental health to the nation as well as SAMHSA grantees. CMHS is also awarding contracts to provide technical assistance, training, and coordination to several institutions, including the Center for Integrated Health Solutions, the Minority Fellowship Program Coordinating Center, and the Tribal Training and Technical Assistance Center.

Several special events during 2018 highlight mental health awareness, including the National Children's Mental Health Awareness Day, which this year focused on child trauma and honored several governors' spouses who have become leaders on this issue. A meeting was held in Rockville for National Older Adult Mental Health Awareness Day, with prominent clinicians, researchers, and peer leaders. In addition, the 13th Annual Voice Awards will be held at UCLA's Royce Hall on August 8.

Mr. del Vecchio finished his presentation with slides showing recent communication efforts, including the updated *After an Attempt* publication series on suicide prevention (also available in Spanish) and blog updates on Mental Health Awareness Month, National Older Adults Mental

Health Awareness Day, and Raising Awareness of PTSD Associated with Mass Violence or Natural Disasters.

Discussion

Mr. del Vecchio encouraged CMHS NAC members to provide recommendations for CMHS publications for FY 2019. Feedback focused on suicide prevention in tribal communities, tribal behavioral health initiatives, diverse culture-specific risk factors for mental health disorders, prevention guides for mental health therapists, and techniques to help children develop resilience.

Dr. Jen suggested that CMHS produce 15-minute videos to help young people develop coping skills and build resilience. This would enable students to find support discreetly in cases where stigma makes them hesitant to seek professional help. Dr. Jen also noted that, in the context of children's mental health, collaboration often fails between school counselors and other mental health professionals because of differences in expertise and professional terminology. Thus, CMHS should consider producing resources to help foster collaboration among mental health professionals with varied educational and experiential backgrounds.

Dr. Embry noted that, in the context of school safety and mental health, many simple behavioral strategies with immense therapeutic value have been demonstrated to decrease bullying and improve school climate but are seldom implemented. For example, assigning students to work as "door greeters" between classes keeps bullies out of the bathrooms and hallways where they can harass other students. Many similar strategies exist, and CMHS could produce resources to help educate schools about how to implement these strategies on a wider scale.

Dr. Tenhula recommended creating documentation that lists, in an accessible and easy-to-read format, well-established evidence-based practices along with the conditions they are effective in treating.

Given the country's rapidly changing demographics, Mr. Patton advocated for placing a greater emphasis on culturally sensitive messaging in publications. For instance, he suggested that future publications refer to "consumers" and "people being served" rather than continuing to use the term "patients."

Mr. Simmons recommended that CMHS create guidelines for working with immigrant and refugee children in school settings, targeted at different audiences (e.g., teachers, school psychologists). He suggested updating past documentation with new policy information to help schools approach these issues. It may even be useful to create an "App" that can be continuously updated that school personnel across the country can easily use. Mr. del Vecchio noted that CMHS is already following the approach of updating existing documentation on many issues, notably disaster relief products.

Dr. Unötzer advocated learning from caregivers' lived experience. For example, families who have raised a child with autism have knowledge that cannot be easily learned from mental health professionals. CMHS should compensate those families to share their knowledge and skills. He also explained that workforce retention should be a priority. People build skills in the mental

and behavioral health workforce, and when they leave their knowledge and skill goes with them. However, Dr. Unötzer also emphasized that these problems may not be best solved with only publications. If the goal is to facilitate real improvements in how mental and behavioral health supports are administered, CMHS should develop tools that clinicians and others can use in real time. Developing smartphone “Apps” may be a very fruitful new direction.

Dr. Adelsheim highlighted tribal suicide rates as an essential issue and reinforced Mr. Simmons’ earlier recommendation that cultural groups be targeted and engaged with more customized strategies and approaches. Dr. Adelsheim also noted the high mortality rate for people with first episode psychosis, suggesting that CMHS consider creating resources that explain the importance of critical brain development during adolescence.

Dr. Rasmus emphasized the need to reduce stigma around mental and behavioral health issues, and reinforced earlier suggestions about ensuring culturally and linguistically appropriate outreach to tribal and other minority communities, including when developing publications and other products. For example, tribal community members may not be responsive to approaches that “medicalize” their mental health struggles.

Dr. Rasmus also noted that health providers who fear HIPAA violations would sometimes ignore information provided by patients’ families. Mr. del Vecchio acknowledged this serious problem and noted that CMHS is developing products to help address it.

Interdepartmental Serious Mental Illness Coordinating Committee Update

*David Morrisette Ph.D., LCSW, CAPT, U.S., Public Health Service, ISMICC Coordinator,
Office of the Chief Medical Officer, SAMHSA
Discussant: Michael Biasotti, M.A., Member, CMHS NAC*

The ISMICC held its first two meetings in August and December 2017. By December, the non-federal members had published 45 recommendations for the federal members. ISMICC has been authorized to produce a report for Congress in 2021, but it is only empowered to make recommendations—it cannot implement them.

The ISMICC’s 45 recommendations are divided into five Focus Areas: Data, Access, Treatment and Recovery, Justice, and Finance.

SAMHSA appointed stewards to lead implementation workgroups for each Focus Area. In March, eight federal departments were invited to assign staff to the implementation workgroups. More than 50 staff from the various departments were assigned, all of whom participated in a daylong conference. The goal was to prioritize among the 45 recommendations. Below are each workgroup’s prioritized recommendations:

Group 1: *Data*

- 1.5** Evaluate the federal approach to serving people with SMI and SED.
- 1.6** Use data to improve quality of care and outcomes.
- 1.7** Ensure that quality measurement efforts include mental health.
- 1.8** Improve national linkage of data to improve services.

3.8 Develop a priority research agenda for SED/SMI prevention, diagnosis, treatment, and recovery services (in collaboration with Group 3)

Group 2: *Access*

- 2.1** Define and implement a national standard for crisis care.
- 2.2** Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization.
- 2.6** Prioritize early identification and intervention for children, youth, and young adults.

Group 3: *Treatment and Recovery*

- 3.1** Provide a comprehensive continuum of care for people with SMI and SED. The group committed to developing a standard continuum of care for SMI and SED, which includes cross-federal input.
- 3.2** Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation.
- 3.6** Make housing more readily available for people with SMI and SED.

Group 3 will also pursue more information on recommendation **3.7**: Advance the national adoption of effective suicide prevention strategies.

Group 4: *Justice*

- 4.2** Develop an integrated crisis response system to divert people with SMI and SED from the justice system.
- 4.6** Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail.
- 4.8** Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities.

Group 4 will also pursue more information on recommendations:

- 4.4** Establish and incentivize best practices for competency restoration that use community-based evaluation and services, and
- 4.7** Strictly limit or eliminate the use of solitary confinement, seclusion, restraint, or other forms of restrictive housing for people with SMI and SED.

Group 5: *Finance*

- 5.1** Implement population health payment models in federal health benefits programs.
- 5.3** Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.
- 5.5** Pay for psychiatric and other behavioral health services at rates equivalent to other health care services.

With the ISMICC, SAMHSA received additional funding, which has enabled 11 Expert Panels meetings covering many topics, including an ISMICC Federal Staff Orientation, Working with Faith-Based Communities, Comprehensive Crisis Services, and Best Practices in Statewide Real-Time Crisis Bed Registries. Deliverable products are expected from each Expert Panel and meeting, and the SAMHSA website now contains an ISMICC webpage where products can be shared.

Capt. Morrisette highlighted the four main areas of federal programs included in the ISMICC federal inventory, which are specified to facilitate interdepartmental coordination: (1) service delivery or payment, (2) program grants, (3) data collection, and (4) research and evaluation.

Discussion

Mr. Biasotti expressed appreciation for the quick emphasis on implementation and noted the challenges that accompany practical implementation at the local level, especially because different states adopt different approaches. For example, while some states require all counties to implement a policy, other states allow individual counties to opt out, creating inconsistencies that make it difficult to achieve standardized and comparable results. Mr. Biasotti also endorsed programs that link local law enforcement with county mental health departments (e.g., required de-escalation training for all new police officers).

Dr. Unützer agreed, adding that, for example, crisis intervention training and similar efforts should be ongoing so that local law enforcement officers maintain the skills that are important to handling crises that arise from mental and behavioral health problems in the community. Dr. Jen relayed an anecdote from Southern California in which an individual experiencing a crisis and holding a hammer in a hotel lobby was shot dead because police were not adequately trained to handle the situation. Mr. Biasotti noted that implementing standards at the level of local law enforcement should not be modeled on large police departments such as the NYPD or LAPD, which are vastly larger than most local police departments.

SAMHSA Update

Arne Owens, M.S., Principal Deputy Assistant Secretary for Mental Health and Substance Abuse

Mr. del Vecchio introduced Mr. Owens, who recently returned to SAMHSA after spending time on Capitol Hill as a Health Policy Advisor for Senator Bob Corker of Tennessee and Senator David Vitter of Louisiana, and as Global Health Policy Advisor for the Senate Committee on Foreign Relations.

Mr. Owens briefly explained the legislative background to the 21st Century Cures Act, including several preexisting bills (e.g., The Mental Health Reform Bill) that were absorbed into the final legislation. He emphasized that people in Washington, DC, particularly on Capitol Hill, need input from professionals in the mental health field working at the local level, and expressed appreciation to CMHS NAC participants for making themselves available to SAMHSA for consultation.

Because of the Cures Act, SAMHSA has gained in prestige, for example through the establishment of an Assistant Secretary for Mental Health and Substance Use position.

SAMHSA is now able to hire more physicians, including four psychiatrists and a Chief Medical Officer. The Cures Act also established the National Mental Health and Substance Use Policy Laboratory, intended to be an “innovation hub” to collect, incubate, and evaluate new ideas.

In addition, and in accordance with the Cures Act, SAMHSA is writing a comprehensive Strategic Plan. SAMHSA’s two main priorities are to deal with the opioid crisis and to address SMI/SED. The SED focus is connected to the President’s Federal Commission on School Safety. The overarching goal is to create a mental health system that works for everyone who lives with SMI/SED and for his or her families. According to 2016 statistics, more than 11 million adults live with SMI and 35 percent receive no treatment. Partly because of this problem, Congress had added funds to address SMI and created the ISMICC. This Federal Advisory Committee is to report on advances in research on SMI and SED related to prevention, diagnosis, intervention, treatment and recovery, and access to services and supports; evaluate the effect federal programs related to SMI and SED have on public health, including outcomes across a number of important dimensions; and make specific recommendations for actions that federal departments can take to better coordinate the administration of mental health services for adults with SMI or children with SED.

SAMHSA does not provide direct services, but it does provide resources—it contributes information and funding to service providers. SAMHSA recently established a new Evidence-Based Practices Resources Center, which is now operational and accessible through the SAMHSA website. This resource is intended to help clinicians and other mental health professionals in the field access evidence-based practices and implement them to improve patient outcomes. Similarly, SAMHSA is currently financing and establishing 10 regional Mental Health Technology Transfer Centers, a Tribal and Hispanic and Latino Center as well as a National Coordinating Center.

Discussion

Mr. Patton noted that his institution in Kalamazoo, MI, is participating in SAMHSA’s technical assistance program, which offers strategic planning for his county regarding veterans’ services. The effort has been very successful so far, and Mr. Patton expressed appreciation to Mr. Owens for SAMHSA’s assistance.

Dr. Embry raised a concern about the standard of evidence used to designate an “evidence-based” practice. He pointed out that this standard should be clearly and openly defined, because high-quality science may be disregarded, or low-quality science may be admitted, depending on how that standard is defined.

Dr. Unötzer raised concerns about the cost of training psychiatrists. Given the lack of public funds for doing so, many psychiatrists choose to open private practices rather than offering public sector psychiatric services. Dr. Unötzer suggested that a relatively small investment of public funds for training psychiatrists could help alleviate some of the mental health work force challenges.

The discussion closed with Dr. Embry emphasizing the need to ask what is *causing* the rise in mental health disorders across the United States. There appears to be a pervasive increase in

behavioral and mental health problems, including among schoolchildren, and SAMHSA's focus should be not only to improve treatment, but also to attempt to understand and address root causes. Mr. Owens agreed that this is a crucial question. He also noted that, as a government agency, with funding directed by Congress for specific programs, SAMHSA's role is in many ways constrained to dealing with downstream effects.

Lunch—Reports from the Field

Paolo del Vecchio, M.S.W.

Mr. del Vecchio introduced the informal lunch break session, "Reports from the Field."

Mr. Patton informed the group that the keynote speaker at this year's annual Mental Health Breakfast at the Kalamazoo Community Mental Health and Substance Abuse Services Center was Mr. del Vecchio. Mr. Patton thanked Mr. del Vecchio for his presentation and relayed to the CMHS NAC that his speech received a rousing standing ovation. Mr. del Vecchio thanked Mr. Patton for his work in Kalamazoo. During his visit, Mr. del Vecchio received a tour of the brand-new facility, which included both a walk-in crisis center and an outpatient clinic.

Dr. Unützer described a program in his home state (Washington) intended to fill gaps in its mental and behavioral health workforce, including partnering with community colleges to help advance psychologist and psychiatrist training efforts. Dr. Unützer's team at the University of Washington hopes to establish programs focused on interventions for first episode psychosis (FEB) and he noted that much of the rural population in Washington does not have access to FEP programs. He noted that recently Washington's state hospital lost CMS funding, so care providers in the state are trying to devise alternatives for care delivery.

Dr. Tenhula explained that the Office of Mental Health and Suicide Prevention in Virginia is focusing on suicide prevention and has adopted a "public health model" to combat the increasing suicide rates among veterans. Of every 20 veterans who die by suicide, 14 have not received care. It is evident that at-risk veterans need proactive assistance.

Clinician training programs in Virginia for Master's level clinicians, previously under-utilized, are being expanded. Efforts to provide mental health services in primary care setting are also increasing.

Dr. Adelsheim noted that the Stanford University School of Medicine intends to build a data collection site support network.

Another area of emphasis is the media attention and portrayal of suicide. Efforts are coalescing to offer guidance to media outlets about how to portray suicides in ways that does not contribute to further attempts. The mental health community has written guidelines for media reporting on suicide, which are reportedly seldom followed. The present aim is to inculcate a shared sense of responsibility among community mental health leaders and the media. Dr. Embry suggested that media outlets that report on suicides in accordance with guidelines should be highlighted with gratitude.

Report from Subcommittee on Consumer Issues

Jeffrey Patton, M.S.W., Chair, Subcommittee on Consumer and Family Issues; CMHS NAC

Mr. Patton summarized the agenda from the previous day's Subcommittee on Consumer Issues meeting. The meeting reviewed the ISMICC recommendations, discussed previous subcommittee feedback and generated Sub Committee recommendations for implementing ISMICC priorities.

Among other issues discussed during that meeting were refugee and immigrant populations, including the need for federal institutions to distinguish refugees from immigrants in official definitions and policy to ensure that each group's needs are met and to provide trauma-informed care for families separated at the border.

Mr. Patton then reported the following recommendations to the NAC:

Recommendation 1: Address barriers to employment for adults living with SMI and youth with SED.

- a. Encourage ISMICC collaboration with relevant federal partners to address the exclusion from certification and employment of adults, young adults, caregivers, and youth who have a criminal justice history.
- b. Encourage discussion with the CMS (and with Departments of Justice and Labor) regarding opportunities to waive federal regulations or policies that limit persons with SMI or youth with SED who have a criminal justice history from employment, including and not limited to substance use convictions.

Recommendation 2: Discuss with CMS and the Department of Housing and Urban Development waiving regulations and policies that prevent the use of Medicaid funds for short-term room and board for persons with SMI and SED.

People with SMI often do not have access to safe and affordable housing. They are often placed in homeless shelters or for a prolonged stay in inpatient settings because they are unable to secure appropriate housing options. This lack of housing can further increase barriers to employment and limit community integration.

Recommendation 3: Develop and finalize a recovery measure for people with SMI that address quality of life, health, and mental health outcomes, employment, and social supports.

Recovery-related factors are actions and events that tend to be correlated with recovery, even though consumers may not necessarily associate them with their own personal journey. Recovery related factors can be an indicator or marker of recovery growth. Utilizing and linking additional federal data sets would help determine new recovery-related factors (processes) or outcomes that might be mediated by peer-supported activities. The linkage of additional federal datasets can also help identify new relationships between peer-supported activities and outcomes.

Mr. Simmons, who was responsible for Recommendation 3, emphasized that, by bringing together several federal agencies, the ISMICC provides an opportunity for data linkage that might be used to identify recovery predictors and previously unknown relationships between recovery-related factors and outcomes. He would like to know which currently validated measures are used to investigate recovery-related outcomes, and to use that data to test peer-mediated outcomes.

Dr. Embry relayed a strategy used by the Meth Free Alliance in Tucson that involved faith-based communities to help improve patient engagement in recovery through community reinforcement and family training at a relatively low cost. Mr. del Vecchio noted that using recovery coaches and peer specialists has likewise shown higher engagement in treatment and recovery while also eliminating some coercive practices that can drive people out of treatment.

Regarding Recommendation 2, Dr. Unützer wondered whether any notable positive examples could be highlighted where housing is adequately provided. No clear examples emerged, but Dr. Embry directed the NAC members' attention to a range of existing literature documenting randomized controlled trials data that show housing improvements are linked to patient outcomes. Mr. Patton reemphasized the scope of the housing shortage for psychiatric patients in Michigan—even available housing is often neither affordable nor safe.

Addressing Disparities: Minority Fellowship Program and Minority AIDS Initiative

LT. CMDR. Alexia Blyther, Public Health Advisor, State Grants Western Branch, Division of State and Community Systems Development (DSCSD); Tanya Gunn, Public Health Advisor, State Grants Western Branch, DSCSD, CMHS; and Ilze Ruditis, M.S.W., CAPT, U.S. Public Health Service, Senior Project Officer, Division of Service and System Improvement, CMHS
Discussant: Wenli Jen, Ed.D., Member, CMHS NAC

Minority Fellowship Program

LT. CMDR. Blyther explained that the Minority Fellowship Program (MFP) aims to reduce health disparities and improve health care outcomes of racially and ethnically diverse populations by increasing the number of culturally competent behavioral health professionals available to underserved populations in the public and private nonprofit sectors.

The MFP helps SAMHSA to increase practitioner training and development. Its goals and objectives are to:

- increase the number of trained professionals,
- reduce behavioral health disparities,
- improve outcomes for ethnic minorities,
- provide financial support for MFP Fellows,
- provide an outline of training opportunities,
- provide resources to MFP Fellows, and
- collect program data to validate the MFP.

Public or private nonprofit professional organizations in the following fields are eligible to apply to the MFP: psychiatry, psychology, nursing, social work, counseling, marriage and family therapy, and substance abuse.

For academic years 2015-2018, 659 MFP Master's program fellows were funded. The traditional MFP Doctoral program has existed since 1974. In FY 2018, the total MFP funding allotment is almost \$10 million. SAMHSA anticipates awarding seven grants at approximately \$6,833,156 for each of the five years.

The MFP Master's program increases the mental health services workforce committed to addressing the behavioral health needs of at-risk children, adolescents, and young adults and provides specialized training to professionals who will focus their services on underserved minority youth.

The MFP Doctoral program provides specialized training to doctoral-level mental health psychiatrists, nurses, social workers, counselors, marriage and family therapists, and psychologists to improve services provided in underserved minority communities. The MFP-Ph.D. initiative has resulted in a significant increase in the number, capacity, and multidisciplinary minority leadership throughout the behavioral health professions.

MFP Fellows are expected to meet program goals, maintain program funding, strengthen their foundation, give back to the MFP community, promote the MFP, and participate in the MFP community of learning.

Ms. Gunn manages the technical assistance contract through the Minority Fellowship Program Coordinating Center (MFPCC), which supports MFP grantees and fellows through the following key functions:

- developing and presenting training webinars
- developing and publishing the MFP newsletter
- maintaining and updating the website and MFP fellow directory
- managing the MFP listserv
- conducting the annual program survey
- maintaining the MFP resource database
- providing technical assistance

Minority AIDS Initiative

Capt. Ruditis explained that the Minority AIDS Initiative (MAI) began in 1999. She emphasized that HIV/AIDS could be eliminated with current knowledge, but only through proactive health programs such as those housed at SAMHSA. One key component of combating HIV/AIDS is to implement early testing and to begin treatment regimens as soon as possible. These actions can help prevent devastating treatment complications.

The pre-exposure prophylactic (PrEP) drug Truvada is an important antiviral medication that can protect individuals from contracting HIV/AIDS. For people living with HIV, HIV Treatment as Prevention (TASP) can prevent transmission and reduce the viral load to undetectable levels.

Across these efforts, it is crucial that health care providers coordinate efforts to ensure that patients are never turned away from treatment, regardless of how they enter the care system.

SAMHSA's efforts align with the National HIV/AIDS Strategy (NHAS) and the National Viral Hepatitis Action Plan. The NHAS has four goals: (1) reducing new HIV infections, (2) improving health outcomes for people living with HIV, (3) reducing HIV-related disparities, and (4) advancing developmental indicators, including reducing HIV stigma and addressing HIV among transgender persons.

Rates of HIV and other blood-borne infections have remained higher for individuals with SMI. Mental health disorders can also interfere with HIV treatment. Racial and ethnic minority communities continue to experience disproportionate impacts of HIV. Hepatitis B and C infections are also increasing in prevalence, fueled in many communities by the opioid epidemic.

Data on the HIV Continuum of Care (CoC) program shows that many patients diagnosed with HIV do not seek care. Ongoing efforts must therefore help to close that gap. SAMHSA's grants prioritize HIV prevention and treatment, particularly for high-risk populations, including minorities and young men who have sex with men, transgender and other minority community members, and individuals with substance use disorder, mental illness, and co-occurring disorders (COD).

MAI-CoC expands and strengthens capacity to provide mental and substance abuse disorder treatment and prevention services in minority communities, particularly for people with (or at high risk for) mental and substance use disorders and HIV/AIDS. From 2014 to 2017, MAI-CoC helped 10,000 individuals in high-risk communities receive mental and substance use disorder treatment and prevention services with integration of HIV and hepatitis prevention and care.

Program data from 2017, compared to baseline, showed several successes: 65 percent of patients showed improved overall functioning, while the proportion of patients with permanent housing increased by 11 percent, the proportion currently employed or enrolled in school increased by 17 percent, and the proportion reporting no involvement with the criminal justice system increased by 4 percent.

The MAI-CoC program will conclude in February 2019. It will be replaced by a slightly refined effort (MAI Services Integration [MAI-SI]) that will focus on individuals with SMI, especially those at high risk for HIV and hepatitis in minority communities. The program will aim to reduce HIV incidence and improve overall health outcomes for individuals with SMI or SMI/COD.

Discussion

Dr. Jen described efforts in Southern California to recruit and retain minority students into the behavioral and mental health workforce. These efforts focus on developing networks of young minority professionals and training them to help reduce disparities. For example, the "mock network mixer" helps students learn how to engage in small talk with others in the field and to describe their work and interests in a semi-professional social setting.

Dr. Embry noted that MFP fellows are currently only permitted to work for nonprofit organizations, which unnecessarily limits their opportunities and their contributions.

Dr. Jen recommended that MFP fellows be encouraged to serve cross-culturally to avoid their developing “tunnel vision.”

Improving Mental Health in Schools

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

Discussant: Dennis Embry, Ph.D., Member, CMHS NAC

Dr. Larson explained that, given the disproportionate amount of time children spend at school, integrating mental health services into schools is vital to improving access to care. School staff are often the first people to identify a potential mental health problem in children, and more than 70 percent of youth who receive mental health services do so in educational settings. Retention rates are often higher for school-based mental health services than for community services generally.

The Wisconsin School Mental Health Framework is represented as an equilateral triangle resting on the ground. The ground represents the foundational integration of mental and behavioral health services with schools. The triangle is divided into three layers: the largest layer at the triangle’s base represents services that apply to all students; the middle layer, services that apply to at-risk students; and the narrowest top layer, services that apply only to the most acute and severe cases, where individual-level treatment is needed. A similar paradigm is the Multitiered System of Supports (MTSS) concept, which emphasizes that as the number of students who fall into each ascending level of care gets smaller, the effort and resources required by community partners to aid in treatment becomes progressively larger.

In March 2018, President Trump appointed Betsy DeVos to lead the Federal Commission on School Safety. The commission includes the departments of Education, Justice, Health and Human Services (HHS), and Homeland Security. The commission will deliver a report to President Trump in October 2018.

HHS hosted a commission meeting focused on expanding the mental health workforce in schools, providing training and technical assistance for school-based clinicians, assuring that stakeholders in schools are equipped to understand and support children’s social and emotional development, and improving standards and quality metrics. Concerns were raised regarding HIPAA/FERPA regulations impeding communication between patients and their care providers. Lawyers tend to advise physicians to be cautious regarding HIPAA violations, so hospital and school lawyers may require further education regarding patient-caregiver communication to remove barriers.

SAMHSA has also hosted several expert panels on school mental health, including one in June titled, “Screening in Schools for Children and Adolescents: Effectiveness, Feasibility, and Response.” A resulting guidance document is in process. This effort aligns with the ISMICC Recommendation 3.2: “Make screening and early intervention among children, youth, transition-aged youth, and young adults a national expectation.”

Project AWARE, one of SAMHSA’s grant programs, enables school personnel across 20 states to receive training in Mental Health First Aid. The project has connected more than 100,000 youth to mental health services or resources. It has also led to improvements in social competency and academic performance, improved behavioral and emotional functioning, and access to care.

SAMHSA hopes these efforts will help to establish new norms, and that a “system of care” approach will become widely adopted and improve access and outcomes across the country.

Discussion

Referring to the rising rates of mental health disorders among children, Dr. Embry stressed that a school-based strategy for behavioral interventions may be the most effective. He highlighted that the main challenge is scaling up all these results from specific studies to the national level. Approaches that show special promise are interventions that involve real-time peer-interactions (e.g., the “good behavior game”). Positive Behavioral Interventions and Supports (PBIS), which has the resources to spread outcomes rapidly throughout the United States, could also help to increase training and support.

Dr. Embry offered several additional recommendations:

- Section 504 and Individualized Education Program (IEP) meetings should be empowered to produce actionable outcomes.
- Legislators in statehouses should be persuaded that investing in early interventions for mental and behavioral health would reduce long-term pressure on state budgets.
- NAC recommendations should be supported by high-quality science and convincing data, both to ensure effective interventions and to improve NAC credibility.

Dr. Jen described a program called *Gateway to Success*, operating in the Los Angeles area, which provides mental health services at schools. She also mentioned that, by leveraging local public health departments, funding alternatives to Individualized Education Programs (IEPs) can be obtained for services such as mental health screenings.

Dr. Larson noted that local heterogeneity poses challenges to expanding models to the national level. Mr. Patton and Dr. Larson discussed the need to balance general federal funding with mechanisms that account for local specificity. Dr. Larson emphasized that engaging state-level institutions is a crucial part of achieving that balance.

Several discussants noted that the many demands on teachers’ time preclude their ability to focus on mental health issues. In addition, a communication problem often exists between the education and mental and behavioral health professions. Many concepts do not translate naturally across those fields, so there is a need for resources to help professionals across disciplines communicate effectively.

Expanding on the issue of demands on teachers, Dr. Embry explained that the most motivating reward for teachers is to provide them with strategies and techniques that facilitate smooth

transitions throughout the school day, and attentiveness, engagement, and good behavior among their students. Many such techniques exist, but they must be more widely disseminated.

Dr. Adelsheim expressed his preference for the continuum of care, prevention, and intervention models rather than the pyramid models of school-based services; the continuum model is more inclusive and lowers the risk of leaving any children neglected by the system. Another challenge is that while services and supports are added to schools, physical space is not. This reality may be undermining program effectiveness. In addition, one priority should be to ensure that students clearly understand confidentiality rules and that those rules can allow them to speak candidly.

Mr. Patton stressed the need for school mental health staff to be indistinguishable from the rest of school staff. They should mesh with the school environment so that students feel comfortable using their services.

Preventing Suicide

Richard McKeon, Ph.D., M.P.H., Chief, Suicide Prevention Branch, CMHS

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

Dr. McKeon highlighted findings from the recently released Centers for Disease Control and Prevention study on suicide rates, which have been increasing in 49 states (the only exception is Nevada, which already had one of the highest suicide rates). Suicide rates have increased by 30 percent in half of states since 1999, and more than half of people who died from suicide did not have a known mental health condition. (Mental health data does not include substance abuse disorders or undiagnosed mental health conditions.) In 2016, nearly 45,000 Americans died by suicide.

A disproportionate number of suicides occur in rural areas, even though inflated urban populations mean overall suicide numbers are higher in cities. Rural suicides are connected as well to elevated suicide rates among American Indian and Alaska Native youth.

Data from the 2015 National Violent Death Reporting System (NVDRS), which includes 27 states and links suicides to contributing causes such as substance abuse, loss of housing, financial, criminal, and relationship problems, show that around two-thirds of suicide decedents were not in mental health treatment at the time of death. Data from the Mental Health Research Network Report show that within 12 months of suicide death, 83 percent of decedents had contact with health care, and of those, 45 percent received a psychiatric diagnosis.

SAMHSA is doing significant work in this area and yet suicide rates continue to increase. Most SAMHSA resources focus on youth and special populations, which are not where most suicides occur. Although evidence shows that suicide rates can be dramatically reduced when all known interventions are implemented, comprehensive implementation remains a serious challenge. Inadequate state and community infrastructure also prevent adequate mental and behavioral health services from fully implementation. Access to comprehensive crisis services are also absent across many states.

SAMHSA’s focus on addressing SMI and SED, and on incorporating suicide prevention as an integral part of these efforts, is crucial to address these challenges. SAMHSA is working to strengthen state suicide prevention efforts through the Garrett Lee Smith grants, National Strategy and Zero Suicide grants. The ISMICC Recommendations 2.1 and 2.2 call for establishing national crisis standards and comprehensive community crisis systems, which align with the broader need to improve crisis services to help prevent suicides. The pending passage of the National Suicide Prevention Hotline Improvement Act could also substantially contribute to these efforts. The National Suicide Prevention Lifeline answered 2 million calls in 2017, and efforts continue to ensure that call centers are adequately staffed.

SAMHSA is also focused on areas where many suicide decedents drop out of the health system, including emergency departments. The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) study demonstrated that telephonic follow-up led to a reduction in suicidal behavior for suicidal people discharged from the ED. In addition, tribally mandated reporting and follow-up for individuals exhibiting suicidal thoughts or behavior led to a 40 percent reduction in suicides among the White Mountain Apache tribe from 2006 to 2012. SAMHSA evaluation studies show that telephonic follow-ups can be highly effective in preventing suicide.

The general need is to implement “air traffic control” models (including call center hubs, mobile crisis services, and crisis facilities), which ensure that patients are never lost in the system because institutional responsibility is always clearly assigned for every individual registered in any crisis system.

Discussion

Dr. Rasmus emphasized the need to separate state-level statistics into smaller localities, because rising suicide rates for a large area may be in specific locations or within specific communities, which is the case in Alaska. In addition, risk reduction is important, but prevention must become a higher priority (including factors as simple as ensuring safe housing). Dr. Rasmus also encouraged ethical reflection on the efficacy and permissibility of blanket mental health screenings in school.

Dr. Embry suggested that an inflammatory response could be partially responsible for the nationwide increase in suicides. Military studies have indicated that several blood-based biomarkers (e.g., vitamin-D deficiency, omega-3 deficiency, and elevated omega-6) were significant predictors for posttraumatic stress disorder and eventual suicide.

Dr. Adelsheim highlighted the need to provide proactive intervention and support services to young people with an elevated suicide risk. Dr. Rasmus stressed the need to extend those services to rural areas. Mr. del Vecchio noted that online youth support communities might provide a novel behavioral health solution. Mr. Simmons also raised the possibility of targeting support services at mixed-race youth and adolescents. In response, Mr. Biasotti cautioned against casting SAMHSA’s mandate as preventing suicide for a specific group, as opposed to preventing suicide for everyone.

Dr. McKeon described one hypothesis proposed by Princeton researchers that describes a rising rate of “diseases of despair” (e.g., alcohol-related liver diseases, opioid use disorder, and suicide) in rural communities. Middle-aged and older white males could be experiencing cumulative disadvantages over time that deepen into depression and suicidal ideation.

It is unclear whether this hypothesis is true, but Dr. McKeon emphasized the need to develop hypothetical explanations in general, to provide a basis for further research and a deeper understanding of the rising suicide rates across the country. Dr. Embry noted that personal exposure to suicides within one’s community could lead to suicide normalization and rising suicide rates. Similarly, exposure to suicide through media reports can increase the likelihood that at-risk individuals will make an attempt.

Public Comment

There was one public comment. Stewart Gordon, Director, National Association of State and Mental Health Program Directors, noted that starting this September, DC Comics will present a new seven-issue miniseries which offers Tom King’s vision of the DC Universe (DCU), titled HEROES IN CRISIS. HEROES IN CRISIS is not a tale of universes colliding and dying. Instead this is a story centering on the humans and superhumans under the “mask”; this is about what allows them to get up and fight when it appears they can’t ever get up and fight again. When it’s too much, heroes go to “Sanctuary” to find a moment of safety before returning to a universe of violence. HEROES IN CRISIS is also about what happens when Sanctuary fails, resulting in catastrophic consequences for the DCU. This is a place where superheroes go when they are in mental health crisis. Mr. Gordon suggested that if you are looking for a positive message to provide to the youth, this might be an effective tool. This is a pop culture moment that SAMHSA’s communication office may want to take advantage of.

Closing Comments and Feedback

Mr. Biasotti recommended that the next NAC meeting spend more time discussing the media’s role in rising suicide rates. Mr. Patton emphasized the need to discuss the criminal justice role in mental and behavioral health issues, including suicide. Dr. Rasmus requested a presentation from grant review and expressed an interest in learning more about the policy lab.

Dr. Adelsheim suggested that the NAC accept Assistant Secretary Owens’ offer to attend the next NAC meeting to discuss the potential for government-funded preventative mental and behavioral health services. He also requested that Mr. del Vecchio provide NAC members with further information regarding SAMHSA’s efforts to prevent psychological harm among refugees.

Adjournment

Ms. Foote thanked all the participants and adjourned the meeting at 5:00 p.m.