

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CMHS National Advisory Council Meeting

Minutes for August 26, 2015
Rock Creek Conference Room

Welcome

Deborah DeMasse-Snell, Designated Federal Official, CMHS NAC, convened the National Advisory Council at 9:00 a.m. for a closed session to review grant applications at SAMHSA headquarters in Rockville, Maryland. Mr. del Vecchio reconvened the Council in open session at 10:00 a.m. and asked staff members to introduce themselves.

Council Members Present: Lori Ashcraft, Ph.D., Nevada City, CA; Lacy Kendrick Burk, M.S., M.B.A, Partner, Change Matrix LLC, Phoenix, Arizona.; Vijay K. Ganju, Ph.D., Consultant, Austin, Texas; Paul Gionfriddo, President and CEO, Mental Health America, Washington District of Columbia.; Jeremy Lazarus, M.D. Professor, Psychiatry Department, University of Colorado, Denver, Colorado; Gilberto Romero, Consultant, Santa Cruz, New Mexico; Jeremiah Simmons, M.P.H., Albuquerque, New Mexico; and Jurgen Unutzer, M.D.,M.P.H., M.A., Professor and Chair, Psychiatry Department, University of Washington, Washington.

SAMHSA/CMHS Staff Present: Paolo del Vecchio, M.S.W, Director, Center for Mental Health Services, SAMHSA, Chair, CMHS National Advisory Council; Elizabeth Lopez, Ph.D., Deputy Director, Anne M. Herron, M.S., Director, Division of Regional and National Policy Liaison, Office of Policy Planning and Innovation; Anne Matthews-Younes, Ed.D., Director, Prevention, Traumatic Stress and Special Programs Branch; Cytrice Bellamy, M.S., M.Ed., Division Director, Division of State and Community Systems Development); Cynthia Kemp, M.A., LPC, Branch Chief, Community Support Programs, Division of Service and Systems Improvement; Ingrid Donato, Branch Chief, Mental Health Promotion Branch, Division of Prevention, Traumatic Stress and Special Programs; CMHS; Keris Jän Myrick, M.B.A., M.S., Director, Office of Consumer Affairs; Steven Fry, Public Health Advisor, Office of Consumer Affairs; Carlton Speight, Public Health Advisor, Office of Consumer Affairs; Patricia Gratton, Public Health Analyst, Office of Program Analysis & Coordination.

Attendees viewed a video memorial of the late Charles Willis, a member of the Subcommittee on Consumer/Survivor Issues and a mental health peer provider. Up until his death on June 14, 2015, Mr. Willis served as Recovery Director of the Georgia Mental Health Consumer Network in Norcross, GA. Charles Willis was a dynamic force, not only for his community in Norcross, but across the peer support network nationwide. His energy and understanding of how peer support empowers those that need assistance in acquiring appropriate social services for their own long term sustainability will be greatly missed.

CMHS Director's Report

Paolo del Vecchio, M.S.W.

Mr. del Vecchio highlighted key CMHS activities, referring to the written Director's Report.

Changes in Key Leadership:

- SAMHSA Administrator Pamela Hyde has retired after six years of outstanding service in leading the agency.
- Kana Enomoto will serve as Acting Administrator. She is a 17-year veteran of the Agency, previously served as principal deputy administrator and as a senior advisor to three previous Administrators.
- Acting Center for Substance Abuse Treatment (CSAT) Director Daryl Kade succeeds Dr. H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, who retired in late 2014.

CMHS has a new addition on the management team:

- Cyntrice Bellamy, M.S., M.Ed., Director, Division of State and Community Systems Development, oversees the block grant and PAMI programs.

SAMHSA is recruiting a new Director of the Office of Program Analysis and Coordination to succeed CMHS Deputy Director Elizabeth Lopez.

Congressional update

Legislation proposed by Rep. Tim Murphy (R-PA) and a companion bill, the "Mental Health Reform Act of 2015," by Sen. Christopher S. Murphy (D-Conn.), would impact SAMHSA.

Both bills:

- Establish an Assistant Secretary (AS) for Mental Health and Substance Use Disorders at the Department of Health and Human Services to promote, evaluate, organize, integrate, and coordinate research, treatment, and services across departments, agencies, organizations and individuals with respect to the problems of individuals with substance use disorders or mental illness ,.
- Establish a national mental health policy laboratory to develop new models of evidence-based care.
- Establish an Assisted Outpatient Treatment (AOT) grant program.
- Address privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). The House bill would change HIPAA rules to allow increased sharing of information with caregivers while the Senate bill seeks to clarify HIPAA's existing rules.

There are several differences between the two bills that involve scope and responsibilities of these provisions as well as whether SAMHSA would remain an independent agency (as per the Senate Bill) or transfer authority to the newly established Assistant Secretary (as per the House bill).

Congress will take up the 2016 federal budget when it reconvenes in September. A continuing resolution with stop-gap funding to run the government until December 2015 is likely.

SAMHSA was the subject of two GAO reports in 2015. *“HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness”* was discussed at the April 26, 2015 NAC meeting. *“Better Documentation Needed to Oversee Substance Abuse and Mental Health Services Administration”* recommends improvements in the CMHS grants administration process. CMHS concurred that these changes were needed and is now upgrading program integrity and quality assurance.

In March 2015, the Behavioral Health Coordinating Council (BHCC) Subcommittee on Serious Mental Illness assumed a larger role to ensure that federal agencies work collaboratively and avoid duplication of their efforts. Co-chaired by the CMHS director, the BHCC SMI Subcommittee is developing a strategic action plan to make HHS more responsive to the needs of people with serious mental illness.

Following the Newtown, CT school shooting in December, 2012, President Obama put forward a plan “Now is the Time (NITT)” to protect children and communities by reducing gun violence. The plan combined executive and legislative actions that would keep guns out of the wrong hands, make schools safer, and increase access to mental health services. Project AWARE (Advancing Wellness and Resilience Education) for State Educational Agencies (SEA) is one component of the plan. AWARE-SEA is designed to make schools safer and increase access to mental health services. The purpose is to build and expand upon the capacity of State Educational Agencies and local communities to improve school climate, increase the mental health literacy of adults who interact with youth, increase awareness of mental health issues among school-aged youth, detect and respond to mental health issues in children and young adults, and connect children, youth, and families who may have behavioral health issues with appropriate services.

Funding for the AWARE-SEA program is awarded to a State Educational Agency who partners with three local educational agencies to develop and implement a comprehensive plan of activities, services, and strategies which expand capacity at both the state and local levels. This program is funded at up to \$1.95 million per year for up to five years. In FY 2014, AWARE-SEA funds were awarded to 20 states. The AWARE-SEA program is supported by a technical assistance center and a multi-site evaluation.

Project AWARE for Local Educational Agencies (AWARE-LEA)

Project AWARE for Local Educational Agencies is another component of the President’s “Now is the Time” plan. The AWARE-LEA program is intended to assist LEAs in supporting the training of school personnel and other adults who interact with school-aged youth, in both school- and community-based settings, to detect and respond to mental illness, including how to encourage adolescents and their families to seek treatment if needed. This is accomplished by training adults in either Mental Health First Aid (MHFA) or Youth Mental Health First Aid (YMHFA). Both MHFA and YMHFA are public education programs that introduce participants to the unique risk factors and symptoms of mental health problems in adolescents and build an understanding of the importance of early intervention, and teach individuals how to help youth in crisis. This program is funded at up to \$50 thousand per year for two years. In FY 2014 AWARE-LEA funds were awarded to 100 LEAs.

Project AWARE - Community (AWARE-C)

Project AWARE - Community grant program is intended to support the training of teachers and other adults who interact with youth in Mental Health First Aid (MHFA) or Youth Mental Health First Aid (YMHFA). Implementation of the AWARE-C program is expected to increase the mental health literacy among youth-serving adults, policy-makers, and administrators of programs serving youth. By training an increased number of adults to be MHFA or YMHFA “First Aiders”, a community can move toward wide-scale knowledge of behavioral health issues that affect youth and become more effective in addressing behavioral health issues that impact adolescents or transition-aged youth. The FY 2015 budget included \$8.6 million for Project AWARE – Community. CMHS intends to award up to 70 grants at \$125,000 per year for three years to public and private non-profit organizations to support the training of teachers and other adults who interact with youth in their communities, including parents, law enforcement, faith-based leaders, and other adults, in Mental Health First Aid or Youth Mental Health First Aid. CMHS expects to increase the mental health literacy among youth-serving adults, policy makers, and administrators of programs serving youth

SAMHSA is partnering with the Centers for Medicaid and Medicare Services (CMS) and HHS Assistant Secretary for Policy and Evaluation (ASPE) on planning grants for states to help certify community behavioral health clinics (CCBHCs). This two-year demonstration program will support the delivery of community mental health and substance use care in order to evaluate the implementation and outcomes of the CMHS demonstration programs in up to eight states. State-certified clinics are eligible to receive grants with enhanced Medicaid funding through a prospective payment system (PPS).

Congress has again allocated about \$25 million for SAMHSA’s Mental Health Block Grant program (MHBG) to support “evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.” The Agency has been directed to require states to set aside 5% of their grants to support the development of early psychosis treatment programs across the United States for team-based, coordinated care to young adults experiencing their first Serious Mental Illness (SMI) episode. CMHS is partnering with the National Association of State Mental Health Program Directors (NASMHPD) to help the states implement their early intervention models. An initial evaluation of the models will highlight the value of data collection, lessons learned, and effectiveness.

The Primary and Behavioral Health Care Integration (PBHCI) program provides grants to the states to improve coordination between behavioral and physical health through strategies, such as co-locating primary care within the behavioral health care settings. The program has expanded with 60,000 individuals served to date.

Drs. Lazarus and Ganju led a discussion with CMHS staff on the findings and recommendations of the Integration White Paper that was developed under their direction. The paper concluded that the recommendations made on the integration of primary and behavioral health can be applied to the Center’s ongoing efforts and urged CMHS and SAMHSA to build on its infrastructure changes to promote integration efforts.

Summary and Discussion

Council members complemented the lead authors on the paper and supported its conclusions. , Mr. del Vecchio thanked the Council members for taking the lead on substantive issues to improve the delivery of integrated care for Americans with mental illness and their family members

Approval of Minutes

Dr. Lazarus made a motion to accept the minutes of April 15, 2015. Mr. Gionfriddo seconded. Dr. Ganju suggested that the recommendations made previously on the development of work force models be included. Mr. del Vecchio asked him to submit corrections to the minutes to include this to Ms. DeMasse Snell. The vote in favor of accepting the minutes was unanimous.

SAMHSA's Role in the Public Health Crises Response

Anne Herron, M.S., Director, Division of Regional and National Policy Liaison, Office of Policy, Planning and Innovation, SAMHSA

A draft SAMHSA report was disseminated to members for their comment, "*The Public Health Crisis Response*," focuses on strategies for reaching out and responding to communities in need of technical assistance and additional resources during a crisis, and providing needed support. In the event of a declared disaster or emergency, SAMHSA's Disaster Technical Assistance Center is the point of contact for coordinating activities and epidemiological work and tracking resources, supports or gaps in service. When a community is faced with an event which does not reach the level of a declared disaster or emergency, there is no identified point of contact. There are challenges providing appropriate resources or systematic support based on clearly identifying a community's needs, education and awareness of how to access or negotiate offers of assistance, and points of contact at the community, state, regional, federal levels may not exist.

The Council's advice was sought on how SAMHSA can be more responsive to a community's disaster needs and coordinate among the Agency's Regional Administrators. Strategic Initiative (SI) of subject matter experts on suicide prevention (Region 8); the opioid overdose deaths in Indiana (Region 5) and the aftermath of the civic unrest in Baltimore (Region 3) were noted.

Summary and Discussion

Mr. del Vecchio said the Center for Behavioral Health Statistics and Quality has prepared a tool to help communities identify their resources and gaps.

Dr. Lazarus asked whether SAMHSA will provide a mechanism for sharing prescription information in future disasters because many patients with mental illness who were displaced during Katrina were not able to fill their prescriptions in other states due to the HIPAA protections. CAPT Eric Hierholzer, public health advisor with the Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB) said a needs assessment and referral tool currently directs people with pre-existing mental health and substance use disorders to treatment services but only post-disaster.

Discussant:

Paul Gionfriddo, CMHS NAC

The City of San Francisco has been discussing plans to move hundreds, if not thousands, of homeless people during the Super Bowl next February. This could be an impending disaster for many individuals within that population who experience behavioral health disorders. Such events present an opportunity for SAMHSA to identify appropriate prevention, intervention and ongoing support strategies that include:

1. Finding and engaging partners in advance. Mental Health America and American Red Cross have signed an agreement to work with active chapters and affiliates,
2. Familiarizing community points of contact with the mental health supports available for planning and responding to an emergency.
3. Leaving behind sustainable partnerships.
4. Developing a follow-up drop-in plan for SAMHSA's points of contact.
5. Training the public health workforce to meet the community's mental health needs and work with its mental health providers;
6. Include schools in the integration strategy.
7. Enlisting local health directors at American Public Health Association conferences and in their communities.
8. Tapping peers to work with people experiencing catastrophes.

Summary and Discussion

CAPT Hierholzer identified SAMHSA's key disaster resources:

- Through an interagency agreement, the Federal Emergency Management Agency (FEMA) funds the Crisis Counseling Assistance and Training Program which provides mental health and behavioral health expertise and assistance.
- The 24/7 Disaster Distress Helpline is a 1-800 number with text capability and crisis counselors available.
- The Disaster app provides behavioral health resources, psycho-educational materials and linkages to a treatment locator. Its communications infrastructure can be emailed to disaster survivors and pre-downloaded before resources are deployed to areas without internet access.
- The Disaster Technical Assistance Center (TAC) creates educational materials, resources, and tip sheets. The Disaster TAC also offers coordinated psychological recovery training and reaches out to state behavioral health coordinators and state commissioners to identify their needs.
- The SAMHSA Bulletin publishes a monthly calendar of disaster-related conferences, events and other topics.
- *Dialogue*, a quarterly behavioral health journal on disaster topics, can be accessed via Google.

Promotion of Evidence Based Practices (EBPs) and Zero Suicide

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

Eileen Zeller, M.P.H., Suicide Prevention Branch, CMHS

Each year about 9 million people seriously consider suicide, according to SAMHSA's NSDUH data reports. Systematic risk assessment and formulation screening skills can prevent many serious injuries or suicides in people at risk. Yet nearly half of the 30,000 clinicians surveyed by the National Action Alliance for Suicide Prevention reported that they lack the systematic clinical and professional skills needed to assess and treat suicidal behaviors.

The Zero Suicide approach, embedded in the National Strategy for Suicide Prevention, offers a framework for stemming suicides in behavioral health and health care systems. A range of Assessing and Managing Suicide Risk (AMSR) curricula options linked to quality improvement, evaluation and innovations in primary care best practices and tools are posted on the www.zerosuicide.com website. SAMHSA supports this effort through its Suicide Prevention Resource Center (SPRC), which provides a toolkit, website, webinars and listserv and learning collaborative with the National Council for Community Behavioral Health Care.

ZERO Suicide encompasses a system-wide, comprehensive suicide prevention approach that includes elements such as:

- Collaborative safety planning on how to stay safe and avoid serious injury or death by restricting access to firearms and lethal medications;
- Continuous quality improvement to develop a competent, confident, and caring workforce;
- Incorporating the voices of family members with lived experience who have lost loved ones;
- Immediate risk assessment by credentialed, suicide savvy clinicians using instruments such as the Columbia Suicide Severity Rating Scale;
- Maintaining contact with people at high risk via an evidence-based enhanced care protocol that flags electronic health records to enable the crisis service to make outreach calls;
- Relating underlying mood, substance use, and bipolar disorder to target and treat suicidality;
- Tailoring cognitive behavior therapy (CBT) for suicide prevention;
- Collaborative assessment and management of suicidality that can be used by anyone regardless of their theoretical orientation;
- Reducing suicide risk via medication treatment for schizophrenia and bipolar disorder; and
- Providing dialectical behavior therapy (DBT) for patients who are chronically suicidal, especially for people with borderline personality disorder.

Discussant:

Jeremiah Simmons, M.P.H., CMHS NAC

In the fall of 2009 the Mescalero Apache community saw a cluster of suicides in Mescalero, NM. Tribal leadership declared a state of emergency, which allowed multiple state and federal resources to be directed towards addressing this issue. At that time, prior to full implementation of the SAMHSA GLS grant, the tribe did not know how to coordinate the effort or communicate with the local media to minimize the contagion. The Mescalero Apache community became

aware that they lacked the capacity and knowledge about when to start crisis planning, how to secure state resources, or whether to partner with the Indian Health Service team deployed to provide assistance.

The Garrett Lee Smith and Native Aspirations grants from SAMHSA helped the community to identify priorities, target populations, and develop more systematic evaluation practices. Diversity approaches focused on evidence-based, outcome-focused best practices which have helped define what needs are to be evaluated.

Summary and Discussion

CAPT Hierholzer said that tribal entities often use presidentially declared disasters to apply for disaster crisis counseling and legal services. A FEMA pilot project will help tribes develop policies to govern the process. CDR Seligman said SAMHSA obtained buy-in from the Indian Health Service, tribal members, and community stakeholders to develop culturally sensitive tip sheets that briefed officers and first responders on what to expect. Dr. Mathews-Younes added that the Suicide Prevention Resource Center (SPRC) through the Action Alliance provides media guidelines to tribal communities traumatized by suicide clusters. SAMHSA also dispatches staff members, accompanied by a Native American technical assistance representative, to communities to do media trainings.

Dr. Unützer asked which best practices are available for communities to plan for, respond, and recover from disasters. CAPT Hierholzer said the TAC webinar series, “*Promising Practices and Behavioral Health Planning*,”¹ is aimed to support State Department of Behavioral Health Coordinators and others involved in disaster planning. Examples of jurisdictions that have integrated Disaster Behavioral Health (DBH) mental health and substance abuse planning approaches into the state’s disaster response structure are provided.

Dr. Lazarus suggested funding a suicide prevention grant program to bring effective disaster practice models to scale. Dr. Ganju said that Maricopa County in Arizona has developed family cluster suicide prevention models that could serve to inform grant programs. He urged CMHS to tap a repository that Jesuit priest Father Easel has compiled on contagion suicides among Pacific Islander youths. Dr. Unützer said that many behavioral health providers typically lack the clinical training and skills needed to help prevent suicide. An Institute of Medicine (IOM)² report on evidence-based psychosocial interventions found that 90% of the providers surveyed do not know how to do Dialectical Behavior Therapy (DBT). The Henry Ford Health System in Detroit, Michigan brought its suicide rates down to the national level after depressed patients switched or received increased dosages of their antidepressants. Ninety percent of the deceased had remained on the same medications for years before their deaths by suicide.

¹ <http://www.samhsa.gov/dtac/webinars-podcasts>

² IOM (Institute of Medicine): *Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-based Standards.*: The National Academies Press. Washington, DC, 2015.
<http://iom.nationalacademies.org/Reports/2015/Psychosocial-Interventions-Mental-Substance-Abuse-Disorders.aspx>

Ms. Kendrick-Burk asked how grantees may secure information about suicide prevention. Dr. McKeon said the resources include the National Violent Death Reporting System (NVDRS), webinars, and listserv and Zero Suicide academies. Dr. Ashcraft asked if any research on the effectiveness of peers in suicide prevention has been reported. Dr. McKeon said no, but findings may emerge from the voices of people with lived experience. For example, community workers in the Apache White Mountain Tribe are a mandated Tribal surveillance system for youths in American Indian and Alaskan Native villages.³

Disparities and Making Connections

Acting Administrator Kana Enomoto, SAMHSA

Ms. Enomoto passed on former SAMHSA Administrator Hyde's best regards to the Council. Ms. Hyde placed much value on the service that NAC members provide as advisors to SAMHSA. In her new role, the Acting Administrator will continue to value their work, time and knowledge. In order to maintain a smooth and seamless process during the Agency's transition in leadership, she will continue leveraging the knowledge that members provide at meetings and on an ongoing basis. She will also continue to promote the priorities that have already identified and is open to suggestions on how the NAC can help SAMHSA improve and find new opportunities. During her conversation with the Council, Ms. Enomoto reported on her goals and what to expect during the transition in leadership.

Ms. Enomoto noted that most of the work that CMHS does focuses on people with serious mental illness and expressed the need to raise awareness that SAMHSA is paying attention to the substance abuse and mental health needs of Americans. She discussed a greater focus at SAMHSA on medical and clinical issues and how Council members can share their expertise in these areas.

The Acting Administrator also emphasized the need to increase the comfort of talking about trauma and trauma-informed approaches so that we can reach individuals before negative outcomes arise, such as unemployment and homelessness. If we give clinicians the tools they need to respond, we can help prevent disability and help people who have experienced trauma to realize good health and behavioral health.

Dr. Unützer said that SAMHSA will improve its education role by increasing a focus on clinical services. He also added that seventy percent of the people who are treated for mental health issues receive medication but only 30% receive outpatient services. The medication visit is an opportunity for primary care physicians to provide counseling or other interventions to their patients.

Dr. Unützer said people with PTSD need to see a specialist who is able to provide the proper exposure-based treatment. Only about 1 in 10 behavioral health providers know how to do cognitive processing treatment or another evidence-based, exposure-based modality.

³ Mullany, Britta et al. "Toward Understanding Suicide among Youths: Results from the White Mountain Apache Tribally Mandated Suicide Surveillance System, 2001–2006." *American Journal of Public Health* 99.10 (2009): 1840–1848. *PMC*. Web <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2741522/> 28 Oct. 2015.

Dr. Ganju suggested using advisory council members as ambassadors for SAMHSA and the Centers to raise public awareness around SAMHSA's products and what the agency is accomplishing.

Ms. Enomoto said that by the time we see people who have experienced trauma, a slow decline and downward trajectory in various systems has been decades in the making. If only those issues could be identified when someone was seen by a pediatrician, an obstetrician or cardiologist before the person was drinking too much, interacted with the criminal justice system, or became indigent and homeless. For that to happen, people have to feel comfortable talking about their traumatic experiences and clinicians need to be given the tools to respond appropriately. If SAMHSA can replicate the early intervention approach used in RAISE, we can help prevent disability and help people realize levels of health, wellness and recovery not currently being achieved.

Dr. Unützer noted that his own patients with PTSD, who have gone through exposure-based treatment, come back as different human beings. "It is magical; but you have to have the right treatment."

Ms. Enomoto reported that she recently went on a tour of a data-driven treatment provider organization that was trauma-informed but they had not thought about interventions for PTSD or other complicated trauma responses. There is a clinical intervention piece to this area that needs more research.

Ms. Enomoto responded that the behavioral health crisis framework is a way to engage the Council and help SAMHSA create a disaster response in going forward, not just in the aftermath.

Ms. Enomoto encouraged Council members to provide input on priorities as the scope of mental illness and addiction, from prevention to treatment to recovery is very broad but each piece is critically important.

Quality and Performance Management Updates

Deepa Avula, M.P.H., Acting Director, Office of Financial Resources, SAMHSA

Mark Jacobsen, Ph.D., Public Health Advisor, Office of Program Analysis and Coordination, CMHS

Yanique Edmond, Ph.D., M.P.A., Public Health Advisor, Mental Health Promotion Branch, CMHS

Michelle Gleason, Public Health Advisor, Division of State and Community Systems Development, CMHS

In response to the recent GAO report on grants management, SAMHSA is developing a comprehensive approach to improve its grants management and administration activities, policies, and procedures. The following changes will bring more uniformity and consistency into the review and scoring process:

- The updated Government Project Officer (GPO) handbook will be implemented across the agency in September;
- Formula and discretionary grants management activities are being strengthened;

- New staff training practices, peer review, and record-keeping protocols and procedures have been instituted;
- All email exchanges and phone calls with the states will now be logged;
- The Financial Risk Assessment Integrity Group Program will not solely be part of the Office of Financial Resources but will be a cross-agency effort;
- A work group will identify risk assessment and mitigation program strategies throughout the life cycle of the grant;
- The peer review process will now describe the reasons for disparate scoring and urge reviewers to reach a consensus during collaborative teleconferences on the merits of an application;
- A new Grants Enterprise Management System (GEMS) will consolidate multiple grants management activities systems from the pre-award funding opportunity announcement through closeout;
- The first pilot of the shared services system module to improve grants management and project officer functions across the agency will be held in April

Grantees that do not meet the review criteria are referred to the Performance Review Board (PRB). The purpose of the PRB is to ensure consistency across GPO grantee monitoring. Six indicators are used to review the performance level of grantee systems and services at the state level. SAMHSA collaborates with the GPOs on ways to improve the performance of at-risk grantees that are identified through the PMS. The GPO uses various tools to provide technical assistance to improve performance. An annual evaluation report assesses the effectiveness and whether the data has been effective.

Discussant:

Vijay Ganju, Ph.D., CMHS NAC

The Council is interested in receiving more information to support their statutory review of the grants review process. More information would help provide context for assessment of reviewer scores. More information about the number of clients served by the program; the validity of outcomes and success stories; aspects of the grants management process; information about field work on disparate kinds of grants; the relationship of client-level services to grant activities and National Outcome Measurements' (NOMs) outcomes; how grants outcomes may be isolated; how multi-sourced client-level grant and program funding information may be isolated; differences between program goals, client infrastructure and how the scales or measures are used; and the definitions of EBP related data and NOMs.

Summary and Discussion

Dr. Lazarus suggested that Council members could be more involved in the peer review process to assess its approval practices. He noted that it would be helpful to provide the names of the experts and quality of the evidence-based practices for the peer review further in advance of the Council review meeting. Dr. Ashcraft asked about whether the benchmark setting provides enough protection against poor performance. Ms. Avula said that grantees are held to a high standard and are held accountable for their performance. As a GPO, Dr. Edmond works directly with grantees to implement programs and oversee their quality. She sees if goals are being met, measures are culturally relevant and evidence-based practices are being monitored before

programs go before the PRB.

Report from the Subcommittee on Consumer Issues

Lacy Kendrick Burk, MS, MBA, Chair, Subcommittee on Consumer Issues; Member, CMHS National Advisory Council

The subcommittee received updates from Mr. del Vecchio and Ms. Myrick on their respective CMHS and Office of Consumer Affairs activities; explored ways to respond and build capacity for communities to prepare for the next disaster; discussed the peer workforce and core competencies and heard about consumer perspectives on suicide prevention. There also was discussion about the Subcommittee's report on the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS); the complex multi-year approval process; timeline for products in the pipeline and methods that CMHS uses to collect data on hospitalization, emergency room visits, and health and wellness programs.

Four recommendations were submitted for the Council's consideration:

1. CMHS should continue its successful collaborations on health care policy innovations; increase the positive impact on behavioral health systems transformation and; improve the accessibility, quality, and affordability of behavioral health treatment and services.
2. CMHS should expand efforts to identify, develop, disseminate, and replicate effective suicide prevention programs and the core components of peer-delivered suicide prevention services.
3. CMHS should update the latest evidence base for peer support, including database outcomes for peer-delivered services that have been shown to reduce hospitalization.
4. CMHS should continue guiding communities on how to more effectively provide crisis response services and prevention and treatment activities for mental and substance use disorders; supports for the development of sustainable healthy communities; peer-provided services for first responders to support behavioral health issues; and peer support in the field.

The subcommittee suggested adapting lessons learned from successful grant programs in the Zero Suicide Initiative; collating managed care organization and IOM report data on how peer support affects mental health and substance use disorders; and creating an evidence-based practice standards framework.⁴

Summary and Discussion

Mr. del Vecchio said that SAMHSA, through the BRSS TACS program has developed a draft set of core competencies entitled "*Peer Workers in Behavioral Health Settings.*" These requirements apply to peers who work with youth, older adults and families in criminal justice, primary care and emergency room settings. The next charge for the subcommittee is to look at

⁴[IOM Recommendations Reflect Importance of Improving Quality of Behavioral Health Services.](#)

organizational capacities for supporting the peer workforce.

Mr. del Vecchio sought feedback on how SAMHSA should support the development of peer workforce financing and training guidelines.

Dr. Lazarus made a motion to adopt the changes. Dr. Unutzer seconded. The motion passed and was approved unanimously.

Two members suggested moving the subcommittee report higher on the agenda to allow for more discussion and enhance the body's legitimacy.

Public Comment

None.

Summary and Discussion

Asked how the format can be improved, Dr. Lazarus applauded the opportunity to raise questions and make suggestions but wants to know what is doable or not and why. Dr. Ganju sought feedback on the integrated care and peer workforce charges. Mr. Simmons proposed an overlapping session with CSAT on substance use topics and more input on the agenda.

The Council will convene by phone for the final grant review at the end of September. Also in September, Ms. DeMasse-Snell will announce the date of the first face-to-face NAC meeting to be held in 2016.

In December 2015, SAMHSA will return to its original headquarters at 5600 Fishers Lane in Rockville, MD. The office space became available after the Food and Drug Administration (FDA) moved to its new campus in Silver Spring, MD.

Mr. del Vecchio commended staff for its perseverance, passion and dedication and praised Ms. DeMasse-Snell and the contractors for helping the Council navigate the NAC process during the Agency's transition.

The CMHS NAC meeting was adjourned at 5:00 pm.

CERTIFICATION STATEMENT

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

Date: 2/21/15

A handwritten signature in black ink, appearing to read "Paolo del Vecchio", written in a cursive style.

Paolo del Vecchio
Chair, CMHS National Advisory Council
Director, Center for Mental Health Services, SAMHSA