

**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, Rockville, MD 20857
March 29, 2022**

Chairperson

Anita Everett, MD, DFAPA, *Director, Center for Mental Health Services (CMHS)*

Designated Federal Official

Pamela Foote, *Designated Federal Official, CMHS, National Advisory Council*

Council Members Present

Jane Adams, Ph.D.

Steven Adelsheim, M.D., Ph.D.

Sergio Aguilar-Gaxiola, M.D., Ph.D.

Mike Biasotti, M.A.

Leonard Bickman, Ph.D., M.A., B.S.

Lori Criss, M.S.W.

Dennis D. Embry, Ph.D.

Jeff Patton, M.S.W.

Lori Raney, M.D.

David Len Shern, Ph.D.

Sampat Shivangi, M.D., FICS

Khatera Aslami Tamplen, B.S.

Ex Officio Members

Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, SAMHSA

to serve as consultants to state and local leaders on issues of mental health.

Ex Officio Members Not Present

The Honorable Xavier Becerra, Secretary, Department of Health and Human Services

Joshua A. Gordon, M.D., Ph.D., Director, National Institutes of Mental Health (NIMH)

Robert K. Heinssen, Ph.D., Director, Division of Services & Intervention Research, NIMH

Christopher Loftis, Ph.D., PMP, National Director, Veterans Administration/Department of Defense, Mental Health Collaboration, Office of Mental Health and Suicide Prevention

Joel Sherrill, Ph.D., Deputy Director, NIMH, Division of Services, and Intervention Research

SAMHSA Staff, CMHS Staff, and Guest Speakers Present

Tom Coderre, Acting Principal Deputy Assistant Secretary, Office of the Assistant Secretary, SAMHSA

Dona Dmitrovic, Senior Advisor, Office of the Assistant Secretary, SAMHSA

Michael King, Ph.D., CAPT USPHS, Acting Director, Center for Behavioral Health Statistics and Quality

Shary M. Jones, PharmD, MPH, BCPS CAPT, U.S. Public Health Service Special Assistant to the Director, CMHS

Nima Sheth, M.D., M.P.H., Senior Medical Advisor, CMHS, OD

Steve Dettwyler, Ph.D., Public Health Advisor, Division of State and Community Systems Development, CMHS

Caitlin Fitzsimmons, Public Health Advisor, Mental Health Promotions Branch, CMHS

Lora Fleetwood, Public Health Advisor, DPTSSP, CMHS

Christine Peat, Ph.D., Program Director, National Center for Eating Disorders

Call to Order and Roll Call

Pamela Foote, Designated Federal Official, CMHS, National Advisory Council

Ms. Pamela Foote called the meeting of the Center for Mental Health Services (CMHS) National Advisory Council (NAC) to order at 1:00 p.m. After conducting roll call and verifying a quorum, the meeting was turned over to Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS) and Chair of the National Advisory Council (NAC).

Welcome and Opening Remarks

Dr. Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS) and Chair of the National Advisory Council (NAC)

Dr. Everett welcomed participants and noted that Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use would not be able to join the meeting due to another engagement. After reviewing the agenda, Dr. Everett asked for a consideration of the meeting minutes from August 17, 2021, which were adopted unanimously.

CMHS Director's Report – Program Updates

Anita Everett, M.D., DFAPA, Director, CMHS, Chair, CMHS NAC

Dr. Everett stated that SAMHSA's priorities, which are aligned with President Biden's agenda, are preventing overdose, enhancing access to suicide prevention and crisis care, promoting child and youth behavioral health, integrating primary and behavioral healthcare, and data realignment. Cross-cutting principles to be considered when addressing each principle include equity, workforce, financing, and recovery.

Regarding financing, CMHS received \$1.67 billion in funding for Fiscal Year 2021(FY 2021), or 30 percent of all SAMHSA funding, which allowed for 1,099 grantee awards. Dr. Everett anticipates doubling the number of awards in one to two years. Further, CMHS anticipates that we will be managing 2,842 grants and, despite the extreme staffing shortage, the center's workforce has grown from 72 to 118 employees.

For FY 2022, the center's budget is just over \$2 billion an increase of \$288,854 from FY 2021. Program highlights include the CMHS Block Grant funded at \$856 million, Certified Community Behavioral Health Clinics (CCBHCs at \$315M), suicide prevention programs (\$187M), Project AWARE (\$120M), and the National Child Traumatic Stress Network (\$81.9M). Dr. Everett noted that much of the suicide prevention funding is going to building the

infrastructure for the new 988 mental health emergency phone number. Notably, there are 45 grant programs; council members were referred to the presentation slides for more information about these budget increases.

Dr. Everett encouraged council members to reach out to SAMHSA's regional administrators. She highlighted the work of Dr. Charlie Smith, Region 8 administrator and former commissioner of Colorado's public mental health system, for his expertise in addressing the needs of the rural population.

The CCBHC program has received additional funding through COVID-19 rescue funds and in the base budget. One issue of the grant program is the duration of grant funding, which is now divided into four years funded at \$1M per year. One set of grants focuses on new grantees while the other set aids experienced grantees. Thankfully, Senator Stabenow from Michigan is a champion of the CCBHC program.

The scope of services provided by CCBHCs is wide and is fulfilled directly through the individual CCBHC along with the Designated Collaborating Organizations (DCOs) and referrals to providers outside of both domains. Specifically, crisis services are provided by the CCBHC "unless there is a state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that dictates otherwise". There are now 430 grantees with almost 200 yet to launch and all but five states have a CCBHC. SAMHSA is working closely with the Centers for Medicaid and Medicare (CMS) to support the CCBHC sustainment. Members may view the presentation slides for specific services and state participation information.

The program is shown to be effective. Though it is a limited data set, the SAMHSA's Performance Accountability and Reporting System data reveal that people served by CCBHCs are doing better than when they began the program. Dr. Everett highlighted that 68.6 percent fewer clients report hospitalization in the previous 30 days and 56.9 percent fewer report emergency room visits in the last 30 days. Meanwhile, 53.6 percent report increase in social connectedness. [Note: Lori Raney chatted that South Carolina does not meet the criteria for having a CCBHC due to its statewide electronic medical records.]

The workforce shortage has impacted all America and the behavioral health field is not immune. During this time of "the great resignation", the shortage impacts the ability to provide care. Shortages in the behavioral health workforce vary by region and 37 percent of the U.S. population lives in regions impacted by the shortage. Further, there the field diversity gaps within the field. Of the estimated 41,000 psychiatrists in the nation, only two percent are Black and only four percent of psychologists are Black. SAMHSA's Minority Fellowship Program, coming up on its 50th anniversary, addresses these inequities and supports graduate-level training to improve behavioral health outcomes for minority communities.

Children and youth behavioral health is also a priority. In alignment with the Biden Administration, SAMHSA has invested \$527M into multiple programs, including comprehensive programs for children with serious emotional disturbances (SED) and systems of

care (SOC), Mental Health Awareness Training, and Project AWARE- State Education Agency (SED), and Resiliency in Communities After Stress and Trauma (ReCAST).

SAMHSA is helping address the needs of refugee youths. Working with the Department of Defense, SAMHSA provides multiple services (psychoeducation, case consultation, psychiatric evaluations, etc.), through the Disaster Distress Helpline (DDH) grantee, and may also take part in serving the needs of Ukraine refugees. We are currently contributing to the mental health needs of Afghanistan allies and with families that were separated at our southern border.

Another focus for SAMHSA is the national suicide crisis. Suicide is the 12th leading cause of death in the nation. In 2020, almost 46,000 Americans died by suicide and there were 1.2 million attempts. Further, the number of people thinking about (ideation), and planning suicide increased, which may be attributed to the rise in much younger children being part of these totals. SAMHSA has various long-standing suicide prevention programs and some data on the duration of an intervention. For example, when the Garrett Lee Smith (GLS) grant program was expanded to four years, there was a longer lasting effect and a reduction in the actual population rate of death by suicide. In new evaluations, grantees are encouraged to also collect data on ideation and planning.

Dr. Everett noted that because tribes have reported SAMHSA grants are not accessible enough to them, SAMHSA is planning a listening session to learn more and ensure tribes know how to successfully engage in the SAMHSA grant application process.

Crisis lines are an important component of a mental health crisis response system. Effective Crisis services decrease the incidents of police involvement, emergency room visits, and the need for inpatient stays. Unfortunately, some regions of the nation have not yet heard of 988, which currently operates as the National Suicide Prevention Lifeline. 988 launches nationally in July 2022 giving access to every American when they need mental health support. When a crisis cannot be resolved with a phone call, mobile crisis teams can respond on-site, or a crisis receiving center may be the best option.

In closing, Dr. Everett stated that mental health is a bi-partisan, national priority. System capacity, connecting people to care, and creating a continuum of support and healthy environments are part of the Biden Administration's strategy.

Dr. Everett then turned the meeting over to Cynthia Kemp, Deputy Director at CMHS, who introduced Dr. Steve Dettwyler, the Government Project Officer overseeing the SMI Adviser and Mental Health Technology Transfer Centers (MHTTCs).

Technical Assistance Discussion

Steve Dettwyler, Ph.D., Public Health Advisor, Division of State and Community Systems Development, CMHS

Mental Health Technology Transfer Centers (MHTTCs).

Dr. Dettwyler explained that the MHTTC Network seeks to accelerate the dissemination and implementation (D&I) of evidence-based practices for mental health prevention, treatment, and

recovery, as well as enhance the capacity of the workforce to provide services. The network consists of 10 regional centers that correspond to each of the Department of Health and Human Services (HHS) regions whose work is based on annual project plans and needs assessments. The network includes the national American Indian and Alaska Native Center, the National Hispanic and Latino Center, and the Network Coordinating Office. This regional approach enables centers to use D&I science to customize services while having the advantage of the network to collaborate on national projects.

In addition to assisting on a broad range of topics, each center has a specialty training focus. For example, different trainings have been developed for trauma-informed care based on regional needs. In their fourth year, MHTTCs have realized numerous accomplishments, including delivering over 2,200 trainings and events to over 207,000 mental health professionals and others, and offers over 1,600 products for the field.

The survey of regional key stakeholders, mental health organizations, practitioners, and others resulted in a list of technical assistance needs, including a national focus on culturally responsive care to racism, discrimination, and health inequities, the need for continued integrated care for co-occurring disorders, and how the pandemic affected the nation's mental health. For more information, visit the MHTTC website.

Each year of the grant cycle, the network has been awarded a supplement to provide technical assistance and training for implementing regionally based mental health services in schools and school systems, linkage to services, and including school mental health as part of the continuum of care. Among many initiatives, the network has collaborated on the MHTTC School Mental Health Initiative. Some topics include tele-mental health services, social isolation; grief, loss, and bereavement; mental health disparities; impacts of racial injustice; returning to school; COVID- 19; educator wellness.

The network has also disseminated information on best practices for school-based mental health and national resources to support those efforts, including the 2019 National School Mental Health Implementation Guidance. The resource includes trainer and participant manuals, slide decks, recorded learning sessions, an eight-part learning series, a best practices supplement guide, regional learning collaborative, and other intensive technical assistance projects. Another resource, Classroom WISE, provides training and resources for educators and school staff to support students with mental health concerns while in the classroom. A three-part collaborative project, Class WISE includes an online course, video library and resource collection and website.

SMI Adviser

SMI Adviser focuses solely on mental healthcare for those with schizophrenia, major depression, and bipolar disorder. This free, clinically focused resource for individual practitioners and families of people with SMI offers education, vetted resources, and on-demand consultation to support delivery of evidence-based practices.

The SMI Adviser website has received more than 1.3 million visits since its launch in 2019 while the smartphone app has more than 19,000 downloads and 35,000 email subscribers. SMI Adviser has also delivered more than 350 live webinars, on-demand courses, and in-depth learning collaboratives, has more than 140,000 registrants for learning activities, educated more

than 50,000 learners, and issued over 61,000 Continuing Medical Education credits to a diverse audience.

SMI Adviser creates learning communities for clinicians, such as the Clozapine Center of Excellence, the Long-Acting Injectables Center, and the Digital Health Community of Practice, which helps clinicians at the intersection of digital health, mental health, and clinical practice. The Peer Support Learning Community allows peers specialist to share and discuss best practice challenges and resources in rural care delivery.

A multi-disciplined, clinical expert team developed more than 1590 vetted resources, many of which are accessed during clinical visits. Further, resources to educate and help individuals with SMI and patient advocates are also offered.

SMI Adviser clinical experts have provided over 2,700 clinician consultations held via brief email exchanges, in-depth phone calls, and extended consultations on myriad topics, including how to achieve status as a Federally Qualified Health Center and implementing measurement-based care on an Assertive Care Team, to name a few. In fact, entire states are requesting consultation. Examples include the Ohio Association of County Behavioral Health Care Health Authority (87 counties) receives consultation to address and identify knowledge and skills gaps and all clinicians in North Carolina receive training and resources regarding inpatient and residential admission and care for those who have COVID-19 and SMI.

National agencies have also benefit from SMI Adviser. The National Judicial Task Force receives consultation on examining how state courts respond to mental illness. The FDA is also receiving guidance on implementation and utilization of the Clozapine Risk Evaluation and Mitigation Strategies (REMS). Virtual town halls on this and long acting injectables have also been convened. Further, the FBI National Threat Operations Center receives consultation and training because threat intake examiners have limited experience and field approximately 4,200 calls and e-tips per day and over two million contacts annually.

Lastly, SMI Adviser consultation addresses organizational change of workforce and systemic issues and includes SAMHSA leadership and staff, such as Dr. Charles Smith, Dr. John Palmieri, Dr. James Wright, and Dr. Richard McKeon.

Ms. Kemp thanked the presenter and turned the meeting over to Caitlin Fitzsimmons, a Public Health Advisor in CMHS's Mental Health Promotions Branch and Government Project Officer (GPO) overseeing the Center of Excellence for Eating Disorders.

Eating Disorders

Caitlin Fitzsimmons, Public Health Advisor, Mental Health Promotions Branch, CMHS
Christine Peat, Ph.D. Program Director, National Center for Eating Disorders

Ms. Fitzsimmons introduced Dr. Christine Peat, Program Director of the National Center for Eating Disorders, and Director of the National Center of Excellence for Eating Disorders (NCEED) that develops and disseminates training and technical assistance to healthcare providers. Based at the University of North Carolina (UNC), Chapel Hill, NCEED has many

resources in the region, such as a robust clinical research program established in 2003 led by Dr. Cynthia Beulah, who identified the first genetic marker associated with anorexia nervosa. In 2018, UNC was granted the first Center of Excellence for Eating Disorders that offers technical assistance via help from those with lived experience, clinicians, primary care providers, and residency training. They offer an aggregated, vetted, evidence-based set of resources to guide healthcare providers and the public and have directly trained over 7,000 healthcare providers, indirectly trained 16,000, and given over 700 CME/CEU credits.

Dr. Peat overviewed a 2020 study by Deloitte Economics, in collaboration with the Academy for Eating Disorders and others. Though too often viewed as a rare condition, eating disorders are common and affect roughly 28 million Americans at some point in their life and 10,000 people die annually as a direct result. Further, eating disorders have one of the highest fatality rates of any mental health condition, including substance use disorders, and often result in suicide.

Suicide is a national priority in terms of addressing some of the gaps and services that are available and in as much as, NCEED provides technical assistance for addressing the overlap between eating disorders and risk for suicide. As Dr. Peat stated, “These are not simply young people who are struggling with a phase in their life. These are individuals who are dealing with life-threatening and serious conditions.”

Eating disorders take an incredible toll on the national healthcare system and impact the workforce as well. Deloitte’s research found that the expenditure on eating disorders treatment was roughly \$4.6 billion (\$4.6B) with the highest levels of care, (inpatient hospitalization, residential care) accounting for approximately \$107M. They also found that the annual productivity loss associated with eating disorders is about \$48.6B. When adding the cost of care with the economic losses, eating disorders were estimated to cost the U.S. economy \$64B annually.

Like those with other mental health conditions, people with eating disorders were negatively impacted by the pandemic. Caseloads increased two to three times more than pre-pandemic levels most likely due to the significant and unprecedented increase of social media engagement. Studies show that social media and other online sources encourage eating disorder behaviors while algorithms embedded in the social media outlets encourage continued engagement with the content. Since numerous publications expose the harm social media can have on those vulnerable to eating disorders, and even though some safeguarding strategies are already in place, further action must be taken to protect this population.

Addressing eating disorders has become a national priority as evident by the National Eating Disorders Awareness Week that included a virtual summit held by the Office on Women's Health, and a proclamation from the White House. Notably, calls to eating disorder hotlines increased by 70 percent, and hospitalizations for eating disorders have doubled.

Multiple challenges arise in providing technical assistance to clinicians. Effective screenings and treatments are often overlooked by clinicians and loved ones may not have the tools to support those struggling with these disorders. NCEED meets these challenges with evidence-based guidance enabling everyone involved to be part of the solution.

NCEED’s mission is to advance the education and training of healthcare providers and the public on eating disorders and their treatment. Their goal is to ensure everyone involved has the right information so those affected by eating disorders can be accurately identified, treated, and supported on their recovery journey.

NCEED’s website (nceedus.org) also offers resources, such as live and on-demand training with free CMEs and CEUs and has a global reach of over 25,000 viewers. Further, the site offers a resource library similar to SMI Adviser, the offers a vetted resource library with current evidence-based materials with over 7,000 resource downloads. Notably, NCEED also has over 2000 newsletter subscribers and their social media strategy is reaching health care providers and the public.

Looking ahead, the center is focused on launching an “expert for eating disorders” to integrate care and assist front-line workers and providing tailored consultation and education for specific kinds of providers such as providers to military and veterans populations.

In closing, Dr. Peat provided QR codes for council members to access the partner tool kit and education calendar.

Ms. Kemp thanked the presenter and opened the floor for discussion on technical assistance.

Technical Assistance Discussion

[Beyond webinars] what methods have you seen that are effective in changing practice or providing sustained information?

Jane Adams noted people with mental illness need access to those with lived experience similar to how patients with cancer are flooded with access to people with lived experience. She noted that the presentations given to the CMHS NAC by doctors and researchers are “expert to audience” instead of from those with lived experience.

Dr. Sergio Aguilar-Gaxiola concurred, stating that webinars are not accessible to everyone. Having worked with immigrants and refugees, he attested to their challenges. He suggested that centers conduct listening sessions for vulnerable populations. He also noted that SAMHSA’s crisis counseling services are having a significant impact on these populations.

Dr. Everett appreciated the input and segued to SAMHSA Updates.

SAMHSA Updates

Recovery Stories

Tom Coderre, Acting Principal Deputy Assistant Secretary, Office of the Assistant Secretary, SAMHSA

Tom Coderre thanked the council and expressed excitement that mental health is a priority in the Biden Administration. He shared his lived experience and recovery, noting that not everyone has access to services like he did, but that they should. This includes creating safe home environments with staff who are knowledgeable and supportive.

Mr. Coderre also highlighted the critical importance of peer support in recovery. He expressed the hope and faith that working with peer support gives a person who wants to find stability and serenity, people like him and millions of Americans. His passion for prevention, treatment, and recovery continues to spur him on to give back, specifically through his work at SAMHSA.

Recovery Office Status and Plans

Dona Dmitrovic, Senior Advisor, Office of the Assistant Secretary, SAMHSA

Dona Dmitrovic thanked Mr. Coderre and explained that during National Recovery Month, Dr. Delphin-Rittmon announced the establishment of a new office (Office) focused on recovery under the Office of the Assistant Secretary.

As background, SAMHSA convened leaders in the field in 2010 to develop a definition of recovery: Recovery is a process of change, through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Notably, symptom remission is neither a prerequisite of recovery nor a necessary outcome. Further, recovery pathways are many and highly personal, and may or may not involve clinical treatment. With a long history of recovery support, SAMHSA committed to building a recovery leadership and infrastructure that would undergird its work, hence the launching of the new office. Now with one institutional entity, they will further raise the recovery banner and help communities pave the way for those who seek it.

The new Office will coordinate with all centers and offices to ensure SAMHSA has the capacity to bring together voices from recovery communities, to ensure that the millions of Americans who have yet to find recovery can do so, and that the millions in recovery are able to sustain and strengthen that recovery. Additionally, the Office will ensure the voices of individuals in recovery are involved in policy, programs, and services within the agency, and that there is a recovery focus throughout all agency programming and strategies. Notably, the Office's work will be inclusive of mental health and substance use.

With recovery as a guiding principle, the Office seeks to:

- Ensure that recovery is a guiding principle in SAMHSA's policies, programs, and services;
- Promote the involvement of people with lived experience throughout agency and stakeholder activities;
- Identify health disparities in high risk and under-served populations and ensure equity for recovery support services across the nation;
- Foster relationships with internal and external organizations in the mental health and substance use recovery field;
- Promote training and public education opportunities on recovery;

- Explore opportunities to partner with the philanthropic and private sectors to support innovative programming to address disparities and advance recovery transformation;
- Support implementation of any dedicated recovery resources to states for recovery support services, working with the Peer Center for Excellence.

Currently, the Office is still being staffed and recommendations for roles and positions are under consideration. Personnel will liaise with CMHS teams and activities include an agency wide recovery work group with over 60 staff from across SAMHSA; reviewing and updating recovery materials; ensuring recovery is prominent on the website; grant programs dedicated to developing and expanding peer recovery supports; and data and evaluation.

Related SAMHSA programming includes the National Consumer and Consumer Supporter Technical Assistance Centers; Targeted Capacity Expansion grants; the State Consumer Network; the Community Services Program; Building Communities for Recovery; and other discretionary grants for states, tribes and community-based organizations with innovative practices and programs for promoting long-term recovery.

The Office is also able to provide “lessons learned” for: building community and professional capacity to help create a movement of peer support specialists and recovery advocates; draw attention to local, state, and national discriminatory policy and barriers to sustained recovery; foster the need for recovery research; educate families and allies about the reality of recovery from mental illness and substance use.

In the future, the Office wants to provide data on the effectiveness and value of recovery support services, to demonstrate people can and do recover from mental illness and substance use disorders.

Consumer Affairs Question Discussion: CMHS NAC Members

What roles and functions have you seen, or do you recommend CMHS consider for the Office?

Jeff Patton stated that people in recovery should be recognized as people, not patients and consumers, that can and do lead in the recovery arena with talent that needs to be developed. He noted his appreciation for the focus on peer support.

Dr. Steven Adelsheim, who focuses on people ages 12-25, noted that using “recovery” in the name of the office may not reach this age group. Instead, the name should be framed in broader terms of early intervention and in a meaningful way to that population.

Khatera Tamplen suggested naming it the Office of Recovery and Resiliency. She stated the importance of authorization for funding to protect it in the future. Grants should also be part of its structure to revive stigma-reduction efforts and advance the peer workforce. Further, peers and family members should be included in the roll-out of 988. She also believes the Office should have a role (deputy directors) to allow a direct line to the Office of the Assistant Secretary. Further, a “flourishing scale” should be used to relate the needs and desires of those with lived experience.

Dr. Dennis Embry shared his experience of being a child of parents with substance use disorder. He is intent on population-level prevention and noted that 60,000 teachers have been trained in the Good Behavior Game. For the first time, there is a population-level random control trial to prevent childhood psychiatric disorders with many states implementing the process. The Prize Bowl is also a proven population-level effort. He urged CMHS to consider these types of efforts that any community can use to reduce lifetime addictions and psychiatric disorders.

Dr. David Shern concurred with previous comments on population-level efforts, using the flourishing scale, and the framing of resiliency. To move beyond managing illness and improve overall health and well-being, he mentioned the need to address the lifespan and content from Public Health 3.0, a 2016 white paper. He also urged the inclusion of those with lived experience, a focus on prevention, and reaching young people who may not relate “mental illness” or may not yet have a mental health disability.

Dr. Sampat Shivangi asked for guidance on how to use the funding surplus in his state, and whether the suicide rate has increased during COVID-19 for those with alcohol and substance use issues. Dr. Everett said she would set up a meeting with him and the Mental Health Block Grant team. She also explained that the increase cause of death has not been from suicide but rather overdose, which may or may not be suicide related. Further, suicide ideation and planning has increased along with the number of adolescents who visit emergency departments with a suicide attempt or ideation diagnosis.

NSDUH Data/Disparities AI/AN

Michael King, Ph.D., CAPT USPHS, Acting Director, Center for Behavioral Health Statistics and Quality

CAPT. Michael King is the Region 4 Administrator based in Atlanta as well as Acting Director for the Center of Behavioral Health Statistics and Quality (CBHSQ), which is the lead federal source for this data in the nation. CBHSQ recently published the 2020 National Survey on Drug Use and Health (NSDUH) products as well as state level estimations. County level estimates have been or will be published soon and 2021 data will be published towards the end of 2022. CAPT. King noted CBHSQ is also updating the 2019 Behavioral Health Equity Report.

[Note: During a technical issue, Dr. Shern noted that after the GLS program ended, the data show a return to pre-program suicide rates. Dr. Everett confirmed and stated the full report is available to council members. SAMHSA is considering how to shape funding announcements to promote sustainability.]

The Drug Abuse Warning Network (DAWN) identifies increases in emergency department (ED) visits involving specific substances and hospitals and the characteristics of those visits to act as “an early warning system” for the emerging or novel psychoactive substances. Later this year, the system should be capable of providing national estimates of ED visits related to substance use. Weighted DAWN data will soon be released in a preliminary report while national estimates will be released around November or December. Notably, DAWN provides - or will be able to provide – a breakdown of selected illicit substances.

CBHSQ also runs the Behavioral Health Services Information System (BHSIS), which is the primary source and a collaborative effort between national, state, and local stakeholders providing information on services, characteristics of individuals, and treatment. Different data collection activities include survey facilities and state data reporting.

The most recent change to BHSIS is the National Substance Use and Mental Health Services Survey, which captures all U.S. substance use and mental health treatment facilities. Created in 2021 to reduce the data reporting burden on facilities and streamline the collection process, this annual survey replaces and combines both the National Survey of Substance Abuse Treatment Services and the National Mental Health Services Survey. Further, the data is used to update the online behavioral treatment services locator.

CAPT. King shared various examples of BHSIS data including treatment episode data, mental health client level data, and uniform reporting system tables; this and other data can be found at [SAMHSA.gov/data](https://www.samhsa.gov/data).

CAPT. King highlighted the Behavioral Health Treatment Services Locator, which received over 1.97 million views in 2020. Accessed through SAMHSA's Evidence-Based Practices Resource Center, the locator lists substance abuse and mental health treatment facilities. A series of short video tutorials are on the main page. Health Resources and Services Administration's (HRSA) health care centers, Veterans Administration facilities, and buprenorphine practitioners are also listed. The two federal behavioral health service locators, findtreatment.samhsa.gov and findtreatment.gov, are being merged and the findtreatment.gov URL will be retained.

Lastly, CBHSQ promotes access and use of national substance use and mental health data through the Substance Abuse and Mental Health Data Archive (SAMHDA) site. This site has both public and restricted-use data analysis systems available to researchers.

Discussion

- CAPT. King pointed members to Dr. Stephanie Evergreen, a data scientist and data visualization expert, and her website (stephanieevergreen.com) where county level data can be extracted.
- Ms. Tamplen asked if data includes demographics and if the data captures whether the services are voluntary or involuntary since there is a disproportionate number of black and brown individuals placed involuntarily with less access to voluntary services. CAPT. King replied the sets include demographics and there is a justice-involved variable, but he is unsure if there is a court mandated field in the data sets and will find out.
- Referring to the mental health client level data slide, Dr. Aguilar-Gaxiola asked if CAPT. King could provide data on Hispanics. CAPT. King replied that in the NSDUH and other datasets, Hispanics are disaggregated, and the slides were only an example and not meant to be exhaustive.
- Dr. Embry asked about pediatric data. CAPT. King noted that age is a common variable. The NSDUH, in fact, is an in-home interview that includes the children and provides a unique analysis opportunity. Dr. Embry mentioned the multiple population level strategies that have been implemented across the nation.
- Dr. Shivangi invited CAPT. King to present to his board in Jackson, Mississippi.

- Lori Criss noted that NSDUH captures data from households when psychiatric inpatients and those incarcerated have a prevalence for mental illness and substance use disorders. CAPT. King stated SAMHSA is working to target those gaps, adding that ethical issues and cost limit the ability to survey those populations.

Diversity, Equity, and Inclusion (DEI) Work Group

Shary M. Jones, PharmD, MPH, BCPS CAPT, U.S. Public Health Service Special Assistant to the Director, CMHS; Nima Sheth, M.D., MPH Senior Medical Advisor, CMHS

Dr. Everett introduced the two presenters, CAPT. Shary Jones and Dr. Nima Sheth, co-facilitators of the Diversity, Equity, and Inclusion (DEI) workgroup, which serves as a model for all SAMHSA centers.

CAPT. Jones explained the mission, vision, goals, and purpose of the volunteer work group center on the elevation, promotion, and implementation of DEI efforts and values internally and externally regarding mental health and well-being in safe environments. Dr. Jones stated the workgroup strives to foster trust, resiliency, cultural humility, and celebrate individuality. She also noted that CMHS is the primary resource for strategies and best practices for promoting DEI in employment, again, both internally at CMHS and externally.

Established in April 2021, the workgroup created a charter and consulted with the Office of Behavioral Health Equity (OBHE) and other CMHS groups to align activities and efforts with DEI best practices. Dr. Jones turned the floor over to Dr. Sheth who added that the working group has been incredibly involved every step of the way before introducing their new project.

Though offices and programs are expected to be DEI oriented, the DEI Benchmarks Project (Project) seeks to develop specific guidelines for CMHS, including grantees, contractors, and within cooperative agreements, to gauge the success of DEI implementation.

The Project has five phases:

- **Phase 1 (August 2022):** Environmental scan, literature review, presentation of findings, listening sessions with select internal CMHS staff, grantees, and contractors, and data analysis.
- **Phase 2 (December 2022):** Additional listening sessions with external stakeholders and a Request for Information (RFI).
- **Phase 3 (March 2023):** Summaries, lessons, and guidelines derived from earlier phases, RFI to CMHS staff, creation of program-specific DEI benchmarks, strategic planning, and implementation planning.
- **Phase 4 (April 2023):** Activating the implementation plans via a DEI committee and with the intention of spreading to other CMHS programs, or perhaps even SAMHSA-wide.
- **Phase 5 (possibly July 2023):** Program evaluation.

To give a visual example of how the program might work, Dr. Sheth used a trauma-informed care screening tool encompassing trauma aware, trauma sensitive, trauma responsive, which could be mirrored with DEI.

DEI Workgroups Question Discussion: CMHS NAC Members

Dr. Jones asked the council for input on other organizations or experts that should be invited to the listening sessions, terminology to use or avoid, feedback on the timeline itself, or other projects that might be replicated.

Jeff Patton noted that the Kalamazoo Community Health Needs Assessment found significant disparities around mental health, particularly racial. Yet, the consultants, who specialize in employment issues, stated there is not enough mental health data when that is not the case. He asked for SAMHSA's help. Dr. Everett suggested meeting with Kalamazoo and stated that the NSDUH data is reliable at the county level. Dr. Shern added that Tampa counties have also identified mental health and substance use as the number one need.

Dr. Aguilar-Gaxiola stated other organizations are addressing DEI, which are mechanisms for realizing health equity. As part of his work over the last two years with the National Institutes of Health, a recent paper was published in the New England Journal of Medicine and will be shared with NAC members. The paper includes strategies and recommendations, with accountability emerging as a critical issue. He also broached the topic of structural racism, stating that NIH directors such as Dr. Francis Collins have been very open about the topic.

Ms. Tamplen stated that communities are reporting that the trend of using the acronym BIPOC (Black, Indigenous, Person of Color) is not representative; each group is unique with needs that deserve specific attention. Similarly, using SMI as a blanket characterization for anyone with mental health disorders misses the mark. Dr. Everett affirmed the point adding that remaining person-centered is the key while labels may not be useful.

Dr. Embry advocated for an ecological approach to mental, behavioral, and emotional health. Rather than seeing just an individual as sick, it would be beneficial to look at the locale and the socio-economic conditions surrounding the person. He urged SAMHSA to look at population-level strategies that would reduce the prevalence of these disorders, such as the Good Behavior Game, which turned around psychiatric disorders at the population level.

Mr. Patton added that "ablism" is another term used to describe discrimination of people with disabilities. Dr. Sheth added that "native American", "American Indian", "minority", and "underserved" are also problematic.

Dr. Shern noted there is active resistance against DEI, mentioning Florida specifically. He asked about these challenges in the national context with grantees. Dr. Sheth stated that inviting open conversation is one way to address the issue and perhaps it would come up at the external listening sessions. She added that focusing on this area during the literature review and

environmental scan would be helpful. OBHE is seriously looking at the diversity impact statement, which is a requirement for grantees.

Ms. Tamplen noted that “illegal alien” is no longer to be used per the White House.

Ms. Adams shared that her work in Kansas for the last two years has also involved looking carefully at grouping people as those with “lived experience”; she fully supports the work of the DEI workgroup.

Public Comment

Ms. Foote stated there were no public comments.

Closing Remarks

Dr. Everett asked the council for feedback on the agenda and structure of the meeting. She opened the floor to members to make any closing remarks.

- Ms. Tamplen stated that originally there was a Consumer Family Advisory Committee to the NAC, which was a valuable component that should be reinstated.
- Dr. Shivangi suggested an in-person meeting would be helpful.
- Dr. Embry urged CMHS to focus on kids at one of the upcoming council meetings.

Adjournment

Ms. Foote adjourned the meeting at 4:45 p.m.

DECISION:

Approved Disapproved

Anita Everett MD DFAPA 06/03/2022
Anita Everett, M.D., DFAPA Date