U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

National Advisory Council Meeting Minutes

April 25, 2023

SAMHSA
5600 Fishers Lane
Rockville, MD 20857

Submitted by:
Jami Hudson Craig

Table of Contents

CALL TO ORDER AND ROLL CALL 3

WELCOME, OPENING REMARKS, INTRODUCTION OF NEW MEMBERS 4

CONSIDERATION OF THE AUGUST 18, 2022, MEETING MINUTES 5

CMHS DIRECTOR'S REPORT – PROGRAM UPDATES 5

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) 8

SCHOOL BASED MENTAL HEALTH SERVICES 11

MENTAL HEALTH BLOCK GRANT 16

SAMHSA UPDATES FROM ASSISTANT SECRETARY 23

CMHS RESPONSE TO DISASTERS 26

PUBLIC COMMENT 29

CLOSING REMARKS 30

ADJOURNMENT 30

PUBLIC COMMENT 31

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. After conducting roll call and establishing a quorum, she turned the meeting over to Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS) and Chair of the National Advisory Council (NAC)

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.
Sergio Aguilar-Gaxiola, MD, Ph.D.
Leonard Bickman, Ph.D., M.A., B.S.
Lori Criss, MSW
Charles Dike, MD, FRCPsych, MPH, DCP, GACHE
Anthony Fox
Michelle Reid, MD, DLFAPPA, FACPsych
David Shern, Ph.D.
Sampat Shivangi, M.D., FICS
Conni Wells

Council Members Absent:
Lori Raney, M.D.
Khatera Aslami Tamplen

Ex Officio Members:

Miriam E. Delphin-Rittmon, Ph.D.
The Honorable Xavier Becerra
Joshua A. Gordon, MD, Ph.D.
Robert K. Heinssen, Ph.D.
Chris Loftis, Ph.D.

Welcome, Opening Remarks, Introduction of New Members

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

Dr. Anita Everett introduced the newest council members:

- Anthony Fox, President and Chief Executive Officer, Tennessee Mental Health Consumers Association
- Dr. Charles Dike, Director, Law and Psychiatry Fellowship Program, and professor of psychiatry, Yale University; Chief Medical Officer (CMO), Office of the Commissioner, Connecticut Department of Mental Health and Addiction Services
- Dr. Michele Reid, CMO, CNS Healthcare, a Certified Community Behavioral Health Clinic (CCBHC), Michigan
- Ms. Conni Wells, Regional Director, Northeast Region, Tennessee Voices

Dr. Everett requested the rest of the council members and CMHS staff introduce themselves as well.

- Dr. David Shern, Senior Public Health Advisor, National Association of State Mental Health Program Directors; professor and dean at the Florida Mental Health Institute at the University of South Florida in Tampa; former president and CEO of Mental Health America (2006-2012)
- Ms. Lori Criss, Director of the Department of Mental Health and Addiction Services, Ohio
- Dr. Sampat Shivangi, physician, Jackson, Mississippi; Chairman, Board of Mental Health
- Dr. Jane Adams, Executive Director, Keys for Networking, Inc. (family organization in Kansas)
- Dr. Sergio Aguilar, Professor of Clinical Internal Medicine, University of California Davis; Director, Center for Reducing Health Disparities; Community Engagement Program Director, Clinical and Translational Science Center; member, National Advisory Council of National Institutes of Health's National Center Advancing Translational Sciences
- Dr. Leonard Bickman, professor, Florida International University; former professor of psychology, Vanderbilt University [Dr. Bickman is also the chief artificial intelligence officer for an unnamed for-profit company]
- Dr. Ezer Kang, temporary advisor at Center for Mental Health Services (CMHS); professor, Howard University
- Dr. Sunny Patel, Senior Medical Advisor, CMHS

Dr. Everett suggested holding a meeting before the next council convening to create an agenda based on the interest of the members.

Dr. Everett overviewed the agenda, noting Assistant Secretary Dr. Miriam Delphin-Rittmon would be joining the meeting at some point.

Consideration of the August 18, 2022, Meeting Minutes

CMHS NAC Members

Dr. Everett asked for a motion to approve the August 18, 2022, meeting minutes; they were approved unanimously.

CMHS Director's Report – Program Updates

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

Dr. Everett stated NAC meetings are public, and participation is available through a formal process. She explained this convening was a type of orientation with new members and highlighted the mission statement: Lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. Referring to the recovery tag line, "home, health, community, purpose", Dr. Everett stated the goal is for everyone to have good health, a home, and a sense of community and purpose.

Dr. Everett explained SAMHSA's strategic plan has five priorities:

1. Preventing Overdose
2. Enhancing Access to Suicide Prevention and Crisis Care
3. Promoting Resilience and Emotional Health for Children, Youth and Families
4. Integrating Behavioral and Physical Health Care
5. Strengthening the Behavioral Health Workforce

Crosscutting principles include equity, workforce, financing, and recovery.

Dr. Everett noted, beyond SAMHSA, there are several agencies within Health and Human Services (HHS), such as the Centers for Medicare and Medicaid Services (CMS), the Federal Drug Administration (FDA), Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), the National Institute of Mental Health (NIMH) within the National Institutes of Health (NIH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Dr. Everett explained SAMSHA, in its 31st year, accomplishes most of it work through funding; about 50% through block grants and 50% through grants SAMHSA operates under the discretion of Congress (discretionary grants). Discretionary grants are competitively scored, and some are reviewed by the council. They also have several different types of contracts and provide technical assistance (TA).

Dr. Everett described SAMHSA's organizational structure, stating the following centers provide a foundation for its work:

- CMHS: Center for Mental Health Services
- CSAT: Center for Substance Abuse Treatment
- CSAP: Center for Substance Abuse Prevention

- CBHSQ: Center for Behavioral Health Statistics & Quality

Other offices are under the direction of the Assistant Secretary such as the Office of Recovery, a new office directed by former CMHS director, Mr. Paolo del Vecchio, and the Office of Behavioral Health Equity (OBHE).

As for their budget, SAMHSA works with allocated funds, which have been increasing; disproportionately so in 2021 to address mental health concerns due to COVID-19. Congress is currently deliberating over the 2024 proposed presidential budget and the 2025 budget is currently being prepared for submission to the White House.

Dr. Everett further explained CMHS operates three block grants, including the Mental Health Block Grant (MHBG), its longest standing grant. MHBG's funding, which has doubled over time, goes to all states and several territories, and is broadly distributed based on population. CMHS also has the Projects for Assistance in Transition from Homelessness (PATH), and the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program. Further, they operate about 45 discretionary grants, with Congress adding a few more with almost every budget, and about 25 TA centers. TA funding opportunities include requirements for marketing expertise to ensure effective outreach through channels designed to meet the intended beneficiaries of the TA centers. CMHS is also trying to adopt an adult-centered learning paradigm with active engagement of the participants. Lastly, the increased funding may demonstrate the faith Congress has in and the value of SAMHSA programs.

Passed in December 2022, the Restoring Mental Health and Well-Being Act reauthorized SAMHSA and allocated funding. Dr. Everett summarized the authorized work in the legislation as follows:

- Enhancing access to suicide prevention and crisis care
- Promoting resilience and emotional health for children, youth, and families
- Integrating behavioral and physical health care
- Strengthening the behavioral health workforce

Other provisions include mental health parity, a maternal mental health hotline, and flexibility to provide mental health and substance use disorder (SUD) services to incarcerated youth through the state.

SAMHSA has been through many changes in the recent past. To build a strong foundation, CMHS is focused on strengthening internal processes, increasing stewardship of their budget, becoming an even stronger resource to a variety of stakeholders, and assuring a healthy workplace, which has improved every year as evident in the federal employee viewpoint surveys.

Beyond 2023, Dr. Everett explained CMHS will be doing more outreach to spread the word about its programs and services and encourage partners to utilize its programs. To that end, CMHS is focused on three main strategic priorities. The first priority is excellence in grantmaking, including documenting effective practices and standards for government project

officers, a policy on site visit management, grant reporting, and using data to make data informed decisions about grant programs.

The second priority is to provide high quality TA that significantly impacts the field. The goals are to increase communication, marketing, and dissemination of information to internal and external stakeholders; pursue opportunities with professional organizations; and engage at the national, regional, and local level. One example is to spread the word among those interfacing with youth about the positive and negative impacts of social media. Recently, CMHS briefed the Surgeon General and the Assistant Secretary for Health, Dr. Rachel Levine, on the TA center. Strengthening and advancing the behavioral health workforce also falls under this priority, along with using data and information to inform TA center quality improvements, Notice of Funding Opportunity (NOFO) development, and strategy for allocating resources.

The third priority is staff development and engagement. CMHS is committed to recruiting, empowering, equipping, retaining a highly trained and collaborative workforce, and fostering a healthy workplace culture. Their work toward this goal is evident in the over 50% increase of their workforce over the last two years, partially because of the ability to hire remote workers.

Dr. Everett opened the floor, and the following questions and comments were shared:

SAMHSA: What are ways we can effectively more engage with our NAC members?

- Dr. Reid asked about communication between NAC meetings; Dr. Everett stated thus far, it has only been for meeting preparation and left the issue open-ended for people to share their experience from other boards they have served on.

- Ms. Criss wondered what input SAMHSA is looking for from the council and if advance notice of topics would create dialogue opportunities and help drive improvements. Dr. Everett noted constraints, including the public and the involvement of the Federal Register. However, subcommittees could be formed to address particular topics and report outs could be shared at council meetings.

- Dr. Adams asked about the possibility of a post-meeting summary. Ms. Foote noted a phone call is allowed. Dr. Reid suggested sending a survey and explained the platform used by the American Psychiatric Association called BoardEffect allows for participants to see the survey immediately following the meeting and then gives two weeks to complete the survey.

- Dr. Aguilar-Gaxiola asked for updates about reports and funding opportunities released by SAMHSA to allow council members to be local ambassadors. He also asked for help navigating public-facing databases. Dr. Everett suggested discussing the challenge with Dr. Delphin-Rittmon when she joined the meeting.

Certified Community Behavioral Health Clinic (CCBHC)

Mary Blake, Senior Public Health Advisor, Community Support Programs Branch, CMHS

Ms. Mary Blake overviewed Certified Community Behavioral Health Clinics (CCBHCs), a model of integrated and coordinated care for individuals across the lifespan with - or at risk for - mental illness and SUDs. Designed to increase access to behavioral health services regardless of ability to pay, CCBHCs provide a comprehensive range of services responsive to local needs and incorporate evidence-based practices, such as care coordination. Across the range of services they provide, CCBHCs must meet standards for access, including availability of crisis services 24/7, and routine outpatient care available within 10 business days after an initial contact.

Established under the 2014 Protecting Access to Medicare Act, the CCBHC demonstration program was designed to improve community behavioral health services through Medicaid funding. Section 223 established a federal definition of a CCBHC and required criteria to frame and guide the work of CCBHCs. The section also stipulated state taking part in the demonstration could receive an enhanced Medicaid reimbursement rate based on the anticipated cost of care (states can bill for the cost of care).

Three major federal partners work on the broader CCBHC initiative: SAMHSA develops planning grants for establishing the criteria and quality measures; Centers for Medicare and Medicaid Services (CMS) develop and oversee the prospective payment system; and under HHS, the Assistant Secretary for Planning and Evaluation (ASPE) administers the national evaluation of the demonstration program.

CCBHCs can be funded in three ways: the demonstration program, direct funding to clinics by SAMHSA under the grants, and then other state efforts. There are some differences between clinics participating in the CMS demonstration versus clinics receiving grants directly from SAMHSA. For example, SAMHSA grants do not reimburse through a prospective payment system. Notably, some sites in the CMS demonstration program also receive SAMHSA grants.

The CCBHC program began with eight states and 62 clinics. Currently, there are over 500 CCBHCs across the country in 46 states, the District of Columbia, Guam, and Puerto Rico. [Note: Ms. Blake shared a map showing how CCBHCs are distributed across the nation along with funding methods.]

The 2022 Bipartisan Safer Communities Act provided an additional $40 million for a new round of CCBHC state planning grants, expanding the authority to add states to the demonstration program. The Act also included an extension of time for the demonstration states. Further, SAMHSA announced awards of 15 new states, preparing them for applying to the demonstration program in 2023.

Another CCBHC evolutionary highlight occurred when SAMHSA created two tracks for CCBHC clinics under the grant program in 2022. The CCBHC-Planning, Development and Implementation (CCBHC-PDI) track was established giving 151 clinics not yet meeting the requirements for certification up to one year of capacity building and infrastructure development to do so. The second track, CCBHC-Improvement and Advancement (CCBHC-IA), funded 150

clinics already demonstrating compliance with certification criteria to deepen their work, improve quality, expand or improve their work as a CCBHC. For fiscal year (FY) 2023, new NOFOs for CCBHC-PDI and CCBHC-IA will include up to 62 awards for up to $1million for up to four years with an anticipated start date of September 30, 2023. Applications are due May 22, 2023.

As stated, CCBHCs need to operate according to six specific standards of care within the certification criteria related to staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational governance and authority that includes people with lived experience with mental illness and SUDs as well as family members.

Further, CCBHCs must provide nine required services: crisis services, targeted case management, peer support, family support, psychiatric rehabilitation services, and primary care screening and monitoring.

Ms. Blake explained updated certification criteria were posted to SAMHSA's website in March 2023. Reasons for the update include new developments in the field as well as outdated criteria (electronic health record standards), and responsiveness to suggestions from those in the field (increasing the focus on SUDs and social determinants of health).

To solicit feedback from the field, SAMHSA held stakeholder interviews and hosted public webinars. After an initial round of stakeholder comments, SAMHSA posted the first draft of revised criteria, solicited input again, made additional edits and then reposted the criteria. Based on this input, SAMHSA built out crisis care criteria, providing linkages to 988 through CCBHCs and additional crisis stabilization information, as well as criteria for responding to the opioid crisis and addressing health equity. They also provided greater clarity on psychiatric rehabilitation services and elevated the role of supported employment. Useful links to review these developments are:

- Updated Criteria
- Original Criteria
- Summary of Changes
- Redline from Original to Update

Ms. Blake also highlighted data on the expansion grant program from **SAMHSA's** Performance Accountability and Reporting System (SPARS) from FY2021 through 2023, revealing a compelling positive impact from the CCBHC program of 14.5% increase in overall health, almost a 26% increase in everyday functioning, and a 15% increase in social connectedness. Further, data shows decreases in binge drinking, illegal substance use, homelessness, and significantly fewer people report being hospitalized for mental health care or SUD in the last six months and there is a significant drop in emergency department visits.

In closing, Ms. Blake related a story from the field describing successful coordination of care and highlighting the importance of a coordinated team environment addressing immediate needs of those in need. Another example was how one CCBHC met the requirement for lived

experience on their governance board. This center set up an advisory board with the CEO attending its meetings for the first three months. Realizing the wealth of knowledge and expertise in the field and from consumers, the advisory board integrated this experience and collaborated with stakeholders. The advisory board eventually became an integral part of their quality improvement work and a springboard for people to join the actual governing board.

Discussion

Dr. Reid, CEO of CNS Healthcare, a CCBHC in Michigan, confirmed the importance of including people with lived experience in governance. Michigan requires one third of the board of trustees to be primary or secondary consumers of mental health services, and 50% of CNS Healthcare board have lived experience. She also explained they merged with another CCBHC-E grantee, allowing a major expansion in children's services, including a fulltime child and adolescent psychiatrist on staff.

As for the National Outcome Measures for people at risk, the center has significantly impacted physical health services. Partnering with two different Federally Qualified Health Centers (FQHC), they were able to get monitors for pre-diabetics and secured the services of a registered dietician in spite of Medicaid disallowing such services and aids.

Dr. Reid related the CCBHC was able to continue to serve those with mild to moderate mental illnesses who would otherwise be sent back into a community that would not accept Medicaid. Having a CCBHC also helped streamline activities and increase efficiency with getting people into services. Dr. Reid related they have also been able to develop a care pathway for suicide, where there once was none, resulting in almost a 60% reduction in suicide attempts. She added the technical assistance from the national council has been invaluable.

Ms. Blake was enthused by the feedback, stating many of the expansion grantees are adding children's services with varying degrees of success, and a few child-focused centers are adding adult services.

Dr. Shern champions coordinated specialty care for first-episode psychosis (FEP), which is an effective, evidence-based practice that has components that are not covered in a fee-for-service insurance reimbursement. He explained CCBHCs can build this care into its cost report, and either contract those services from a specialty agency or create the service in-house. He shared that a clinic in Buffalo, New York uses the CCBHC model to finance their FEP program.

When Dr. Shern wondered about paying for the workforce, Dr. Everett stated it is an allowable expense. Dr. Reid added thanks to CCBHC funding, CNS Healthcare was able to retain staff and increase salaries.

Dr. Shern inquired about the Federal Medical Assistance Percentage (FMAP). Ms. Blake explained it varies from state to state and depends on which prospective payment system (PPS) the state chooses. Notably, CMS is currently updating the PPS guidance. Further, states participating in the demonstration program determine which evidence-based practices must be

delivered under a CCBHC and thereby, which ones will be financed. Dr. Shern asked for clarification regarding which entity makes the decision. Ms. Blake stated there is a partnership in the demonstration program between the mental health authority, the substance use authority (if it is separate), and the Medicaid authority.

Ms. Criss stated Ohio, which is looking to become a demonstration state, has several CCBHCs through the discretionary grant and a planning grant. With the Bipartisan Safer Communities Act creating a pathway for every state to be a CCBHC state through Medicaid and the single state authority, she wondered how the programs dovetail into one another, noting Ohio is determining how many CCBHCs the state needs. Ms. Blake stated there have been clinics in the expansion program who have been demonstration state clinics from the very beginning allowing for the funding of services they might not have been able to offer otherwise. Dr. Everett noted the demonstration model allows for cost-based payments for much needed services and likens some of the grants to capital or startup funds enabling programs to build out crisis services. Regarding a certificate of need, Dr. Everett noted it could be challenging to regulate. Ms. Blake suggested contacting existing demo states about how they navigate the issue.

Ms. Blake explained a community needs assessment is the foundation for the delivery of CCBHC services. The revised criteria provides much more information and guidance as well as a tool each local CCBHC should use to demonstrate need. Dr. Reid offered to connect members with her Michigan network and explained how centers were able to enter the two programs.

Ms. Criss noted the financing model is also challenging and learning how FQHCs became permanently established might be helpful. Another participant suggested creating a learning community around these issues. Ms. Criss stated they used one-time funds to conduct a national review and are awaiting the report.

Dr. Everett highlighted the effort of the team to elevate the criteria and Ms. Blake's presentation. Ms. Blake thanked her team and added SAMHSA is conducting a national evaluation of the expansion programs.

When asked if the increased block grant budget would continue, Dr. Everett stated the President's budget includes a permanent increase; it is next up to Congress.

School Based Mental Health Services

Ms. Nancy Kelly, Branch Chief and Ms. Jennifer Treger, Government Project Officer, Mental Health Promotion Branch, SAMHSA

Ms. Jennifer Treger greeted the council and Ms. Nancy Kelly explained the branch handles Project AWARE, trauma-informed services in schools, a mental health awareness training grant portfolio, and an infant and early childhood portfolio with Project LAUNCH, Indigenous-LAUNCH, and infant and early childhood mental health projects. The branch includes three centers of excellence addressing eating disorders, social media, and mental wellbeing, and infant and childhood mental health consultation.

Ms. Treger presented mental health and youth mental health statistics. Results of the Adolescent Behaviors and Experiences Survey conducted by the Centers for Disease Control (CDC) from January to June 2021 revealed youth challenges due to the pandemic. Specifically, more than one in three high school students experienced poor mental health during the pandemic and nearly half of students felt persistently sad or hopeless. Further, one out of every 10 students attempted suicide during the prior year.

Female students identifying as lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+), experienced disproportionate levels of poor mental health and suicide-related behavior. Additionally, many of the populations experiencing greater inequities before the pandemic also had greater risk during the pandemic related to mental health, suicide, substance use/abuse, and racism. The survey also revealed school connectedness (a sense of being cared for, supported, and belonging at school), had a very positive impact on students.

Another study of adolescent health from the Youth Risk Behavior Survey shows 10-year (2011-2021) trends on health behaviors and experiences among American high school students. Collected every two years, the data includes the COVID-19 pandemic timeframe and reveals a decline in mental health among students, including a 14% increase since 2011 of students experiencing persistent feelings of sadness or hopelessness, for a total of 42% for 2021. Further, Black students were significantly more likely than Asian, Hispanic, and White students to have attempted suicide while female students were faring more poorly than male students across all measures (substance use, violence, mental health, suicidal thoughts, and behaviors). Alarmingly, nearly 60% of female students and nearly 70% of LGBTQ+ students experienced persistent feelings of sadness or hopelessness; 15% of high school students were bullied on school property; and 16% of were electronically bullied. These results stress the importance of programs like Project AWARE that provide critical skills training for adults interacting with youth to ensure a connection to care.

According to the National Survey on Drug Use and Health (NSDUH), youth ages 12 to 17 with major depressive disorder have an increased risk of drug use and 56 to 60% of these may not be getting the appropriate care they need. For those receiving care, 17.5% receive it in an outpatient setting, 11.9% in an educational setting, and 10.6% through virtual services.

Many factors influence youth mental health, such as genetics (individual); relationships with parents and caregivers (family); relationships with peers (community); access to healthy food and green space (environment); discrimination, racism, and culture (societal).

A time of emotional development and vulnerability, adolescence is often when mental illness symptoms appear. Further, 50% of all chronic illness is diagnosed by age 14, and 75% by age 24, leaving school an important avenue of identification. Interrelated factors for an increased risk of mental illness include hormonal changes, peer influences, experimentation with substances, increase in risk-taking behavior, concerns about appearance, domestic violence, trauma, and bullying. Protective factors include a sense of control over one's life, healthy coping skills, strong family or social support, community bonding, and healthy practices. Because another very important factor is feeling close to at least one adult, the school and school community can play a significant role. Through mentoring and opportunities for engagement with school community,

positive norms, clear expectations, and creating psychologically and physically safe environments for young people, adults who interact with students can provide a safe place for students to open up.

Project AWARE (Advancing Wellness and Resiliency in Education), a program aimed at increasing mental health awareness in schools. From FY2018 to 2021, Project AWARE was funded through states and tribal education agencies. Cohorts sought "to build or expand the capacity of the state education agency or tribal community in partnership with state mental health agencies to advance wellness and resiliency", by focusing on:

- Early identification
- Increasing awareness about youth mental health challenges
- Training for anyone who interacts with students to detect and respond to these challenges
- Training to support the mental health needs of the staff
- Connecting those experiencing challenges - and their families - to needed services

Beginning in 2022, grant implementation followed a three-tiered public health model built on a foundation of collaborative partnerships within the schools, staff wellness and support, and family engagement. The model must be implemented in culturally relevant, developmentally appropriate, trauma-informed, and community-based ways to ensure equity.

Tier one is universal prevention (reaching every child within the school) and mental health promotion, such as prevention programs, suicide prevention training, mental health literacy training, social/emotional learning programming, classroom experiences, resiliency skills training, and violence prevention. Tier two is secondary prevention and brief intervention for children at risk (higher truancy or absentee rate, struggling academically, etc.). This tier employs targeted interventions such as social skills groups, brief intervention services, and additional screening and identification of children in need. Lastly, tier three covers tertiary intervention and behavioral health treatment.

To benefit from lessons learned, Ms. Treger explained they review the prior funding opportunity to learn how to make the funding opportunities more user-friendly and address community issues by building a sustainable program. Ms. Treger highlighted the following:

- The importance of collaboration in the school and the school community
- Tailoring the work of the grant to the community
- Addressing stigma
- Buy-in at all levels (state/county/school) to prioritize mental health
- Sociopolitical climates and the impact on implementation
- The need for ongoing staff and teacher support
- The importance of family engagement

Ms. Treger shared a quote from an Arizona grantee and the following successes:

- Disparity impact work resulting in more culturally relevant service provision
- Building relationships, collaboration, rapport, and trust

- Medicaid billing progress for school mental health purposes
- Removing barriers to care and increasing the access to services
- Implementation of universal screening
- Ability to pivot during the pandemic and stay connected with students
- Workforce training and Mental Health Literacy training
- Interdisciplinary team approach
- Continuous focus on improving school climate and educator and staff wellness

Continuing priorities include:

- Building workforce capacity and address shortages
- Addressing ongoing stigma
- Prioritizing mental health at the state level
- Addressing increased violence in school
- Addressing increased need for mental health services
- Addressing ongoing challenges of the COVID -19 pandemic (time limitations, added responsibilities, restricted travel, teacher burnout, hybrid learning, technology, the "digital divide", lack of internet access, overall increased anxiety of staff and students, ongoing grief support for students and staff)

In closing, Ms. Treger stated grantees are expressing Project AWARE changes the way the community infrastructure responds to disasters and student crises while connecting families and youth to services. She looks forward to the current evaluation to learn how schools and school communities implement this critical work. Ms. Kelly concurred, stressing the importance of infrastructure and sustainability.

Discussion

Dr. Shivangi inquired about statistics on post-COVID-19 mental illness in youth and adults. Ms. Kelly stated the current evaluation will provide such data as well as data on new trauma-informed services in schools. Anecdotally, grantees report a significant impact of COVID-19 on their young people.

Dr. Aguilar-Gaxiola asked about societal impacts such as neighborhood safety on mental health. Ms. Treger reiterated partnerships between the school and school communities are helping mitigate the effect of negative impacts. For example, one grantee is looking at the impact of food insecurity on mental health and expanding services. Project AWARE also helps stakeholders address barriers to reaching particular students such as culture. One grantee added a cultural liaison to ensure mental health services were culturally appropriate.

Dr. Bickman asked if grantees take responsibility for tracking individuals through a complex system and ensure students do not fall between the cracks. Ms. Kelly explained because the program is an infrastructure grant, Project AWARE grantees only collect aggregated data while anecdotal information is collected through the annual performance report. Though they do not collect client-level data, the trauma-informed school services grantees will.

Dr. Reid asked about age limits for the program and inclusion of those with intellectual and developmental disabilities. Ms. Kelly explained no one is left out, including transitional-age youth.

Dr. Reid also asked how many schools are involved in Project AWARE and percentages by type of institution. Ms. Treger stated there are 92 grantees mostly from public schools and tribal entities. Dr. Everett added the program has been in most states; some states have multiple grants.

Ms. Criss explained Ohio views Project AWARE as a framework to create an infrastructure to benefit all schools. They recently awarded the school-based prevention and early interventions center of excellence to Miami University, which runs the Ohio School Wellness Initiative, giving them a larger technical assistance type role. Ohio is also creating legislation empowering districts to use 50% of their student wellness and success funds to implement student assistance programs and employ behavioral health wellness coordinators. They are discerning how to convey the importance of their work (funded in partnership with the Ohio Department of Education) to a broader audience, and how the model is affecting change in school-based measurements (better attendance, decreased behavioral incidents in the classroom). She wondered if SAMHSA could help frame the conversation with those who authorize the spending.

Ms. Kelly responded each grantee has developed their own performance or project measures, and some do look at school-based measurements such as attendance and test scores. Though direct correlations cannot be made when providing multiple services in a school, overall progress can be seen in the school climate and are captured in the annual performance reports. Ms. Criss believes messaging should give credit to all the positive changes coming from this and other SAMHSA programs.

Dr. Adams asked how the program has engaged families and garnered their support rather than feed into their fears. Dr. Everett added a couple states would not approve the application because of the emotional and social learning. Ms. Treger stated engagement comes through partnerships with community-based organizations, hiring people from the community, working within the schools, and reaching out through Parent-Teacher Associations (PTAs). At its core, the work is about building relationships, which can take longer in some locales.

Dr. Dike asked if cultural education, cultural humility, or awareness trainings are embedded in the program. Ms. Kelly stated those components are built in and grantees can use their dollars to provide trainings specific to their programs and communities, including Mental Health Awareness Training through the grant program. Further, SAMHSA's development of a disparity impact statement raises the bar of expectation for grantees to provide training to anyone interested.

When Dr. Everett asked about the use of peers in the program, Ms. Treger stated many programs use older peers to work with the younger students, and some programs like Mental Health First Aid have a peer component. Additionally, some evidence-based or evidence-informed practices have a peer component, and some grantees use family as peers as well.

AFTERNOON SESSION

Dr. Everett welcomed the council back after the break and introduced Mr. Tison Thomas. Mr. Thomas manages three formula grants within his division: the Mental Health Block Grant, which is the largest grant and received a funding increase of up to $1 billion; the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program; and the Projects for Assistance in Transition from Homelessness (PATH) program. The states receive and distribute the grants to their sub-grantees or providers. Mr. Thomas then introduced the MHBG coordinator, Asha Stanly, to give an overview of block grants.

Mental Health Block Grant

Asha Stanly, MSW, LICSW, Public Health Advisor, State Grants Western Branch, CMHS, SAMHSA

Ms. Asha Stanly stated 2023 marks the 60-year anniversary of the Community Mental Health Act signed into legislation one month before President Kennedy's assassination. The Act was the first federal policy shifting funding and services from institutionalized settings to community-based services allowing those with mental illness to be treated at home, rather than being kept in state institutions.

Measured by reductions in hospital placements, deinstitutionalization was considered a success, dropping from 75% inpatient episodes in 1955 to 7% in 1977, and to 1.6% in 2020. Over the years, community-based services have steadily increased, with 9,634 community mental health centers in the United States as of 2020.

In 1982, another shift occurred; the new federalism turned control of resources over to states to address their own unique local needs, and funds for community mental health shifted into the form of block grants to states.

While the mental health program was administered by NIMH during the 1980s, a decade later SAMHSA and CMHS were created through the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, transferring the oversight of MHBG to CMHS, making it the largest single program administered by CMHS and the largest single federal funding stream dedicated to community mental health services for both adults with SMI and children with serious emotional disturbance (SED).

In 1986, Congress amended the statute, which now requires states to submit a comprehensive mental health plan and an extensive report about their public mental health systems to CMHS annually. States must also establish an independent mental health planning council - with mandated membership of different state agencies, consumers, and families - to review and advise on the state's mental health plan, among other required duties.

Ms. Stanly highlighted the MHBG cycle:

- Congress appropriates block grant funding.
- SAMHSA uses the statutory formula to make allocations.

- Application guidance is published.
- States submit their applications to SAMHSA by September 1 and implementation reports on December 1 of each year.
- Awards are issued by SAMHSA's Division of Grants Management.

CMHS monitors and provides oversight of state grantees through the review of state plans and reports, monthly update meetings, and onsite monitoring methods.

CMHS distributes the block grant funds to all 50 states, Washington D.C., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Republic of Marshal Islands, Micronesia, and the Republic of Palau. The appropriate amount of block grant funding is calculated through the block grant formula, which is based on three components: size and risk of the population needing services, the state's ability to pay (resources), and the relative cost of services in that state.

Because the block grants do not provide enough funding for states to develop and implement the required comprehensive mental health plans, other financial resources are needed. As Ms. Stanly explained, "Although the block grantees are a small percentage of a state's mental health budget, it is viewed as providing an important and flexible source of funding to support a broad range of activities specific to the needs of that state."

During the pandemic, states received more than their regular 2021 allocation of $757.5 million. In 2022, the regular allocation increased to $857.5 million, and the Bipartisan Safer Communities Act enacted in 2022 provided states an additional $250 million. With a steady increase over the years, the 2023 regular appropriation totaled $1.01 billion. Further, for FY2024, President Biden proposed an increase of $645 million for the mental health block grant for a total of $1.6 billion.

States received a COVID-19 relief supplement in 2021to address challenges the pandemic brought to the forefront. Specifically, $825 million was released to state authorities through the MHBG, and another $825 million was distributed directly to community mental health clinics (CMHCs). SAMHSA provided specific guidance and recommendations for potential funding use, (crisis lines, training, reentry supports, etc.) and almost all states requested an extension past the expiration of March 2023 to use the funds until March 2024.

In addition to the COVID-19 supplemental funds, the American Rescue Plan Act also allocated an additional $1.5 billion in 2021 for the MHBG, which must be used by September 30, 2025. SAMHSA issued guidance asking states to enhance their mental health services and improve their IT infrastructure and telehealth capacity to advance mental health service delivery.

Lastly, the Bipartisan Safer Communities Act provides $250 million in supplemental funding for the MHBG between 2021 and 2023. The MHBG comes with a "maintenance of effort" (MOE) requirement, which means states must maintain state expenditure at a level no less than the average of the two fiscal years preceding the fiscal year of the grant. If a state fails to meet their MOE requirement, it can request a waiver based on extraordinary economic conditions or a determination that the state materially complied the requirement for that fiscal year.

The number of individuals served in the community has steadily increased from over six million people in 2009 to about eight million individuals served in 2021 while the number of individuals in both state psychiatric hospitals and other psychiatric inpatient settings has remained relatively steady across the years.

Since 2014, Congress requires states to set aside a specific percentage of their MHBG to support evidence-based programs addressing the needs of individuals with early SMI (ESMI), including psychotic disorders. In 2014 and 2015, 5% of the block grant was set aside, which increased to 10% in 2016. Though congressional language was broad enough to allow the use of any evidence-based program addressing ESMI, coordinated specialty care (CSC) for FEP was specifically mentioned.

Spending on CSC programs totaled $82 million in 2021, with the majority of CSC spending funding MHBG at $63 million. Spending on other ESMI programs totaled $7 million with about $6 million spent on mental health program across the 18 reporting states.

The number of CSC programs increased every year since the set-aside began in 2014 (59 programs) to 145 programs in 2015, and 170 in 2016, the same year the 5% set-aside increased to 10%. As program awareness spread among states, the number increased to 214 in 2017, and currently 381 CSC programs across the nation.

States with larger populations such as California, Texas, Florida, and New York, have set-asides of $2.5 million and above while other states like Alaska, Montana, and Maine have less than $500,000.

Ms. Stanly also shared statistics on suicide and suicide prevention. In 2020, there were approximately 45,000 reported suicides and 26% of 51 million adults with mental illness reported feeling an unmet need for services. For those living with SMI, the percentage was 48%. With the need for a more accessible and complete psychiatric crisis care continuum, in 2020, Congress designated 988 as an emergency crisis line to be operated through the existing National Suicide Lifeline. Since July 16, 2022, all states now operate local 988 call centers, a critical first step towards a transformed national crisis care system.

Crisis services need to be available nationwide to anyone, anywhere, anytime. In 2020, SAMHSA published the national guidelines for behavioral health crisis care best practice toolkit recommending a comprehensive crisis continuum in every state, consisting of three core elements: crisis call centers, mobile crisis teams, and crisis receiving and stabilization facilities. Today all states fund or operate some form of 988 lifeline call centers and 32 states have all three core components. In 2022, only 17% of calls resulted in a mobile crisis being dispatched by a crisis call center, and only 3.6% of calls resulted in law enforcement being dispatched. Further, in 2022, 44 states reported having a total of 1,287 mobile crisis teams; 31 states are opening over 173 additional mobile crisis teams in 2023; and 15 states have dedicated mobile crisis teams exclusively for children and adolescents.

Crisis receiving and stabilization facilities (CRSFs) provide short-term observation and stabilization services in a homelike non-hospital environment. Currently, 39 states have CRSFs,

and nine additional states are planning to open these facilities in 2023. Further, 19 states reported serving 130,000 persons in CRSFs in 2022.

States are spending their MHBG set-aside in various ways to ensure there is someone to talk to (call center), someone to respond (24/7 mobile crisis teams), and a place to go (stabilization program). The 988-implementation process received the most funding across 24 states while 19 states funded mobile crisis teams, followed by non-Lifeline call centers and crisis facilities operating less than 24/7. Many states are working on legislation to fund 988 with tax revenue, similar to how 911 is funded, with Virginia being the first state to pass such legislation.

In closing, Ms. Stanly explained SAMHSA offers technical assistance (TA) to all states and territories receiving block grant dollars with the aim of improving effectiveness and efficiency of using block grant dollars and providing consultation and resources to meet the evolving needs of states. Assistance can be accessed easily by emailing the state TA team.

Discussion

Dr. Shivangi asked for current statistics to show how 988 has helped across the country and which states have maximum or low incidences of hospital admissions or catastrophic outcomes because of the 988 program.

Dr. Everett explained it took about 60 years to develop a reliable, consistent 911 system, and 988 launched less than a year ago. A large amount of separate funding has been received to support the necessary infrastructure to make 988 available nationally and to reduce the response times. However, there is a long way to go. Because of the importance of the 988 office, the Biden Administration pulled it out of CMHS (though they continue to support the related spectrum of care) and made it a stand-alone office under the Assistant Secretary.

Dr. Shivangi noted though Mississippi has a 988 program, crisis services do not include transportation to hospitals or medical centers. Dr. Everett suggested he ask how the state is spending the crisis set-aside, because 10% should be set aside for crisis services.

Mr. Thomas noted the set-aside is not enough to fund all three core components; however, every state has a mobile crisis team according to the block grant data. Because states are asked to consider the future before training personnel, most states use their funds to implement systemic planning and TA to create sustainability. For accountability, Dr. Shivangi suggested instituting parameters and consequences around the funding, such as giving the state six to 12 months to implement, or funds will be withdrawn. Mr. Thomas explained the issue is not states withholding the funds; they just do not have enough to fund crisis services. Dr. Everett added the hope is for the funding to be a type of startup capital aligned with other grants and funding, such as billing through the state's Medicaid plan.

Ms. Criss noted the cooperation required between SAMHSA and other parts of federal government to create more opportunities at the state level. She likened the need for paying for crisis services to how fire emergency services are handled; people are served without regard to how services will be paid.

Dr. Everett stated the preferred team structure for crisis response is a behavioral health professional paired with a peer specialist going onsite instead of law enforcement whenever possible. States with this system are having good success.

Ms. Criss asked about using the MHBG to support people who are criminal justice involved or forensically involved. Mr. Thomas stated money can be used for outpatient or community-based programs, including detention services, but not prisons, jails, and forensic psychiatric hospitals. He stated during the last administration, SAMHSA sent a letter to all commissioners specifically stating money could be used for competency restoration. Many states received approval for using MHBG funding to connect those being released from jail or prison to a community mental health program.

With no further questions, Dr. Everett segued to the next presentation and thanked Mr. Thomas for his multi-faceted service as division director and interim deputy.

Black Youth Suicide Prevention Activities
Walker Tisdale III, MPH, MA, LMSW Public Health Analyst, Office of Behavioral Health Equity; Billina R. Shaw, M.D., MPH, FAPA, FASAM Senior Medical Advisor, Office of the Director, CMHS

Dr. Billina Shaw introduced the Black Youth Suicide Prevention Initiative (BYSPI) to the council. The notion of Black people being at a lower of risk of dying by suicide has shifted over the last decade. Prior to the pandemic, the Congressional Black Caucus published a report called Ring the Alarm, inciting government to focus on Black youth suicide. This was followed by a report from HHS on Black youth suicide, and the alarming data trends persist.

According to the CDC's 2021 Youth Risk Behavior Surveillance System (YRBSS) and current mortality data, Black students were more likely than Asian, Hispanic, and White students to attempt suicide; the percentage of Black students injured by suicide increased from 2011 to 2021; and other groups had no change or decreased. [Dr. Shaw added a couple of other minority groups such as Asian American young people have started to create a slight aberration to their trend.]

BYSPI's main goal is to "reduce suicidal thoughts, attempts, and deaths of Black youth and young adults between the ages of 5 to 24 in the country." The strategy to meet the goal is being developed with help from the Assistant Secretary for Planning and Evaluations (ASPE) Equity Technical Assistance Center.

Dr. Shaw overviewed the following:

- **Cross-cutting equity initiatives:** Multiple grant programs touch Black youth and BYSPI seeks to incorporate the multiple grant programs touching Black youth.
- **Best practices:** Currently, there is a lack of data on intervention and best practices to help this emerging population. In collaboration with the NIMH and Office of Minority Health, SAMHSA wants to develop a toolkit for dissemination on best practices and will

host The Policy Academy from July 17 to 19, 2023, in Baltimore, Maryland. SAMHSA is considering a summit related to Black youth suicide prevention for grantees and those in the field and other product development, such as an advisory board through their evidence-based resource center.

- Training and Technical Assistance: The Policy Academy is the flagship activity that will be going on soon. Also, there is talk about a summit related to Black youth suicide prevention for our grantees and broader for the field and other product development, such as an advisory through our evidence-based resource center.
- **Community awareness:** The initiative seeks to reduce stigma and ensure communities are aware of the concern and how to best respond through provider and consumer marketing.
- **Data and evaluation:** SAMHSA wants to understand both the process and the outcome measures related to Black youth suicide prevention, the long-term trajectory of impacting deaths is important, but then also what are our steps along the way, and we'll be having ASPE help us in development of that as well.

As for media development (and provider technical assistance), SAMHSA is considering developing a call to action for 988, based on formative research from the 988 communications office. Other activities include having the topic of Black youth suicide as part of ABC News during mental health awareness month. The issue will also be a focus topic at the American Psychiatric Association meeting.

Dr. Shivangi asked about the percentage of suicide attempt or suicide rates by ethnicity. Dr. Shaw stated she can access and share that data, which shows Black youth suicide is disproportionate to the percentage of the population.

The floor was turned over to Mr. Tisdale to present on the Policy Academy, an initiative stemming from recommendations for program or service delivery from an August 2022 expert panel. The goal of the Policy Academy is to support about nine state teams to develop action plans to reduce suicidal ideation, attempts, and deaths among Black youth and young adults ages 5 to 24. At the conclusion of the academy, attendees will have an increased knowledge of prevention, intervention, and postvention strategies; identify needs, gaps, assets, potential key informants, policy recommendations and barriers, and potential partners in their states; and develop an action plan and timeline to address Black youth suicide in their states.

Because funding was inadequate to implement initiatives nationwide, the team evaluated which states had a high rate of suicide among Black youth using CDC WONDER, and mortality data, and census data. States selected to participate include Georgia, Kentucky, Indiana, Arizona, Wisconsin, Texas, Virginia, Ohio, Pennsylvania, and Maryland.

To create a multidisciplinary team, states must have key staffers to support the goals, beginning with the state suicide prevention specialist coordinator or director as the point of contact. The team will also include a local clinician, a state Department of Education representative, college, or university representation (preferably from a Historical Black College or University, HBCU), and a community or faith-based organization. Lastly, an individual with lived experience, preferably age 18 to 24, and a family member will round out the team.

SAMHSA will hold a pre-meeting with subject matter experts (SMEs) and SAMHSA staff before the Policy Academy convenes and follow up with TA to support the state teams in handling priorities and addressing challenges or barriers.

During the convening, states will hear presentations from various subject matter experts, including Dr. Dawn Tyus, Project Director, African American Center of Excellence at Morehouse; Dr. Alex Crosby, medical epidemiologist, formerly with CDC, now at Morehouse School of Medicine; Dr. Sonyia Richardson, University of North Carolina Chapel Hill, who conducts research and work in adapting interventions for African American youth. State teams will be given dedicated time to begin developing their plans with their designated SME and SAMHSA staffer.

Discussion

Dr. Shaw circled back to answer Dr. Shivangi question about the percent change in deaths for ages 10 to 24 from 2018 to 2022: American Indian or Alaska Native youth, had an 18% increase, and persistently have the highest rate over time; Asian youth or youth and young adults, had a 10% increase; Black youth had a 39% increase; White youth had a 2% decrease; and Hispanic youth had an 11% increase.

When asked about the root cause for this significant increase, Dr. Shaw replied it is unclear; however, hopelessness, current events around race relations, and access to lethal means is concerning. Mr. Tisdale added there are very wide gaps in the research on effective interventions for Black youth. Most interventions are based on youth of European descent and do not account for the very unique risk factors such as anger or frustration, which can be misconstrued as a behavioral issue in school settings.

Mr. Tisdale explained the workforce shortage and lack of access to care also play a role. Dr. Shaw added there are better health outcomes in communities with providers and physicians of color, so cultural competence is also a factor.

Dr. Reid asked for more information on direct-to-consumer marketing. Dr. Shaw stated SAMHSA has a role in providing information to every citizen, be they in the field and part of the general population.

Dr. Everett noted feelings of unworthiness are also a barrier to seeking treatment. Dr. Shaw added there is a cultural difference between parents and second-generation youth in help-seeking behaviors, with the latter being much more amenable to care than prior generations. However, oftentimes parents are gatekeepers to care, meaning children must go through them to receive it.

Dr. Reid asked if there has been any effort to coordinate with the Zero Suicide grantees to leverage existing resources. Mr. Tisdale stated they are encouraging the state coordinators to facilitate that interaction. Additionally, Dr. Everett stated if the initiative is successful and other states are interested, SAMHSA may repeat the effort.

Dr. Everett noted there is under-counting and a spectrum of actions included in the data from thinking about suicide, planning for suicide, and attempting suicide, which helps the field determine where to intervene. Regarding data collection, Dr. Dike emphasized the importance of participatory and diverse research, adding Black youth have experienced discrimination and adversity for all time.

Dr. Sergio Aguilar-Gaxiola asked about such a young end of the age range. Mr. Tisdale explained because the literature shows people as young as age five have expressed wanting to die, SAMHSA wanted to provide flexibility to include them. Dr. Shaw added the general population also has increasing data on the younger age group and they wanted to use ages consistent with CDC cohorts.

In response to Dr. Everett's comment about the number of cases, Dr. Shaw stated there is an undercount of suicides in general because the intent is hard to determine. Further, older literature revealed when presented with the same case but changing the race to Black, the medical examiner, coroner, or others who are untrained were less likely to deem it a suicide.

When Dr. Shern commented on irritability and anger in the context of greater awareness and outcry of the inequities Black people face, Dr. Shaw explained the increases have taken place for a decade or more and precede the most recent Black Lives Matter movement. Yet, people are living with the overt racism and are challenged in a different way than previous generations.

Mr. Tisdale highlighted the research gap regarding the "adultification" (forced to grow up before their time) of young people of color in mental health settings, education, criminal justice, juvenile justice, etc.

When asked about the role of social media in suicidality, depression, anxiety, and other experiences around mental health, Dr. Shaw stated SAMHSA's new Social Media Center of Excellence will look at the possible negative effects of the suicide contagion that can happen online, and how to use media to send out healthful messages.

Lastly, Dr. Shaw explained the Policy Academy is not just looking at immediate antecedents to death but also the social determinants and other concerns (mental health, social supports), around suicide.

SAMHSA Updates from Assistant Secretary

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

Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use, began with an overview of SAMHSA's interim strategic plan, which is out for public comment, highlighting important changes: workforce has been added as a key priority area; trauma-informed care has been added as a crosscutting principle; and commitment to data and evidence has moved from a key priority area to a crosscutting area. The plan also addresses data, data collection, increasing access to suicide prevention care, preventing overdose, integrating primary care and behavioral health, and promoting resilience in children, youth, and families. Notably,

the strategic plan builds on the President's Unity Agenda, the Bipartisan Safer Communities Act, and the HHS Strategic Plan and Health Workforce Strategic Plan.

Across the federal government, harm reduction is a new focus area. One of SAMHSA's key priorities is the overdose prevention strategy – addressing overdose through harm reduction - which includes primary prevention, treatment, and recovery. In collaboration with multiple partners, the harm reduction framework will be released summer 2023 to address definition, key activities, policies, and programs.

Dr. Delphin-Rittmon explained harm reduction goes beyond programs and services to meeting people where there are. For example, one site provides portable restrooms while another holds activities to build relationships and increase awareness of its programs and services. Other areas addressed through the harm reduction program include social determinants of health, increasing access to care, formation of community partnerships, updating policies, and incorporating cultural approaches and nuances into care.

As part of its overdose prevention work, SAMHSA continues to implement state and tribal opioid responses (SOR; TOR), which currently receives about $1.5 billion in the President's FY24 budget with increases on the horizon. The goal is for each state to have a naloxone saturation plan, a goal supported through the upcoming policy academy.

SAMHSA is also working to address overdose through a range of policy changes and policy related work. With the signing of the Consolidated Appropriations Act 2023 in December 2022, which included both the Mainstreaming Addiction Treatment (MAT) Act and the Medication Access and Training Expansion (MATE) Act, the requirement to obtain a data waiver to prescribe buprenorphine was removed along with caps on the number of people prescribers can treat and the counseling requirement. However, the MATE Act requires prescribers to have eight hours of training. SAMHSA, the Drug Enforcement Agency, and the Department of Justice collaborate to determine what training is necessary.

Dr. Delphin-Rittmon stated suicide prevention and crisis care continue to be a primary focus. With the launch of 988 in July 2022, an additional 172,164 people reached out for help. Calls increased by 48% and texts increased by 1,445% while the answer rate dropped from 172 seconds to 44 seconds. Dr. Delphin-Rittmon asked NAC members to help disseminate the 988 Partner Toolkit, which includes digital shareables for social media, alongside their own national media campaign ahead of Mental Health Month in May.

SAMHSA is also updating the National Strategy for Suicide Prevention (NSSP) through the Behavioral Health Coordinating Council chaired by Admiral Rachel Levine. This update is being done in partnership with the Action Alliance, the Suicide Prevention Resource Center, and many of other community partners. Dr. Delphin-Rittmon also briefly touched back on the BYSPI, with a grant application closing date of May 15, and CCBHCs.

Recently, the National Standards for Peer Certification went out for public comment. With an anticipated 2023 release, this guide sets the standards for implementing peer support and peer certification training programs.

Under the direction of Captain Karen Hearod, director of the Office of Tribal Affairs, the Tribal Behavioral Health Agenda is also being updated based on feedback from tribal leaders and communities through both the Secretary's Tribal Advisory Council and SAMHSA's Tribal Technical Advisory Council.

Lastly, Dr. Delphin-Rittmon reminded the council of SAMHSA's focus on expanding and supporting the workforce through its SAMHSA STRONG initiative to create a supportive, transparent, respectful culture, opportunities for advancement and career development, and growth. Their success at this endeavor is evident in their quick rise in the recent "Best Places to Work in the Federal Government" rankings.

Discussion

Dr. Reid stated the strategic plan is circulating among the American Psychiatric Association membership and listservs. She expressed appreciation that the plan's equity definition includes persons with disabilities, persons who live in rural areas, and persons otherwise adversely affected by persistent poverty or inequality.

Dr. Reid also noted the Zero Suicide framework has been so successful the number of suicide attempts decreased by almost a 60 percent for those on that pathway in Michigan. However, overdose deaths have increased by about 30%; perhaps a similar pathway would be successful in reducing overdoses. Dr. Delphin-Rittmon stated certain aspects of Zero Suicide might be helpful to incorporate and naloxone saturation is critical for responding to an overdose. Dr. Reid pointed out once Narcan becomes available over the counter (OTC), the increased price point could be another obstacle. Dr. Delphin-Rittmon explained the OTC drug is 4 milligrams and insurance companies will likely continue to pay for the 8 milligrams dose.

Dr. Bickman emphasized there must be a change in how services are funded to make any progress; insurance companies will only pay for treatments making them a profit. Dr. Delphin-Rittmon noted SAMHSA collaborates with many stakeholders, including CMS, on the topic of financing. Yet, creating sustainable, impactful care systems of care is critical. Dr. Shern added many high-risk people who are insured by commercial insurers are either denied services or their insurance companies get a free ride. He appreciates SAMHSA taking the application for a billing code to the CMS administrator because the current code for coordinated specialty care is used by payers for other services. Dr. Delphin-Rittmon stated she will continue to raise the issue in those discussions.

Ms. Criss stated at the state and local levels in Ohio reporting outputs and outcomes are very challenging. She appreciates SAMHSA's definition of recovery that includes wellness and social determinants of health. Gathering a core dataset pointing to meaningful outcomes is essential to help people understand the work. Dr. Delphin-Rittmon stated SAMHSA is looking to streamline collection of performance data and determine which measures documented and tracked. Ms. Criss followed up with a comment on streamlining the national outcome measures (NOMs) as well.

Mr. Anthony Fox expects SAMHSA to ensure people with lived experience are considered in the CCBHC metrics. He also inquired if there is data from each state on the response time to text and chat to share with his state's commissioner. Dr. Delphin-Rittmon answered affirmatively, adding SAMHSA has crisis coordinating office under the direction of Monica Johnson that is there to provide support. Ms. Chessen explained 988 texts and chats are handled nationally while states build their individual capacity. Dr. Delphin-Rittmon added backup providers are available to field 988 calls as well, which is an important piece of the full network.

Returning to the topic of CCBHCs, Dr. Everett stated governance requirements expect half of those hired to have lived experience, which encompasses peer support specialists and family support specialists. Further, the psychosocial rehabilitation component was strengthened and now includes supported employment. Dr. Delphin-Rittmon explained sites must meet those new standards to be certified.

Dr. Adams stated SAMHSA's leadership and insistence to include those with lived experience is critical making headway at the state level. One of the best ways to access that voice is through the statewide family networks and the statewide consumer organizations. Dr. Delphin-Rittmon appreciated the commitment to engage, stating the new fully staffed Office of Recovery is developing a national recovery agenda and ongoing support, input, and feedback is vital to its work. During Mental Health Month and Recovery Month, there will be additional engagement opportunities. Dr. Everett stated contacting Ms. Foote is a concrete way to engage.

Before departing, Dr. Delphin-Rittmon thanked the council and highlighted the joint NAC meeting the following day.

Ms. DiFonzo pointed attendees to SAMHSA.gov and findsupport.gov, a new user-friendly resource focused on mental health and drug and alcohol issues. She stated the toolkit is a one-stop-shop with different key messages and weekly themes with social media sharables highlighted each week of May. In the first week, Dr. Everett launches a blog on the importance of self-care, and the third week is about working together and helping each other. SAMHSA will do a five-part series with a local ABC news station on different mental health topics and work with social media influencers to reach a younger and more diverse audience. Dr. Everett stated the link will be sent to the council who are asked to help spread the word.

CMHS Response to Disasters

CAPT Erik Hierholzer, BSN, Sr. Public Health Advisor, CMHS; Maggie Jarry, M.Div., MS, Emergency Coordinator, OAS/Office of Intergovernmental and Public Affairs

Ms. Maggie Jarry explained SAMHSA's provides consultation, coordination, communication, and collaboration for disasters and emergency response and support situational awareness at various jurisdictional levels. Internal coordination occurs across the centers and offices within SAMHSA, such as the Office of the Assistant Secretary, CMHS, Office of Intergovernmental and Public Affairs (OIPA), Center for Substance Abuse Treatment (CSAT), and the Office of Management, Technology and Operations (OMTO). They also coordinate with external partners, such as states, local, territorial, and tribal behavioral health authorities and within HHS, the

Administration for Strategic Preparedness, Response and Recovery (ASPR) and the Office of Human Services Preparedness and Response, located within the Administration for Children and Family Services. Other external coordination takes place with the Department of Justice, Department of Education, and Department of Homeland Security (DHS). Whoever they partner with, as an emergency coordinator in the OIPA, Ms. Jarry is responsible for communicating ongoing situational awareness and reports for the agency.

Ms. Jarry explained the concept of "All disasters are local." State, territory, and tribal leadership determine the effects on their community and what is needed while SAMHSA provides supports and continual communication, internally interfacing to support and meet the need.

The SAMHSA Emergency Response Grant (SERG) allowing SAMHSA to act immediately in emergencies requiring a behavioral health response. The grant differs from other grants in that the SERG is a SAMHSA-wide grant opportunity and up to 2.5% of SAMHSA funds can be used for mental health services, substance use treatment, and prevention programs not approved for funding under the Crisis Counseling Assistance and Training Program (CCP). Generally, the SERG is awarded in the absence of a presidential declaration of disaster under the Stafford Act. SERG monies are considered "funds of last resort" and cannot supplant or replace other private and public existing funds. Currently, a SERG grant process is in the works with New Palestine, Ohio, related to the train derailment and chemical spill. The SERG was also used after the May 2022 shooting in Buffalo, New York and after the November 2022 Club Q shooting.

CAPT Eric Hierholzer took the floor to present on disaster behavioral health and the CCP, noting a seminal study by Dr. Fran Norris revealing almost half of its 60,000 participants showed moderate impairment after a natural disaster, which is indicative of prolonged stress. Stress, anxiety, and other depression-like symptoms after a disaster are common and normal reactions to a very abnormal and stressful event. However, most disaster survivors do not develop new diagnosable behavioral health or SUD conditions as a result of the disaster.

Because coping strategies do not fit every person in every situation, disaster behavioral health seeks to support community and individual coping that facilitates recovery. Thankfully, many survivors are naturally fairly resilient, do not need formal interventions or services, and recover over time with the help of a natural support system (family, church, classmates or teachers, coworkers, other community connections). When people need more support, disaster behavioral health workers help them understand the reactions they have and offer successful coping strategies, stress management activities, and linkage to community resources.

Yet, 10 to 15% of survivors of every disaster have a more severe, long-term reaction requiring clinical mental health or substance use treatment services. Risk factors for this population are the severity of exposure and the trauma experienced (death of a loved one, severe injury, exposure to very traumatic or grotesque scenes); pre-disaster risk factors such as persons living with physical illness, mental illness, or substance use issues; being a member of ethnic, cultural, or linguistic minority groups wherein connection to resources is limited; and lack of financial resources or access to educational resources. Children or older adults who depend on others in their day-to-day lives are also at higher risk for a more severe reaction. Post-disaster environmental factors

such as the loss of home, severe property damage, loss of transportation, and being displaced or involuntarily relocated are other risk factors associated with a more severe reaction.

To support behavioral health related to a disaster, CMHS has crisis counseling assistance and training program (CCP) grants, which use a behavioral health outreach model. Trained paraprofessionals canvas the community after a disaster and provide basic crisis counseling and psychoeducation to help people understand what they may be experiencing and any associated behavioral health symptoms. People are linked to community recovery resources and benefit from behavioral health assessments conducted by trained counselors. For those with more severe reactions, treatment referrals are provided. Grant eligibility requires a presidential major disaster declaration, which includes a designation for individual assistance. Recent legislation allows emergency declarations to also be considered for CCPs. Discussions are underway with the Federal Emergency Management Agency (FEMA) to determine how this legislation will be rolled out.

There are two CCP grants: 1) A 60-day immediate services program (ISP) grant; and 2) a nine-month regular services program (RSP) grant. Between the two grants, five required trainings to paraprofessionals are provided. Grantees are also eligible to apply for funding for other trainings useful to their community. Via an interagency agreement, SAMHSA administers the grants and provides the behavioral health oversight expertise while FEMA funds the grants.

The last full year of grant data was captured in FY2022. At that time, there were 54 grantees serving over 1.5 million people through individual encounters lasting more than 15 minutes or group encounters initiated by crisis counselors, which were eventually taken over by survivors for continuity. Further 2.1 million people were served through brief educational contacts lasting less than 15 minutes, and almost 2 million people were served through telephone and email contact. An anonymous grant program, only data related to program reach and quality are tracked through an aggregate community-level response.

One of the major disaster resources is the National Disaster Distress Helpline (DDH), a confidential, multi-lingual, toll-free number with text capability; American Sign Language services are available via videophone. Available all day every day, DDH is dedicated to providing immediate crisis counseling for people experiencing emotional distress from natural or human-caused disasters. If a disaster event happens, SAMHSA's Office of Communications will send out a press release to the affected communities about the DDH.

In FY22, 27,700 callers and about 3,400 text messages were fielded on the DDH. To date in FY23, there have been a little over 19,000 calls, consistent with the projection of about 38,000 calls this year.

The Disaster Technical Assistance Center (DTAC) provides consultation, training, and TA for CCP grantees, identification and promotion of best practices, and myriad materials and resources (tip sheets, toolkits, webinars). DTAC publishes a monthly newsletter and a quarterly journal related to disaster behavioral health. They also have a disaster behavioral health information series, and an online database of annotated resources and toolkits searchable by disaster or audience type that go to affected communities.

Discussion

Ms. Criss expressed appreciation for the quick response to the train derailment in East Palestine, Ohio. She explained the local community is driving the process, and technical assistance and guidance has proved to be a very supportive experience. CAPT Hierholzer added the local effort of individuals from that community being heavily involved in the decision-making process and the services implemented in those communities is a best practice.

Ms. Criss stated the Bipartisan Safer Communities Act requires states to increase their disaster response capacity and asked if the presenters are connected to this work. Dr. Everett had not heard of that, and Ms. Jarry stated it may be through DHS. Several interdepartmental efforts focus on bringing trauma-informed services to all of the disaster services across all federal agencies. There is also a center inside DHS focused on taking a public health approach to preventing violence. CAPT Hierholzer requested more information on the matter because the DTAC assists states with disaster preparedness planning.

Impressed by the presentation, Dr. Shern stated he had much to learn about the resources available to support people following a natural disaster, which are becoming more and more frequent. CAPT Hierholzer added there is currently a CCP ongoing in Florida in response to Hurricane Ian.

Ms. Jarry noted the White House fact sheet on the Bipartisan Safer Communities Act revealed it runs through DOJ. Further, there is collaboration with all federal partners in a number of areas. The goal is to better understand which treatment and prevention facilities are impacted, and how quickly they receive the needed resources to rebuild resilience over time and not just around the immediate event.

With no further questions, Dr. Everett thanked the presenters and closed the discussion.

Public Comment

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

Dr. Everett explained though the meeting was open to public comment, there were no participants to speak verbally and only one written comment that would be added to the record, but not read aloud.

Dr. Reid asked how organizations can participate during the public comment session. Ms. Foote stated for every public meeting, a Federal Register Notice is disseminated, and anyone may participate in the meeting by submitting a comment. For in-person meetings, people who want to attend can notify SAMHSA and be escorted through security into the meeting. Lastly, Ms. Foote encouraged members to peruse the SAMHSA website to see upcoming meetings, review meeting minutes, and read public comments.

Dr. Everett opened the floor for final comments. When Dr. Reid expressed concern that everyone, especially those representing consumer groups, had a chance to speak, Dr. Everett stated everyone had an opportunity, and the onus was on group representatives to educate their members about how to participate.

Closing Remarks

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

Dr. Everett thanked all participants and mentioned the joint NAC meeting scheduled for the following day (April 26, 2023). She noted her intention to have a follow-up meeting to set the agenda for the next meeting.

When Dr. Shern inquired about scheduling time for NAC members to report on what is emerging for them, Dr. Everett stated that could be helpful.

Dr. Shivangi noted there has not been a focus on tribal nations and would like more information on SAMHSA's efforts. Dr. Everett stated that could be part of the next agenda.

Dr. Dike expressed appreciation for the orientation and suggested giving the council advance notice to better prepare for the next meeting.

Adjournment

After Dr. Everett shared the meeting time and place for the joint NAC meeting, Ms. Foote adjourned the meeting at 4:20 p.m.

Public Comment for the Record

Isabelle Shain – Committee for Children

April 11, 2023
Pamela Foote, Designated Federal Officer
CMHS National Advisory Council
5600 Fishers Lane, Rockville
Maryland 20857

Re: Public Comment on School-Based Mental Health Services for April SAMHSA, CMHS NAC Meeting

Dear Ms. Foote,

As a nonprofit organization dedicated to working to ensure that each child is able to be safe and thrive in a just and peaceful world, Committee for Children thanks the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services National Advisory Council (CMHS NAC) for their work on School Based Mental Health Services.

To ameliorate the continuing youth mental health crisis in our country, it is vital to ensure access to school-based programs and services that promote student mental wellness. Taking a public health approach to the youth mental health crisis includes ensuring that all schools can implement tier I, primary prevention programs and services that help students to build protective factors upstream and mitigate crises from developing downstream. One important strategy to include in tier I, in consideration of lessening the youth mental health crisis, is helping students to build social skills and emotional skills, such as problem-solving, building healthy relationships, and managing emotions. Doing so supports all students in building their toolbox of skills that have been shown to mitigate experiences of anxiety and depression, deter substance misuse, strengthen comprehensive youth suicide prevention, and promote well-being long into the future. What's more, in the face of a mental health workforce shortage, the strain on the workforce for higher tier interventions can be reduced when all students are supported with tier I programs and services that are preventative and promote well-being.

We appreciate and commend SAMHSA, CMHS NAC's work on attending to tiered systems of support to strengthen a full continuum of care for students, such as by shaping Project AWARE grants to further this work in schools. Continued focus on programs that enable a tiered system with prioritization of strong tier I primary prevention programs and services will strengthen a comprehensive approach in ameliorating the youth mental health crisis and help each student to build their toolbox of protective factors. We have been encouraged by the SAMHSA and CMS joint info bulletin on addressing mental health and substance use in schools. In a similar vein, we have recently published an exploratory policy brief investigating the ways in which Medicaid could be leveraged to cover school-based primary prevention programs and services to ensure equitable access for students. Prioritizing primary prevention, braiding complementary funds, and coordinating efforts across agencies will help to maximize positive impact on youth mental health and well-being.

We are grateful for SAMSHA, CMHS NAC's efforts to incorporate and attend to tiered systems of support as a part of promoting student health and well-being. When students have equitable access to primary prevention programs and services at school, it promotes their learning, safety, and well-being so that they can thrive.

Thank you for your work and consideration.

Sincerely,

Jordan Posamentier
Vice President of Policy & Advocacy
Committee for Children

Certification

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

__June 28, 2023________	_/Anita Everett M.D. DFAPA/__________
Date	Anita Everett M.D. DFAPA Director Center for Mental Health Services Substance Abuse and Mental Health Services Administration

Minutes will be formally considered by the CMHS NAC at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.