

# U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FINAL

Minutes of the Third Meeting of the

## Interdepartmental Serious Mental Illness Coordinating Committee

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Friday, June 8, 2018  
9:00 a.m. to 5:00 p.m. (EDT)

Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Department of Health and Human Services  
Substance Abuse and Mental Health Service Administration



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# Opening Remarks

**Elinore F. McCance-Katz, M.D., Ph.D., Chair, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA), introduced Alex M. Azar II, J.D., Secretary, Department of Health and Human Services (HHS).**

Since January 2018, Secretary Azar has led HHS, which has a 2018 budget of \$1.2 trillion and is charged with enhancing and protecting the health and well-being of all Americans. Prior to his current tenure at HHS, Secretary Azar served as HHS's general counsel, and then as Deputy Secretary, before rejoining the private sector in 2007.

Secretary Azar said that the ISMICC has been a model for intergovernmental and external collaboration on a critical challenge, thanks to Dr. McCance-Katz's leadership and the work of the eight participating federal departments and divisions. The committee's efforts are vital because the U.S. health care system is failing Americans with serious mental illness (SMI) and serious emotional disturbance (SED). The challenge is expressed by the "10/10/10 problem." Ten million Americans live with SMI in any given year; their lives are 10 or more years shorter than other Americans; and by one estimate, there are 10 times as many individuals with SMI in state prisons who are receiving inpatient psychiatric treatment in state psychiatric hospitals. Moreover, an estimated one in 25 Americans with SMI is expected to die by suicide, and the Centers for Disease Control and Prevention (CDC) recently reported that rates of suicide are rising rapidly in nearly every state. Also, Americans with SMI face physical health challenges, such as poor heart disease and cancer outcomes. The New York Times recently called the situation "the largest health disparity that we don't talk about."

Secretary Azar credited ISMICC members with identifying opportunities for action and convening workgroups focused on specific priority recommendations. Given the committee's 5-year time horizon, real action cannot come soon enough. He noted that at HHS, Dr. McCance-Katz is leading not just this effort, but broader efforts to ensure that Americans with SMI receive the treatment that they need. The President's 2019 Budget, for instance, funds two approaches that have success in promoting adherence to treatment: assisted outpatient treatment and assertive community treatment. Secretary Azar also cited the need to better educate teachers, families, and first responders about SMI, and to help communities support those struggling with SMI, such as by engaging faith and community-based organizations. Another priority is to invigorate research on new treatments through the Food and Drug Administration (FDA) and the National Institutes of Health (NIH). Legal issues also must be considered, such as how federal privacy laws may impede family members trying to secure treatment for loved ones.

Secretary Azar added that he and Dr. McCance-Katz have discussed the ISMICC's mission and the importance of harnessing the committee and its workgroups to drive a proactive agenda in the field of SMI. One issue is the association of untreated SMI with acts of violence. The vast majority of Americans with SMI are not violent, but often face daily challenges and small tragedies because of shortcomings in policies and in the health care system. Secretary Azar expressed hope that the ISMICC's efforts to address these challenges will mark a turning point in how America treats those with SMI, solves related issues, and builds a better system of care.

# Call to Order/Committee Roll Call

**Pamela Foote**, Designated Federal Official for the ISMICC, SAMHSA called the meeting to order and conducted the roll call to ensure a quorum.<sup>1</sup>

## **Federal ISMICC Members or Designees Present**

- Alex Azar, J.D., Secretary, Department of Health and Human Services (HHS);
- Elinore F. McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA);
- Tracy Trautman, Deputy Director for the Programs, Office of the Bureau of Justice Assistance (BJA), for the Attorney General, Department of Justice (DOJ);
- Ira Katz, M.D., Deputy Chief Patient Care Services Officer for Mental Health, for the Secretary of the Department of Veterans Affairs (VA);
- Cooper Smith, Special Policy Advisor for the Secretary of the Department of Housing and Urban Development (HUD);
- Jennifer Coffey, Ph.D., Education Program Specialist for the Department of Education (ED);
- Jennifer Sheehy, M.B.A., Deputy Assistant Secretary of the Office of Disability Employment Policy (ODEP), for the Secretary of the Department of Labor (DOL);
- Deidre Gifford, M.D., Deputy Director, for the Administrator of the Centers for Medicare and Medicaid Services (CMS);
- Terry Adirim, M.D., M.P.H., FAAP, Acting Principal Deputy Assistant Secretary of Defense for Health Affairs, for the Secretary of the Department of Defense (DoD);
- Melissa Spencer, Deputy Associate Commissioner, Office of Disability Policy, for the Commissioner, Social Security Administration (SSA).

## **Non-Federal ISMICC Members Present**

- Linda S. Beeber, Ph.D., Distinguished Professor, University of North Carolina-Chapel Hill, School of Nursing;
- Ron Bruno, Founding Board Member and Second Vice President, CIT International;
- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, St. Joseph-Hoag Health;
- David Covington, L.P.C., M.B.A., CEO/President, RI International;
- Maryann Davis, Ph.D., Research Associate Professor, Department of Psychiatry, University of Massachusetts Medical Center;
- Pete Earley, Author;
- Paul Emrich, Ph.D., Undersecretary of Family and Mental Health, Chickasaw Nation;
- Mary Giliberti, J.D., Chief Executive Officer, National Alliance on Mental Illness;
- Elena Kravitz, CPRP, Director, New York Association of Psychiatric Rehabilitation Services;
- Kenneth Minkoff, M.D., Zia Partners;
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court.

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<sup>1</sup> See Appendix B for the official list of meeting participants.

- Elyn Saks, J.D., Ph.D., Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences, University of Southern California Gould School of Law;
- John Snook, J.D., Executive Director/Attorney, Treatment Advocacy Center;
- Conni Wells, Owner/Manager, Axis Group, LLC.

## Welcome and Introductions

**Dr. McCance-Katz** welcomed the meeting participants, then offered an overview of the ISMICC, a unique approach initiated by the 21st Century Cures Act to bring together federal divisions, agencies, and departments to collaborate and receive input from stakeholders. In its first year, the ISMICC's non-federal members developed 45 recommendations for addressing the needs of Americans living with SMI and their families. Most of the recommendations should be attainable with steadfast efforts and continued advocacy by the ISMICC members. Since the committee's first meeting in August 2017, work has been underway to incorporate the recommendations into efforts by SAMHSA and the other federal partners, all of which have assigned resources to support implementation efforts.

Dr. McCance-Katz said she met in March 2018 with many ISMICC federal designees and staff assigned to the ISMICC workgroups, and was impressed with their energy, enthusiasm, and knowledge. However, as noted in the first ISMICC report, realizing the recommendations require changes at the state, tribal, and local levels with assistance from federal policies and programs, as well as legislative action from Congress. For example, Recommendation 3.8 calls for making screening and early intervention a national expectation, but establishing national expectations is not under federal authority. Engagement of non-federal organizations will be needed to achieve the recommendations.

Dr. McCance-Katz described changes at SAMHSA aimed at accomplishing the ISMICC's mission. CAPT. Christopher M. Jones, Pharm.D., M.P.H., is the Director of the National Mental Health and Substance Use Policy Laboratory, established after the December 2017 ISMICC meeting. Dr. Jones has incorporated ISMICC recommendations into planned work at the policy laboratory and is building its capacity. Plans include evaluating U.S. antipsychotic utilization, informing practitioners about best practices, and assessing the integration of peer services into treatment and recovery services for those living with SMI and SED. Later in the meeting, Dr. Jones would lead a discussion on key initiatives for behavioral health policy: updating data on the prevalence of mental and substance use disorders 40 years after the start of the Epidemiologic Catchment Area Study. Given the changes during the past 40 years, new survey data are needed to better determine how to address mental and substance use disorders.

Dr. McCance-Katz has worked with SAMHSA staff on a major renovation of its technical assistance and training programs. SAMHSA has a network of addiction technology transfer centers, as well as a center that serves American Indian, Alaskan Native, and Hispanic/Latino communities. New funding announcements will establish technology transfer centers for SMI prevention and treatment. Also, a new SAMHSA website serves as a repository for evidence-based practices established by the policy laboratory. In addition, SAMHSA will initiate a clinical support system to provide training nationally on SMI-related issues, identify best practices for assisted outpatient treatment, and develop a center of excellence for psychopharmacology to address the use of clozapine for treatment-refractory

schizophrenia. SAMHSA's specialty training centers will address a wide range of needs in behavioral health, including early childhood behavioral health, SED, and integrated care.

Dr. McCance-Katz said Congress recognized SAMHSA's major contributions by providing additional funding in the 2018 budget for mental health issues. That includes expanded children's mental health services, increased funding for programs to raise awareness of mental health issues and help people get assistance, increased funding for programs for transitional age youth, increased funding for certified community behavioral health clinics, and a new program in assertive community treatment for those living with SMI. Current funding announcements are seeking grantees to address these areas of need. Dr. McCance-Katz noted that Mr. Arne Owens, SAMHSA's Principal Deputy Assistant Secretary for Mental Health and Substance Use, has experience in health management and finance, and was deeply involved in the Senate's drafting of the Cures Act and authorization for ISMICC. Mr. Owens gave a presentation later in the meeting and answered questions about the Senate's role in developing ISMICC authority.

## Consideration of the December 14, 2017 Meeting Minutes

Dr. McCance-Katz asked if ISMICC members had comments or questions about the minutes of the December 14, 2017, meeting. Hearing none, she took a motion to accept the minutes, which ISMICC members approved by a voice vote.

## Overview of Federal Efforts

**Dr. Anita Everett, Chief Medical Officer, SAMHSA**, welcomed the attendees and reviewed the agenda for the meeting, the third of 10 full ISMICC meetings. As Dr. McCance-Katz noted, federal departments have embraced the ISMICC recommendations and assigned subject matter experts to the implementation workgroups. Dr. Everett said she had assigned many SAMHSA staff to steward the recommendations and the Center for Mental Health Services has been a valuable partner in creating the required internal structure. Much has happened since the December 2017, ISMICC report to Congress, and SAMHSA wants to review those activities and get ISMICC input on how to proceed. Many ISMICC members participated in a March 20, 2018 call to organize this meeting and prioritize agenda items. Those participants said they wanted to learn about federal actions to address ISMICC recommendations.

Dr. Everett noted that the day's meeting presentations would present information about federal plans and actions, followed by unstructured time to discuss recommendations regarding how to move forward. After Dr. Morrissette describes federal efforts to address the recommendations, she relayed that the focus area stewards would describe workgroup activities to date. Following the reports from the Stewards, a discussion of participation of non-federal ISMICC members in the workgroups was

scheduled. She further accounted that “The afternoon session begins with a presentation by Mr. Owens about development of the 21<sup>st</sup> Century Cures Act. Next, I will describe a series of SAMHSA-sponsored expert panel meetings in which researchers, providers, consumers, family members, and other leaders shared perspectives and helped develop strategies for implementation. A period for public comments about the ISMICC’s activities will be followed by a poster session that will allow meeting participants to talk informally with workgroup members. Next, federal experts will discuss the reliability and validity of SMI and SED prevalence estimates, and invite input from meeting participants about the need for a detailed analysis of prevalence. The final part of the meeting will focus on federal activities and strategies for ISMICC engagement and communication with non-federal organizations, including state and local governments, as well as research, advocacy, and provider organizations.”

**CAPT. David Morrisette, Ph.D., L.C.S.W., ISMICC Coordinator**, SAMHSA described federal efforts to address the 45 recommendations in the December 2017 ISMICC report to Congress. In the first quarter of 2018, Dr. McCance-Katz and several of her staff visited with ISMICC department and agency designees to identify areas where their missions overlap with ISMICC and to discuss how to implement the recommendations. ISMICC federal members assigned more than 50 federal staff to participate in cross-departmental implementation workgroups (named to reflect the five focus areas of the recommendations):

- **Data Implementation Workgroup** (Strengthen Federal Coordination to Improve Care)
- **Access Implementation Workgroup** (Make It Easier to Get Good Care)
- **Treatment and Recovery Implementation Workgroup** (Close the Gap Between What Works and What Is Offered)
- **Justice Implementation Workgroup** (Increase Opportunities for Diversion and Improve Care for People With SMI and SED Involved in the Justice System)
- **Finance Implementation Workgroup** (Develop Finance Strategies to Increase Availability and Affordability of Care)

Dr. Morrisette said the ISMICC departments and agencies assigned their best staff to the workgroups, including several ISMICC designees themselves. A March 28, 2018, meeting of federal staff focused on the process of tackling the recommendations. The workgroup stewards described how they prioritized recommendations for action. It was helpful that several ISMICC non-federal members participated in the March 28 meeting. Those members addressed the full group and spent most of the afternoon meeting with the workgroups to discuss the recommendations.

Dr. Morrisette described the process of aligning federal efforts based on the ISMICC recommendations. After identifying areas where their missions blended with the recommendations and where they could make a contribution, the departments and agencies sought to develop a shared understanding of the recommendations. The next step was to consider the resources of each department and agency, and to consider how policies and regulations may hinder the full use of those resources. Analysis of those findings will lead to identifying opportunities for action. Workgroup members will use several tools to move the process forward, including regular contact within the workgroups, expert panel meetings

aimed at defining problems and possible solutions, creation of a federal inventory of resources and opportunities, development of strategies, and exploration of options for engaging non-federal entities in the process.

Dr. Morrissette noted that many of the focus area stewards have come to the federal government after serving as leaders in local and state government, and in the private sector, and are known as national experts in the field. During the next session, stewards from each of the five implementation Workgroups presented a brief summary of their efforts to date and invited input from ISMICC members.

## Workgroup Report Outs: Focus Area Stewards

### Focus Area 1: Data Implementation Workgroup

**Kirstin Painter, Ph.D., L.C.S.W.**, Public Health Analyst, Center for Mental Health Services, SAMHSA

**CAPT. Christopher M. Jones, Pharm.D., M.P.H.**, Director, National Mental Health and Substance Use Policy Laboratory, SAMHSA

**Kirstin Painter** noted that despite the workgroup's name, its focus includes much more than data. Initial meetings with federal agency partners led to a focus on four priority ISMICC recommendations: 1.5 ("Evaluate the federal approach to serving people with SMI and SED"), 1.6 ("Use data to improve quality of care and outcomes"), 1.7 ("Ensure that quality measurement efforts include mental health"), and 1.8 ("Improve national linkage of data to improve services"). The workgroup decided to work on all four of those interdependent areas. During conference calls held every two weeks, the workgroup formed two subgroups, one to focus on data and the other to focus on quality measurement. The workgroup's next step is to conduct face-to-face meetings of the two subgroups and develop a work plan for each.

**Christopher Jones** said the inventory of federal activities that Dr. Morrissette discussed later in the meeting is critical for capturing data sources to inform quality improvement efforts. One of the workgroup's first actions was to identify partners in the federal government who were data owners, were working on quality measurement, or were otherwise involved in the focus areas. All of those individuals agreed to participate in the workgroup. The workgroup would like input from ISMICC members as to whether there are exemplar programs at the state or local level that involve data linkage or quality measurement, and that could benefit efforts to link data at the federal level. A person's claims data may not be linked to information about other human services such as those involving employment, training, housing, and Medicaid. Moreover, available data often is not linked to mortality or other outcomes.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<p><b>1 Exemplar programs</b></p>	<ul style="list-style-type: none"> <li>a. The Texas legislature has mandated that all state government departments involved in funding or services related to mental health organize quality efforts in a strategic plan that guides funding approval and oversight.</li> <li>b. Providence St. Joseph Health is developing a dashboard for data about health care and other services, and can assist the workgroup.</li> <li>c. The data-driven justice initiative of the National Association of Counties involves public-private partnerships to assist in data collection and analysis activities relevant to the ISMICC effort.</li> </ul>
<p><b>2 Development of federal quality metrics</b></p>	<ul style="list-style-type: none"> <li>a. The CMS is reassessing its quality metrics. When federal departments or agencies propose new measures, or phase out measures, the capacity to drive the ISMICC agenda should guide the changes.</li> <li>b. Quality measure development at HHS can benefit from insights from other federal departments and agencies that are doing related work in their own target populations.</li> <li>c. The recently issued scorecard for Medicaid included behavioral health measures to help inform service delivery. ISMICC members would like to contribute to refinements related to gathering information on factors such as getting care quickly and getting needed care.</li> <li>d. FDA is not involved in ISMICC, but has important data on the safety and effectiveness of pharmacological treatments, and could contribute to ISMICC efforts.</li> <li>e. An interagency taskforce on veterans' mental health has reached agreement about some measurement issues. That work, and a recent executive order about transition and veterans' mental health, should be coordinated with ISMICC efforts focusing on subpopulations.</li> <li>f. When considering data points to integrate, a developmental or life-course perspective can guide collection of data relevant to children, transition-age youth and young adults, adults, and older adults.</li> </ul>

## Focus Area 2: Access Implementation Workgroup

**Richard McKeon, Ph.D., M.P.H.**, Chief, Suicide Prevention Branch, Center for Mental Health Services, SAMHSA

**Steven Dettwyler, Ph.D.**, Public Health Analyst, Division of State and Community Systems Development, Center for Mental Health Services, SAMHSA

**Richard McKeon** said the workgroup, which has been meeting by teleconference every other week, includes representatives from VA, DOJ, HUD, and ED, in addition to SAMHSA and HHS (including the Office of the Assistant Secretary for Planning and Evaluation, CMS, and the National Institute of Mental Health). The workgroup decided to give priority initially to three ISMICC recommendations: 2.1 (“Define and implement a national standard for crisis care”), 2.2 (“Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization”), and 2.6 (“Prioritize early identification and intervention for children, youth, and young adults”). The workgroup is planning a July 2018 expert panel meeting to focus on the crisis-related Recommendations 2.1 and 2.2. With assistance from expert consultants, the workgroup will assess the use of real-time hospital and crisis bed registries to help maximize the use of acute care resources. The workgroup plans to get input from SAMHSA about the experience of veterans in the community emergency and crisis system. Regarding Recommendation 2.6, the workgroup is getting input from ED. In addition, an expert panel held a meeting on March 14<sup>th</sup> and offered input on Recommendation 2.4 (“Reassess civil commitment standards and processes”), and SAMHSA participated in a congressional briefing on supporting families with a suicidal loved one.

**Steven Dettwyler** emphasized that as the workgroup addresses issues related to access and crisis services, it is seeking to communicate with the other ISMICC workgroups.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Participation in workgroup activities</b>	<ul style="list-style-type: none"><li>a. ED should make it a priority to participate in all of the activities of this workgroup and the ISMICC in general.</li><li>b. The Bureau of Prisons could contribute to the activities of this workgroup and the Justice Implementation Workgroup, including the effort to address the issue of the use of solitary confinement.</li><li>c. The workgroup should work with the Finance Implementation Workgroup to explore whether the Medicaid Section 1115 demonstration program for substance use disorder treatment could be extended to address services for people with SMI.</li></ul>

Topic	ISMICC member comments
2 Data collection	<ul style="list-style-type: none"> <li>a. The workgroup should consider partnering with states and counties to conduct a baseline inventory of the availability of crisis services.</li> <li>b. Bed registries are useful but insufficient. It is crucial to track data about whether care coordination mechanisms ensure that people receive needed services in the crisis care continuum.</li> </ul>
3 Workforce issues	<ul style="list-style-type: none"> <li>a. The American Psychiatric Nurses Association is interested in helping the workgroup explore how nurses can work with other community mental providers to meet the need for crisis care services.</li> </ul>

### Focus Area 3: Treatment and Recovery Implementation Workgroup

**Justine Larson, M.D., M.P.H., M.H.S.**, Senior Medical Advisor, Center for Mental Health Services, SAMHSA

**Cynthia Kemp**, Deputy Director, Office of the Chief Medical Officer, SAMHSA

**Tracie Pogue, M.Div., L.C.S.W.**, Public Health Analyst, Office of the Chief Medical Officer, SAMHSA

**Cynthia Kemp** said the workgroup includes 21 federal staff who have had multiple conference calls and a half-day in-person meeting hosted by DOL. The workgroup identified three recommendations as foundational: 3.1 (“Provide a comprehensive continuum of care for people with SMI and SED”), 3.2 (“Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation”), and 3.6 (“Make housing more readily available for people with SMI and SED”). For Recommendation 3.1, a process is underway to assess the services and programs in a comprehensive continuum of care for adults and children. Two papers, one focusing on adults and one focusing on children, youth, and young adults, will describe a continuum and principles.

**Justine Larson** introduced herself and invited Jennifer Coffey, Ph.D., Education Program Specialist, from ED, to describe an expert panel meeting on screening to be held June 25-26, 2018, at ED headquarters, in support of Recommendation 3.2. Dr. Coffey said the purpose of the meeting is to look at the feasibility and goals of screening school-aged children (K through grade 12), including the approach for providing services to students. A monograph will address the workgroup’s wider focus on screening and early intervention for children, youth, and young adults.

**Tracie Pogue** said a subgroup on housing was formed to address Recommendation 3.6. The subgroup includes representatives from HUD, DOJ, CMS, and the U.S. Interagency Council on Homelessness. The first meeting of the subgroup is scheduled for July 2018.

**Justine Larson** noted that the workgroup will pursue the seven other ISMICC recommendations within the topic area. For example, regarding Recommendation 3.7 (“Advance the national adoption of effective suicide prevention strategies”), the workgroup felt a need to learn more about implementing

the Zero Suicide model; to that end, Richard McKeon (Focus Area 2, Access steward) met with the workgroup to discuss the topic. In addition, several workgroup members are joining other existing non-ISMICC federal interagency workgroups, such as workgroups on suicide and trauma.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Providing appropriate services</b>	<ul style="list-style-type: none"> <li>a. Implementation efforts should give special attention to transition-aged youth. When the system of care focuses on children and adults as the main age categories, older adolescents and young adults may not receive developmentally appropriate services.</li> <li>b. The workgroup should reach out to the Corporation for Supportive Housing, which is a good model for efforts to reduce homelessness.</li> </ul>
<b>2 Continuum of care issues</b>	<ul style="list-style-type: none"> <li>a. Efforts to describe the continuum of care must go beyond identifying relevant programs, and must use a population-based approach to address the need for services within various systems of care.</li> <li>b. The VA has developed a well-articulated set of mental health treatment standards that could be a model for defining a continuum of care for adults, as well as for developing suitable quality measures.</li> <li>c. Continuum of care models should include peer services as part of the workforce required to help people with SMI at all steps in the screening and treatment process.</li> </ul>

## Focus Area 4: Justice Implementation Workgroup

**Larke Huang, Ph.D.**, Director, Office of Behavioral Health Equity, SAMHSA; Lead, Trauma and Justice Strategic Initiative and Senior Advisor – Children, Youth and Families in the Administrator's Office of Policy, Planning, and Innovation, SAMHSA

**Jennie Simpson, Ph.D.**, Staff Lead, Criminal Justice, Office of Policy, Planning, and Innovation, SAMHSA

**Jennie Simpson** described the framework for the nine justice-related ISMICC recommendations in terms of early identification and diversion from the criminal justice system, more humane and quality practice for those in the criminal justice system, and helping people transition from the criminal justice system and be successful in the community. The workgroup decided to give priority to four recommendations: 4.2 (“Develop an integrated crisis response system to divert people with SMI and SED from the justice system”), 4.3 (“Prepare and train all first responders on how to work with people with SMI and SED”), 4.6 (“Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail”), and 4.8 (“Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities”).

During conference calls held every two weeks, the workgroup identified two other recommendations to work on after obtaining additional information: 4.4 (“Establish and incentivize best practices for competency restoration that use community-based evaluation and services”) and 4.7 (“Strictly limit or eliminate the use of solitary confinement, seclusion, restraint, or other forms of restrictive housing for people with SMI and SED”).

**Larke Huang** said the workgroup recognizes the importance of stable housing for people with SMI, especially for those involved with the justice system. To achieve the changes needed to implement the priority ISMICC recommendations, the workgroup is focusing on developing federal resources into technical assistance toolboxes and on-site training for county jails as well as state partners. Workgroup activities have included contacts with county-to-county networking and learning collaboratives, consultations with key external stakeholders, and collaboration with the MacArthur Foundation and various professional organizations. The workgroup is interested in learning about relevant exemplar programs at the state or county level.

The table below summarizes key points made during the subsequent discussion.

	<b>Topic</b>	<b>ISMICC member comments</b>
<b>1</b>	<b>Elements of crisis response and justice diversion programs</b>	<ul style="list-style-type: none"> <li>a. Efforts to help people with SMI in the criminal justice system should focus on empowering mental health services for crisis response, rather than relying on law enforcement or criminal justice services.</li> <li>b. In developing policies and procedures, it is important to consider the principles of trauma-informed care to ensure that well-intentioned programs don’t lead to stigma and trauma for people with SMI.</li> <li>c. Diversion programs should focus on applying the sequential intercept model and achieving the “zero intercept” (avoidance of initial arrest).</li> <li>d. Toolkits and technical assistance programs are helpful, but states must enact legislation that makes mental health screening and treatment a legal requirement for people with SMI in the justice system.</li> <li>e. Consider whether existing grant programs operated by DOJ could include requirements or incentives aimed at promoting mental health screening.</li> <li>f. Efforts to provide crisis stabilization services are limited by the person’s right to refuse treatment, which is a key reason that people with SMI cycle back into the criminal justice system.</li> </ul>

Topic	ISMICC member comments
<b>2 Exemplar programs</b>	a. Miami-Dade County Judge Steven Leifman has developed a recovery-oriented approach for facilitating competency restoration and expediting access to behavioral health services.  b. In Tucson and Phoenix, law enforcement uses a system that sharply reduces the time needed to address the behavioral health care needs of people with SMI and divert them from the justice system.
<b>3 Workgroup representation</b>	a. The workgroup’s membership should include representation of the juvenile justice system, such as someone from the Office of Juvenile Justice and Delinquency Prevention. (see ISMICC member comment for Access Implementation Workgroup 1.b requesting participation by the Bureau of Prisons).

## Focus Area 5: Finance Implementation Workgroup

**Chris Carroll, M.Sc.**, Director, Health Care Financing and Systems Integration, Office of Policy, Planning, and Innovation, SAMHSA

**David DeVoursney**, Chief, Community Support Programs Branch, Center for Mental Health Services, SAMHSA

**Chris Carroll** said the workgroup decided to give priority to three ISMICC recommendations: 5.1 (“Implement population health payment models in federal health benefit programs”); 5.3 (“Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses”); and 5.5 (“Pay for psychiatric and other behavioral health services at rates equivalent to other health care services”). The workgroup identified two other recommendations that will merit attention based on assessment of ongoing funding and activities: 5.7 (“Fund adequate home- and community-based services for children and youth with SED and adults with SMI”) and 5.8 (“Expand the Certified Community Behavioral Health Clinic (CCBHC) program nationwide”). Regarding population health payment models (Recommendation 5.1), the workgroup is monitoring CMS’ plan to approve Medicaid Section 1115 demonstration projects focusing on SMI. Regarding service parity in Medicaid (Recommendation 5.3), SAMHSA is working with other federal departments to develop tools, starting with a parity-training tool for state regulators and behavioral health staff. Regarding payment parity (Recommendation 5.5), “equivalent” rates may not be adequate in some contexts, such as in providing intensive treatments for people with substance use disorders. The workgroup welcomes input about relevant reimbursement innovations in the commercial sector.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Elements of finance implementation</b>	<ul style="list-style-type: none"> <li>a. Focus on the likelihood that state Medicaid programs are unlikely to pay for all of the elements required to support an ideal system of SMI crisis response and justice diversion.</li> <li>b. Consider approaches for updating Medicare reimbursement policies, which do not cover basic services for people with SMI such as case management or justice diversion services.</li> <li>c. Efforts to achieve parity of services for people with SMI should include the need for psychiatric rehabilitation services to support recovery following acute episodes of SMI.</li> <li>d. Keep in mind the need for funding streams that support the delivery of integrated services for people with co-occurring SMI and substance use disorders.</li> <li>e. Federal-state coordination of block grant funding with state Medicaid plans could reinforce SAMHSA policy initiatives.</li> <li>f. The Center for Medicare &amp; Medicaid Innovation should consider offering a round of grants for state programs for people with SMI.</li> <li>g. Improved financing for first-episode psychosis treatment programs could replicate the documented success of such programs in reducing hospitalization and promoting employment.</li> <li>h. Better financing mechanisms are needed to support interventions aimed at the large increases in suicide rates in recent years.</li> </ul>
<b>2 Workgroup representation</b>	<ul style="list-style-type: none"> <li>a. Given the importance of federal reimbursement policy, the workgroup should identify a CMS partner to help lead the workgroup's efforts.</li> <li>b. The VA, which is a large provider of mental health services, also is emerging as a potential payer and would value an opportunity to participate in the workgroup.</li> </ul>

# ISMICC Member Involvement in Implementation

**David Morrissette** invited the implementation workgroup stewards to join ISMICC members in a discussion focused on the participation of the committee’s non-federal members in the ongoing activities of the workgroups. **Anita Everett** noted that SAMHSA has adopted a policy of inviting two non-federal members to attend subject matter expert panel meetings that concern ISMICC topics. In addition, four non-federal members attended the March 2018 ISMICC planning meeting. The current discussion focuses on how non-federal members can participate more directly in workgroup implementation activities.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Workgroup participation</b>	<ul style="list-style-type: none"> <li>a. Federal staff should provide guidance on how non-federal ISMICC members can monitor workgroup implementation activities.</li> <li>b. To facilitate efficient workgroup monitoring and participation, ask non-federal members to state their personal expertise and interest in engaging in workgroups and in implementation of specific recommendations. <i>Follow-up:</i> ISMICC members will communicate later to develop an appropriate roster.</li> <li>c. Workgroups should develop a plan that specifies when non-federal members can best contribute to specific workgroup meetings, such as to discuss state initiatives or other efforts that are beyond the authority of the federal members.</li> </ul>
<b>2 Communication about implementation activities</b>	<ul style="list-style-type: none"> <li>a. Workgroups should circulate periodic interim reports about their meeting agendas, activities, progress, and (when feasible) the expected timelines for completing specific tasks.</li> <li>b. The ISMICC should develop an annual report on the overall progress of the implementation activities and the priorities for future implementation efforts.</li> <li>c. Non-federal members, who developed the ISMICC recommendations, should develop their own annual report that assesses the workgroup implementation activities and guides future work.</li> <li>d. When non-federal members submit a list of written suggestions about the ISMICC meeting agenda, incorporate that input in the meeting record.</li> </ul>

Topic	ISMICC member comments
<b>3 Communication to support workgroup implementation efforts</b>	<ul style="list-style-type: none"> <li>a. Encourage non-federal members to work on implementation at the state and local level and thereby complement workgroup efforts to pursue implementation through federally funded programs.</li> <li>b. ISMICC non-federal members raised questions about engagement with elected officials regarding ISMICC. It was advised that, as citizens, any individual has the right to address congress and advocate, however it is beyond the scope of a FACA member to call on a Congressional Member as a representative of ISMICC to lobby on behalf of ISMICC.</li> <li>c. Develop a process to ensure that the secretaries of the federal departments and agencies in ISMICC are aware of workgroup recommendations, take steps to deal with barriers, and move forward with implementation.</li> <li>d. Dr. McCance-Katz will consider presenting an update at the next ISMICC meeting to summarize federal budget changes and other actions taken to implement ISMICC recommendations.</li> <li>e. Seek to underscore the importance of the ISMICC implementation effort by promoting communication among the secretaries of the federal departments and agencies in ISMICC.</li> </ul>

## Comments from Mr. Arne Owens, Principal Deputy Assistant Secretary for Mental Health and Substance Use, SAMHSA

**Anita Everett** welcomed meeting participants back after lunch and noted that this is the third in a series of 10 planned ISMICC meetings. She thanked Paolo del Vecchio, Director of SAMHSA’s Center for Mental Health Services for his leadership role in the startup of ISMICC. She then introduced Arne Owens, SAMHSA’s Principal Deputy Assistant Secretary for Mental Health and Substance Use, to speak about the origins of the ISMICC.

**Arne Owens** noted that he served previously as the health care policy adviser and legislative assistant to former Senator David Vitter of Louisiana and Senator Bob Corker of Tennessee. He also was detailed to work with Senator Bill Cassidy of Louisiana, who teamed up with Senator Chris Murphy of Connecticut to draft Senate Bill 1945 (the Mental Health Reform Act of 2015). That bill became the framework for Senate Bill 2680 (the Mental Health Reform Act of 2016). At the time, the public was demanding action amid concern that not enough was being done to address SMI.

Interagency coordination is a major challenge in government. HHS is the key player in addressing the needs of people with SMI and SED, and multiple agencies within HHS play a role in delivering mental health services. For example, SAMHSA funds a broad array of services, and the Health Resources and Services Administration (HRSA) supports delivery of behavioral health services through community health centers. In addition, DOJ is an important player in addressing people with SMI, and DoD, VA, HUD, and ED touch the lives of people with SMI and SED.

Senate Bill 2680 focused on federal coordination among federal agencies and departments, and it delegated implementation details to the agencies. In addition to forming the ISMICC, the legislation included development of a policy laboratory at SAMHSA and positions at SAMHSA such as the Assistant Secretary for Mental Health and Substance Use and the Chief Medical Officer. The bill passed by a vote of 94 to 5, reflecting bipartisan support for action. The bill was then combined with a bill by Senator John Cornyn of Texas, which focused on DOJ and the Bureau of Prisons, and included training for law enforcement personnel. The integrated bill became part of the 21st Century Cures Act.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Congressional intent</b>	<ul style="list-style-type: none"> <li>a. Based on the legislative language and the senators involved in the legislation, it is clear that the intent was not for the ISMICC to function as an oversight entity, but rather as a conduit for increased collaboration within the federal government.</li> <li>b. The ISMICC is expected to report back to Congress. The final report to Congress should state what the next steps should be and identify any additional actions that Congress should take to improve the lives of people with SMI and SED.</li> </ul>

## Public Comments

**Elinore McCance-Katz** opened the telephone lines for public comments.

**Pamela Foote** read the names of the public, in order, per the Federal Register Notice.

**Katrina Velasquez, Policy Director of the Eating Disorders Coalition (EDC)**, said the EDC is a nonpartisan advocacy organization of treatment providers, researchers, advocacy organizations, and families and people affected by the SMI of eating disorders. As addressed in the 21st Century Cures Act, there is a great need to increase screening and early identification of eating disorders and other

SMI/SEDs among children, youth, and young adults nationwide. The EDC offers these recommendations:

1. Regarding universal screening within jail systems, the EDC encourages the ISMICC to expand this goal to include relevant training for medical professionals and their staff, including physician assistants, nurse practitioners, nurses, and dental hygienists.
2. Regular screening and referrals for SMI/SED (including serious eating disorders) within federally funded systems can begin with basic steps such as adding additional screening questions to patient intake forms.
3. Provide all health care professionals who work with clients with SMI/SED with handy resources such as a lab coat card to help them screen, and note best practices for talking to patients about mental illness, briefly intervening, and referring people with SMI/SED to additional resources.
4. It is important to implement sections 13005 through 13007 of the 21st Century Cures Act, which address eating disorders.

**Nathaniel Counts, Senior Policy Director of Mental Health America (MHA)**, said MHA was one of the organizations that led the Mental Health Liaison Group letter to eight federal agencies encouraging them to work in this area. MHA offers its assistance in these areas:

1. Develop a standard approach for scaling up evidence-based interventions, going beyond having SAMHSA be the primary funder. Determine standards for evidence-based practices, and determine when there is enough evidence to scale up intervention across federal entities. For example, scaling up supportive housing would involve CMS, SAMHSA, HRSA, and HUD.
2. Provide on-the-ground coordination to implement evidence-based interventions. Many federal agencies are involved, each with its own concerns about community efforts. It may be possible to build on initiatives such as the Center for Medicare & Medicaid Innovation Accountable Health Community models.
3. Host listening sessions so the ISMICC can learn from communities that are working to incorporate evidence-based practices, explore opportunities and challenges to coordinate federal funding streams, and help troubleshoot problems.
4. Focus on SED-related trauma prevention mitigation.

**Junqing Liu, Research Scientist, National Committee for Quality Assurance (NCQA)**, said the NCQA supports the ISMICC report and especially the recommendations on data sharing and equality measurements. The NCQA has developed performance measures addressing mental health and substance abuse care, including measures addressing the needs of people with SMI. Not all of the measures are included in the Healthcare Effectiveness Data and Information Set (HEDIS) and other public reporting programs. The NCQA welcomes the opportunity to work with the ISMICC on implementing measures and developing new measures that focus on outcomes, particularly measures that use patient and family reports on symptoms, functioning, and recovery.

**Joel Miller, Chairperson for the National Coalition on Mental Health and Aging (NCMHA)**, said the NCMHA helps 100 national and state associations and coalitions to improve mental health services for older Americans through education, research, and increased public awareness. The NCMHA offers these recommendations:

1. Designate a responsible entity to coordinate federal efforts to develop and strengthen the nation's geriatric mental health and substance use workforce, as recommended in the 2012 Institute of Medicine Report, "In Whose Hands?"
2. Allocate funding from all existing federally funded mental and behavioral health programs to older adults in an amount proportionate to their share of the U.S. population.
3. As the Executive Director and CEO with the American Mental Health Counselors Association, Mr. Miller expressed that organization's support of the ISMICC recommendation to remove exclusions that disallow payment to certain qualified mental health professionals, including licensed professional counselors, within Medicare and other federal health benefit programs.

**Jeanne Gore, Coordinator for the National Shattering Silence Coalition (NSSC)**, said the NSSC is an alliance of people uniting to ensure that the mental illness, health care, and criminal justice systems address the needs of people with SMI and SED and their families in all federal, state, and local policy reforms. The NSSC offers these recommendations:

1. Inpatient admission criteria need to be standardized at the federal level using "need for treatment" and "gravely disabled" standards, along with the patient's capacity to understand the need for treatment. This must replace the dangerous standard of "imminent danger to self and others."
2. Assisted outpatient treatment is vital and must be instituted at a national level. Many people with SMI do not start treatment because of anosognosia, or a lack of insight into their illness.

**Gwen Bartley, Executive Director of Amazing Grace Advocacy**, a nonprofit in North Carolina, who is a committee member of the NSSC, said Amazing Grace Advocacy serves children living with SMI and SED. As the parent of a 17-year old son with schizoaffective disorder, she offered these comments:

1. The Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization system are used to assess needs, progress, and treatment outcomes but are not well known to clinicians, and should be disseminated at the local level.
2. Many children with SED are not identified as ill in school and do not receive Individualized Education Programs and 504 plans. All students who struggle socially and emotionally should undergo school-based evaluation and receive necessary supports.
3. It is important to address the serious shortage of school social workers, counselors, special education teachers, psychologists, and school nurses.

**Janet Hays, President of Healing Minds**, a nonprofit in New Orleans, who is a member of the NSSC, said jails and prisons in New Orleans have become the first stop for many people with untreated SMI and co-occurring substance use disorders and/or addictions. She offered these recommendations:

1. Make “gravely disabled” a federally mandated disability category in relation to SMI and SED in all states.
2. Acknowledge that recovery-oriented models of team-based care do not address those who cannot recover. The reality is that many people with SMI will never reach a full recovery despite receiving the best treatments and care. Since currently all mental illnesses are viewed as recoverable, many families have to reapply for services annually.
3. Align the way SMI is handled with the way autism spectrum and other neurological brain-based illnesses are addressed.

**Diane Harris, member of the National Shattering Silence Coalition**, is the parent of a young man with schizoaffective disorder. She offered these comments about access:

1. HHS should promote creation of more inpatient beds for people with SMI and those who are in crisis. The shortage of inpatient beds and discrimination by some inpatient units against challenging patients (those who are violent or likely to require long-term hospitalization) leads to long waits for beds and often to premature discharge without follow-up treatment.
2. Support the formation of emergency departments specifically designed to treat people with SMI and SEC. Also, support crisis stabilization units.
3. End the Medicaid IMD (Institutions for Mental Disease) Exclusion, and provide more psychiatric hospital beds and more community-based alternatives to hospitalization.

**Katherine Flannery-Dering, member of the National Shattering Silence Coalition**, whose brother had schizophrenia and died of lung cancer at age 48, focused on ISMICC Recommendation 3.6 on making housing readily available and Recommendation 5.3 on service parity. Long-term supportive housing for people with SMI is critical for their well-being. For patients with Alzheimer’s disease, Medicaid will pay for nursing home care if they have no means of their own. Yet the IMD Exclusion prevents comparable coverage if someone age 22 to 64 has a mental disease. Eliminating the IMD Exclusion, providing realistic coverage for treatment, and moving people with SMI into supportive housing with wraparound services would be much less expensive in the long run, and more humane, than relying on the justice system.

# Report Out on Expert Panels

Anita Everett thanked those who provided public comments, then provided an update on subject matter expert meetings that SAMHSA has convened since the December 2017 ISMICC meeting. The meetings provided an opportunity to learn how such meetings can inform ISMICC members and obtain their input. Each meeting included at least two non-federal ISMICC members.

1. The **expert panel meeting with chairpersons of departments of psychiatry** sought to increase awareness of ISMICC and identify opportunities to partner on future projects. SAMHSA sees the meeting as a model for developing partnerships with other professions.
2. The **expert panel meeting on psychiatric advance directives** led to the development of a toolkit that should be completed by October 2018.
3. The **expert panel meeting on civil commitment** reflected SAMHSA’s recognition that civil commitment is the purview of state government, as well as interest in the influence of federal leadership. A key theme was the shift from civil commitment as a public safety function toward a mechanism for facilitating needed treatment. A set of principles that can inform states as they review their civil commitment policies will be developed as a result of this meeting.
4. The **expert panel meeting on the workforce to serve older adults with SMI** was an experiment to explore how such a meeting could address implementation of ISMICC recommendations specific to certain populations, in this instance through the lens of geriatric providers.
5. The **first annual meeting of federal staff to learn about ISMICC** was an orientation meeting that included several ISMICC members and 50 federal government participants.

ISMICC workgroups will convene additional subject matter expert meetings in the coming months. The meeting work products will be posted on the ISMICC website, and some will also be disseminated to the field.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Expert panel meetings</b>	a. ISMICC members would like to know the schedule of expert panel meetings as soon as possible.  b. ISMICC members would like the opportunity to nominate experts for participation in the meetings.

Topic	ISMICC member comments
<b>Expert panel meetings (continued)</b>	<ul style="list-style-type: none"> <li>c. Expert panel meetings should have an explicit goal of developing a post-meeting deliverable fully aligned to support the work of the ISMICC. Inform all meeting participants ahead of time about this goal, to be guided by the question, “How does this work connect with and support the ISMICC recommendations?”</li> <li>d. The expert meetings described in the 21<sup>st</sup> Century Cures Act are to study problems and help the ISMICC come up with sound solutions.</li> <li>e. The ISMICC recommendations require thought about how to translate change into the real world, including clearly defined roles and processes. This can be part of the resulting work products.</li> </ul>
<b>2 Hospital admission and discharge standards</b>	<ul style="list-style-type: none"> <li>a. Revise or redefine standards for hospital admission and discharge. The current legal, non-scientific standard focuses on whether the person is a danger to self or others, which is not adequate or comprehensive. Standards should be based on science and consider the person’s well-being.</li> <li>b. Consider changing the legal and regulatory language around standards for hospital admission and discharge. In part, the medical field relies on the “harm to self or others” standard because it is in the law.</li> <li>c. Educating the courts and the criminal justice system is important for changing practice.</li> </ul>
<b>3 Level of care and access to care</b>	<ul style="list-style-type: none"> <li>a. Consider using the Level of Care Utilization System (LOCUS) tool as a starting point for developing national standards for inpatient care. The American Association of Community Psychiatrists designed LOCUS to help inpatient hospital staff determine the level of care for patients with psychiatric problems, with six levels that range from the least to the most intensive.</li> <li>b. Consider using LOCUS to forecast and stratify the clinical need.</li> <li>c. Consider building on what the American Society of Addiction Medicine has done with a tool that empirically aligns a person’s particular situation with a recommended level of treatment for addiction.</li> <li>d. An ISMICC member suggested using the Milliman Clinical Care Guidelines, as a mechanism for standardizing medical necessity for levels of treatment.</li> </ul>

Topic	ISMICC member comments
<b>Level of care and access to care (continued)</b>	<ul style="list-style-type: none"> <li>e. Most communities do not have the kind of providers and array of resources needed for a comprehensive behavioral health care system that includes various levels of care. Often the hospital is the fastest or only place where a person can get intensive psychiatric care.</li> <li>f. Alternatives to inpatient hospitalization and the justice system need to be in place and part of a comprehensive care network in every community.</li> <li>g. It needs to be easy for people in the community to find help for themselves and their loved ones. Most people do not know how to do that except through the emergency room or police.</li> <li>h. Helping maintain people in the community should be a goal, in order to keep them away from “crisis” when the only alternative is the hospital or justice system.</li> <li>i. Finances often dictate access to care. If a person needs behavioral health care immediately but is not suicidal or homicidal, getting care takes a long time and often involves high out-of-pocket costs. In addressing financing, make the case that access to community treatment can prevent hospitalizations, suicides, and homicide.</li> </ul>
<b>4 Early interventions</b>	<ul style="list-style-type: none"> <li>a. Payers often do not pay for early interventions, such as first episode psychosis programs, viewing those as costly and possibly unnecessary. This needs to change.</li> <li>b. Avoid creating a political environment around behavioral health care. Focus on recovery and prevention.</li> <li>c. Analysis of suicide clusters among veterans shows that the triggering event was often interpersonal (e.g., stress, work, money, and relationships).</li> <li>d. A CDC study of suicide showed that the majority of the people who attempt or succeed with suicide do not have a mental health diagnosis. This suggests that focus should be overall wellness strategies such as teaching active coping skills, problem solving and other evidence-based methods taught in schools, at different age-appropriate levels.</li> </ul>

Topic	ISMICC member comments
<b>5 Justice system as the first (and only) provider</b>	<ul style="list-style-type: none"> <li>a. In many communities, law enforcement is seen as the only route for addressing the behavioral health needs of a person who is potentially violent, and is the only immediate source of help for families needing assistance in addressing the psychiatric needs of a loved one.</li> <li>b. Aim to braid together components of the justice system with the behavioral health system. The current silo approach is not working.</li> <li>c. In Virginia, the state rewrote the voluntary commitment law but saw no big increase in commitments, because there are not enough services and thus nowhere to send a person who is committed.</li> <li>d. Judicial funds are being spent on mental health, but more funding is needed for mental health outreach and non-crisis mental health care.</li> </ul>
<b>6 Continuum of care</b>	<ul style="list-style-type: none"> <li>a. The Crisis Now website is a partnership between the National Association of State Mental Health Program Directors, Action Alliance, National Suicide Prevention Lifeline, National Council for Behavioral Health, and RI International. The website helps communities forecast how much crisis volume they will have during any particular month.</li> <li>b. Peer support services should be part of the continuum of care.</li> </ul>

## Guidance on Recommendation 3.8.a ... That funding for research is commensurate on prevalence of SMI and SED

**David Morrisette** reminded the group that ISMICC Recommendation 3.8 calls for the federal government to increase funding for research at the National Institute of Mental Health, commensurate with prevalence rates of SED and SMI, the direct and indirect costs of these conditions, and the burden of disease they impose. ISMICC members have expressed concern that the prevalence of SED and SMI has not been adequately measured in more than 40 years. ISMICC members were asked to provide input on whether prevalence rates of SED and SMI need to be updated.

**Shelli Avenevoli,  
Ph.D., Deputy  
Director, National  
Institute of Mental  
Health (NIMH),**

gave a summary of NIMH activities, then provided an overview of three major studies on the prevalence and incidence of mental disorders: the Epidemiological Catchment Area Study, the National Comorbidity Survey, and the National Comorbidity Survey Replication.

The **Epidemiological Catchment Area (ECA) Study** was initiated in response to the 1978 report of the Presidential Commission on Mental Health, which evaluated the nation's needs for services and how best to meet those needs. First funded in the early 1980s, the ECA Study focused on five epidemiological sites and was not a nationwide study. The ECA Study estimated prevalence by using data collected from the sites and mapping it to the 1980 U.S. population. Criticism of the ECA Study noted that it was not a nationwide study, and it estimated prevalence and incidence by standardizing the survey against the U.S. population. In addition, there were inconsistencies between the study's lay-administered interviews and clinical reappraisals.

## About the NIMH



- The National Institute of Mental Health (NIMH) is the lead federal agency for research on mental illnesses.
- NIMH supports more than 3,000 research grants and contracts at universities and other institutions across the country and overseas.
- NIMH intramural research program supports approximately 600 scientists working on the NIH campuses.



## Epidemiological Catchment Area (ECA) Study

### Design

Series of 5 epidemiologic studies performed by independent research teams in collaboration with ADAMHA/NIMH staff

- Yale University; Johns Hopkins University; Washington University; Duke University; University of California at Los Angeles

**Sample:** 20,291 total respondents (18,571 households; 2,290 institutions)

**Age range:** 18+

**Response rate:** ≈70-80%

**Assessment:** Diagnostic Interview Schedule (DIS), DSM-III

**Clinical reappraisal:** Standardized Psychiatric Examination

**Wave 2 follow-up:** 12 months later; 21.9% were not re-interviewed



The **National Comorbidity Study (NCS)**, administered in the early 1990s, was an attempt to address the concerns about the ECA Study. This was a U.S. household survey that did not include people from institutions. The NCS estimated prevalence and had a strong emphasis on comorbidity.

The **National Comorbidity Survey Replication (NCS-R)**, conducted in the early 2000s, included an expanded set of diagnoses, in part to reflect changes in the Diagnostic and Statistical Manual of Mental Disorders and also to focus on disorders not covered in earlier surveys. The NCS-R included a wide range of correlates to understand patterns in the community, in-depth clinical validation of diagnoses, and dimensional ratings to address subthreshold- as well as threshold-level diagnoses. Moreover, the NCS-R included many items on disability impairment and service use, and adequacy of treatment. The NCS-R yielded much higher prevalence rates than the ECA study had found 20 years earlier. The NCS-R did not collect data on some low-prevalence disorders such schizophrenia and autism, and focused only on English speakers.

Dr. Avenevoli said these surveys showed that the prevalence of mental illnesses is high, even though the rates varied across the studies. The surveys showed that these disorders begin very early in life, comorbidity rates are very high, and there is substantial role impairment. The data also showed that treatment rates are low, adequate levels of treatment are very low, and delays between illness onset and first diagnosis and treatment is a major public health concern.

### National Comorbidity Survey (NCS) 1990-1992

#### Overview

Nationally representative, U.S. general population survey designed to produce data on the prevalence, risk factors, and consequences of psychiatric morbidity and comorbidity

#### Design

Sample: Household survey of 8,098 respondents

Age-range: 18-54

Response rate: 80.2%

Assessment: Modified version of Composite International Diagnostic Interview, DSM-III-R

Clinical reappraisal: Present State Examination

Other feature: Supplemental nonresponse survey



### National Comorbidity Survey-Replication (NCS-R) 2001-2003

#### Overview

Nationally representative survey designed to investigate time trends over the 1990s and address substantive and methodological issues raised by the NCS

#### Design

Sample: Household survey of 9,282 respondents

Age-range: 18+

Response rate: 70.9%

Assessment: International World Health Organization-CIDI (WHO-CIDI), DSM-IV, laptop computer-assisted personal interview

Clinical reappraisal: Structured Clinical Interview for DSM (SCID)

Other feature: Non-response interviews

Dr. Avenevoli noted that small changes in diagnostic criteria or methods of ascertainment can influence prevalence rates. She cautioned that before the ISMICC concludes that new estimates are needed, the purpose of any new survey should be clearly defined. The ISMICC should convene an expert panel to discuss the state of the art of survey design and consider how to design a modern psychiatric epidemiology study.

**Christopher M. Jones, Pharm.D., M.P.H., CAPT, U.S. Public Health Service, Director of National Mental**

**Health and Substance Use Policy Laboratory**, SAMHSA discussed the National Survey on Drug Use and Health (NSDUH). Funded by SAMHSA, this annual household survey is the primary source of statistical information on U.S. substance use rates. The survey includes people age 12 and older, with separate question sets for those ages 12 to 17 and those over age 18. The NSDUH includes questions related to mental health, and yields nationally representative estimates, as well as state-level estimates.

The survey includes people who live in-group quarters, including homeless shelters, rooming houses, dormitories, and civilians living on military bases. The NSDUH excludes certain populations that represent a high burden for the behavioral health system such as individuals who are homeless or transient people not living in shelters, military

personnel who are on active duty, or residents of institutional group quarters (including people in the criminal justice system, prisons, or jails). Also omitted are people in hospitals, residential substance use facilities, or mental health facilities.

Dr. Jones noted that a value of the NSDUH data is that scientists can analyze estimates against many other factors that the survey captures. For example, the data allow calculation of rates of co-occurring substance use disorders among people with mental illness. The survey is a rich data source for assessing correlates among people with mental illness.

### Key Considerations for Future Studies

- Estimates of prevalence vary across studies
  - Relatively small changes in diagnostic criteria and methods of ascertainment have produced substantially different estimates
  - Differing opinions on the “best” estimates
  - Truth is unknowable
- Challenge in describing trends
- The landscape for these studies is changing
  - E.g., Low response rates; changes in technology, communication, and social interaction
- Need to address ongoing challenges:
  - Validity of DSM disorders
  - Defining severity
  - Defining and measuring subthreshold syndromes

### National Survey on Drug Use and Health

- Annual survey of approximately 67,500 people 12 years and older in the U.S.
- Provides nationally representative estimates
- Primary source of statistical information on the use of tobacco, alcohol, prescription psychotherapeutics, and other illicit substances
- Includes several series of questions that focus on mental health issues
- In-person interview that utilizes audio computer-assisted interviewing
- Populations included: Non-institutionalized civilian households, non-institutional group quarters (e.g., shelters, rooming houses, dormitories) and from civilians living on military bases
- Populations excluded: Homeless individuals not living in shelters, military personnel on active duty, and residents of institutional group quarters such as prisons or jails, hospitals, and residential substance use treatment or mental health facilities
- Weighted interview response rate in 2016 – 68.4%

Dr. Jones pointed out several differences between the NSDUH and the studies that Dr. Avenevoli described. First, unlike the ECA Study, the NSDUH does not assess specific mental disorders, except for major depressive episode. The NSDUH estimates the prevalence of SMI by using a weighted logistic regression model that has improved over time.

### Generation of SMI Measures in the NSDUH

- SMI estimates in the NSDUH are generated using a weighted logistic regression model
- Definition – Adults were defined as having SMI if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities
- 2012 Model
  - Based on a random subsample of adult NSDUH respondents from 2008-2012 who were administered a follow-up clinical interview using an adapted version of the SCID and the GAF
  - Respondents were defined as having SMI if:
    - They had any of the mental disorders assessed in the SCID (not including SUDs)
    - These disorders resulted in substantial impairment in carrying out major life activities, based on GAF scores of 50 or below
- Predictors in the model:
  - K6 (screening instrument for nonspecific psychological distress)
  - WHODAS (World Health Organization Disability Assessment Schedule)
  - Past-year serious thoughts of suicide
  - Past-year Major Depressive Episode
  - Age variable



Dr. Jones recommended that the ISMICC consider the purpose and goal of any new survey, including the policies and programs that the survey will inform. For example, the ISMICC should consider how a survey will set a baseline for measuring what the ISMICC is trying to accomplish, and how the survey will inform federal policies and programs. Finally, Dr. Jones mentioned that the CDC, VA, and DoD also have large population-based surveys that capture some elements of mental health. A comprehensive review of federal surveys should be considered before deciding to conduct a new survey.

### NSDUH Considerations

- NSDUH provides important information on prevalence of AMI (any mental illness), SMI, and select mental health issues and service utilization
- These data are critical in guiding policy and programmatic efforts
- NSDUH excludes populations that are known to have higher mental illness burden such as incarcerated individuals, homeless not living in shelters, and institutionalized individuals
- SMI is a modeled estimate
- NSDUH does not provide information on incidence of mental disorders
- It does not provide information on specific mental disorders (other than major depressive episode)
- Limited coverage of youth mental health issues

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 Prevalence among young children</b>	a. From a stigma reduction standpoint, it is critical to have data on children under age 12. It is not clear that any federal datasets focus on this group.
<b>2 Populations studied</b>	a. SAMHSA and NIMH datasets do not cover the populations of most interest to the ISMICC. For example, most prevalence estimates exclude people who are homeless or living in jails or prisons, yet mental health conditions are common in these populations.  b. The NSDUH lacks data for SMIs other than major depression, lumps SMIs together, and derives prevalence from a statistical model. This may not accurately estimate the populations of interest to ISMICC.  c. NIMH recently posted an estimated prevalence of schizophrenia that was 2 million lower than previous estimates. It is difficult for federal agencies to justify funding for SMI and SED if prevalence rates are not reported accurately.  d. Accurate estimates of people with SMI involved with the criminal justice system would facilitate efforts to formulate policies and programs.
<b>3 Additional surveys</b>	a. Invite CDC, VA, and DoD to present on their surveys to the ISMICC or to an expert panel.  b. ISMICC should think creatively. For example, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) applications could be a source of data on SMI and SED.  c. SSA collects data on low-income children. It would be interesting to look at SED rates in that population.  d. The Bureau of Labor Statistics lumps SMI with autism and intellectual disability, which is incorrect, provides data is that difficult to interpret, and impairs assessment of the impact of work on people with SMI.  e. It might be helpful to look into the NIMH Research Domain Criteria (RDoC) Matrix.  f. It might be helpful to look at data being collected for the NIH All of Us Research Program, a study of a million people that includes biological data, health record data, and more.

Topic	ISMICC member comments
<b>Additional surveys (continued)</b>	g. It would be interesting to look information on subpopulations in the 2015 consensus committee report by the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine.
<b>4 Defining SMI</b>	<p>a. ISMICC Recommendation 1.4.a calls for establishing uniform definitions of SMI and SED across federal programs. That will help with estimates and would be a first step before initiating any new survey.</p> <p>b. The SAMHSA definitions of SMI and SED are similar, but in reality, the symptoms are quite different.</p> <p>c. It is important to look at the entire lifespan. The transition from childhood to adulthood as an important time for development of mental illnesses.</p> <p>d. Focusing on diagnostic criteria is not helpful to most consumers. It is more important to know what happens to people over time, and to consider how they are functioning in their lives.</p> <p>e. It would be interesting to look at the course of mental illness over time, when remission is likely to occur, and when symptoms peak. This might help determine when to intervene with various age groups.</p> <p>f. There is value in looking at functionality and considering how SMI and SED affect other aspects of a person’s life. What is the overlap between SMI, SED, substance use, and physical health problems? How many people with SMI or SED have jobs or children?</p> <p>g. Definition of prevalence rates will be important because that is how federal efforts and funding will be prioritized.</p> <p>h. ISMICC must think about the impact of mental illnesses—such as cost, outcome, and impairments—in prioritizing policies and programs.</p>
<b>5 Convening an expert panel</b>	a. The group agreed that an expert panel should be convened to address this important issue and determine next steps. The panel should discuss how to design a state-of-the-art study to meet the needs of the ISMICC.

**Dr. McCance-Katz** emphasized the importance of knowing the prevalence of mental health disorders. She warned about the dangers of working with data that is 20 to 40 years old. Up-to-date prevalence rates will allow federal agencies to make informed decisions. She endorsed the idea of convening an expert panel to look at how to obtain accurate prevalence rates.

# Comprehensive Inventory of Federal Activities that Affect the Provision of Services for People with SMI and SED (Recommendation 1.3)

**David Morrisette** began a discussion of the federal inventory in the December 2017 ISMICC Report to Congress. That inventory was abbreviated due to time constraints. ISMICC workgroups appear to need a more comprehensive inventory to make recommendations on how to leverage federal programs, coordinate activities, and direct resources efficiently.

### ISMICC Federal Inventory

**SERVICE DELIVERY OR PAYMENT:** What are the federal supports for SMI and SED around housing, income assistance, primary health care, behavioral health care including mental and substance abuse treatment, reducing justice involvement, case management, employment, and education?

- Veterans Health Administration (VHA), DoD health care facilities, Indian Health Service
- TRICARE
- Medicare, Medicaid and the Children's Health Insurance Program (CHIP).
- Social Security disability programs.
- Housing Assistance programs

**PROGRAM GRANTS:** How does the federal government support service delivery and accelerate the implementation of effective practices?

- Time-limited grant programs to fund development of promising models at the state, tribal, and local levels.
- Longer-term formula-funded programs.
- Grants to provide technical assistance and support.



Dr. Morrisette noted that SAMHSA will lead data collection efforts during the last quarter of fiscal year 2018. This effort will gather information about federal programs that are operating in fiscal year 2018 and that are expected to be operating in fiscal year 2019. The inventory will recognize that these federal programs are not all designed for the same purpose or distributed in the same way.

Dr. Morrisette reported that the inventory effort would collect information within four categories: (1) service delivery or payment, (2) program grants, (3) data collection, and (4) research and evaluation.

The table below summarizes key points made during the subsequent discussion.

### ISMICC Federal Inventory

**DATA COLLECTION:** What federal data is collected on incidence, prevalence, and distribution of behavioral health disorders within departments? What federal data is available on access, quality, and affordability of behavioral health care?

- Surveys and other surveillance programs that provide information on the incidence, prevalence, and distribution of disorders.
- Quality measurement and reporting

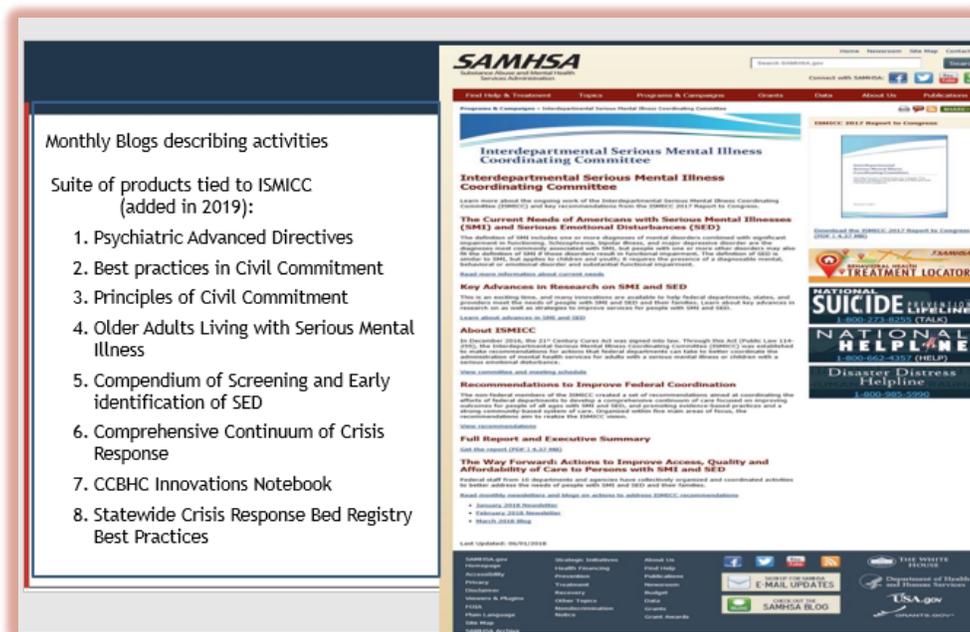
**RESEARCH AND EVALUATION:** How does the federal government measure the impact of its programs on people with SMI, SED, their families and communities?

- Basic and applied research that helps us better understand the course of a disorder and the means to prevent, cure, or lessen its impact.
- Demonstrations and evaluations of prevention, treatment, and support models that can improve the lives of people with SMI and SED.

	Topic	ISMICC member comments
1	<b>Possible additions</b>	<ul style="list-style-type: none"> <li>a. The inventory should have a way to capture information about how federal agencies support implementation within states or health care systems. Otherwise, how will the ISMICC know whether leveraging of federal resources is making an impact on states and communities?</li> <li>b. The inventory should focus on the workgroup areas. For example, the inventory should be able to highlight federal programs/activities that address the major problem of the behavioral health workforce shortage.</li> <li>c. Include federal policies defined by federal agencies that require states or communities to work in a certain way, but lack associated funding. For example, the Individuals with Disabilities Education Act (IDEA) program has requirements for schools but no funding.</li> <li>d. Cover the jail and prison system comprehensively. For example, the federal prison system is an important source of behavioral health funding.</li> </ul>
2	<b>Suggested changes</b>	<ul style="list-style-type: none"> <li>a. The (3) data collection and (4) research and evaluation categories have a lot of overlap. Rephrase the latter to: “How does the federal government measure systematic improvement?”</li> <li>b. The research and evaluation criteria should be revised because the U.S. Government Accountability Office has a definition for evaluation that differs from the proposed definition.</li> <li>c. Consider changing the research and evaluation category title to “Research, Evaluation, and Quality Measurement.”</li> <li>d. Review each of the questions to ensure that child-focused programs within ED fit. They are a major funder of children’s mental health programs.</li> <li>e. Put in a variable regarding whether activities are interdepartmental. It would be interesting to see how many activities span federal agencies.</li> </ul>
3	<b>Additional resources</b>	<ul style="list-style-type: none"> <li>a. SAMHSA and HRSA lead a federal cross-agency behavioral health workforce group that looks at workforce issues. It has completed an inventory of federal programs that might be helpful to ISMICC.</li> <li>b. ISMICC should review a state behavioral health workforce evaluation recently completed by the University of California, San Francisco.</li> </ul>

# Communication Strategy and the Way Forward: National Participation in ISMICC

**Dr. Everett** announced that SAMHSA is developing a webpage that can house the various products coming out of the ISMICC.



**Dr. Morrissette** noted that the webpage will be on the SAMHSA website. The page will have hyperlinks back to the ISMICC report to Congress, and will include monthly blogs. When the workgroups have completed various products, those will go through the standard federal clearance process, including review by all of the federal agencies, and then be posted on the webpage. For example, SAMHSA will convene the medical directors of the Certified Community Behavioral Health Clinics (CCBHCs) from eight states in July 2018. The goal of the meeting will be to put together an “innovations notebook” that will be posted on the ISMICC webpage. Dr. Morrissette noted that SAMHSA would be hosting a meeting on bed registries this summer, in conjunction with the National Association of State Mental Health Program Directors. The meeting will touch on best practices around developing bed registries. A product from that meeting will be posted to the ISMICC webpage.

The table below summarizes key points made during the subsequent discussion.

Topic	ISMICC member comments
<b>1 ISMICC workgroups</b>	<ul style="list-style-type: none"> <li>a. Non-federal ISMICC members would like to see a workgroup membership list that includes federal staff. If membership is supposed to be interdepartmental, the list should reflect that.</li> <li>b. Non-federal ISMICC members would like to be more involved with federal staff, especially within workgroups that are consistent with their expertise. At this point, there is no systematic method for non-federal members to know when workgroup meetings are occurring. Better communication about this is needed.</li> <li>c. Post all workgroup meetings and agendas, even when they do not invite non-federal members. When non-federal members are invited, make that clear and post meeting dates and meeting agendas as soon as possible.</li> <li>d. Minutes from workgroup meetings should be posted on the website.</li> <li>e. It might be helpful to extend the in-person ISMICC meetings to two days, rather than one.</li> </ul>
<b>2 Disseminating and marketing the ISMICC efforts</b>	<ul style="list-style-type: none"> <li>a. It will be helpful to have a set of slides describing the ISMICC. Non-federal ISMICC members could use the slide deck to talk about the ISMICC at various stakeholder meetings.</li> <li>b. It would be good to think through a communication campaign on how to disseminate the ISMICC recommendations and products. A planned effort should consider various target audiences.</li> <li>c. Use the New York Times mortality gap article as a stimulus for an op-ed piece that introduces ISMICC. The National Action Alliance for Suicide Prevention, a similar public-private venture, did something similar.</li> <li>d. Veterans, military people, and their families are an important audience.</li> <li>e. SAMHSA and ISMICC members should provide copies of the recommendations at various meetings and conferences.</li> </ul>
<b>3 ISMICC website</b>	<ul style="list-style-type: none"> <li>a. For products that workgroups develop, it would be helpful to identify the primary audience for the product.</li> <li>b. The website should have some sort of dashboard or list of ISMICC accomplishments, perhaps including the overall timeline and milestones.</li> </ul>

Topic	ISMICC member comments
ISMICC website (continued)	<ul style="list-style-type: none"> <li>c. Dr. Justine Larson did a presentation in New Orleans at the Dialogues Conference that would be a good stimulus for a future blog post.</li> <li>d. Include a comments function for the website so stakeholders can provide input.</li> </ul>
4 Future meetings and products	<ul style="list-style-type: none"> <li>a. A meeting of chiefs of police and a corresponding product focused on law enforcement would be important to include on the website.</li> <li>b. Include information on accountability courts, and develop a toolkit.</li> <li>c. Convene a meeting and develop a product on peer support services.</li> <li>d. Focus an expert panel meeting on how to implement certain recommendations. Include broad stakeholders such as state leaders, county leaders, and advocates.</li> <li>e. Host town hall meetings to get input from various stakeholders, and to achieve buy-in and feedback.</li> <li>f. Expert panel meetings and products should focus on “actionable goals,” and not just “virtuous goals.”</li> </ul>

**Dr. McCance-Katz** ended the meeting by thanking everyone for their participation. She reminded the group that the work of the ISMICC will improve the lives of millions of people living with SMI and SED, and expressed optimism about the work that will continue to occur through the ISMICC.

# Appendix A

## Final Meeting Agenda



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Washington, D.C. 20201

**U.S. DEPARTMENT OF HEALTH AND HUMAN  
SERVICES  
INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS  
COORDINATING COMMITTEE MEETING**

Friday, June 8, 2018  
9:00 a.m. to 5:00 p.m. (EDT)  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 800  
Washington, DC 20201  
Agenda

**OPEN SESSION**

**9:00 a.m. Opening Remarks**

*Alex M. Azar II, Secretary, Department of Health and Human Services*

**9:10 a.m. Call to Order/Committee Roll Call**

*Pamela Foote, Designated Federal Official, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)*

**9:15 a.m. Welcome and Introductions**

*Elinore F. McCance-Katz, M.D., Ph.D., Chair, Assistant Secretary for Mental Health and Substance Use*

*Anita Everett, M.D., Chief Medical Officer (CMO), Office of the Chief Medical Officer (OCMO), SAMHSA*

**Consideration of the Minutes for the ISMICC Meeting of December 14, 2017**

*Elinore F. McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use*

**9:25 a.m. Overview of Federal Efforts**

*David Morrissette, Ph.D., L.C.S.W., CAPT, U.S. Public Health Service, ISMICC Coordinator, OCMO*

**9:35 a.m. Workgroup Report Outs: Focus Area Stewards (10 Minute Presentations/10 Minute Discussions)**

*Data – Kirstin Painter, Ph.D., Public Health Advisor, Center for Mental Health Services (CMHS), and Christopher M. Jones, PharmD., M.P.H., CAPT, U.S. Public Health Service, Director, National Mental Health and Substance Use Policy Laboratory*

*Access – Richard McKeon, Ph.D., M.P.H., Chief, Suicide Prevention Branch, CMHS and Steven Dettwyler, Ph.D., Public Health Analyst, CMHS*

*Treatment and Recovery – Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS, Cynthia Kemp, Deputy Director, OCMO, and Tracie Pogue, M.Div., LCSW, Public Health Analyst, OCMO*

*Justice – Larke Huang, Ph.D., Director, Office of Behavioral Health Equity Lead, Trauma and Justice Strategic Initiative Senior Advisor – Children, Youth and Families Administrator's Office of Policy Planning and Innovation; Jennie Simpson, Ph.D., Office of Policy, Planning, and Innovation (OPPI), SAMHSA*

*Finance – Chris Carroll, M.Sc., Director, Health Care Financing and Systems Integration, OPPI, SAMHSA; and David DeVoursney, Chief, Community Support Programs Branch, CMHS*

**11:15 a.m. ISMICC Member Involvement in Implementation**

*Facilitators: Anita Everett, M.D., CMO, SAMHSA and CAPT, David Morrissette, Ph.D., LCSW, ISMICC Coordinator*

**12:00 p.m. Lunch Break**

**12:30 p.m. Comments from Mr. Arne Owens, Principal Deputy Assistant Secretary, SAMHSA**

**12:40 p.m. Report out on Expert Panels**

*Anita Everett, M.D., Chief Medical Officer, OCMO, SAMHSA*

**1:00 p.m. Public Comments (see attached sheet with names in order to speak)**

**2:00 p.m. Implementation Workgroup Poster Session**

*Focus Area Stewards*

**2:30 p.m. Guidance on Recommendation 3.8.a .... that funding for research is commensurate on prevalence of SMI and SED.**

*Presenters: Shelli Avenevoli, Ph.D., Deputy Director for the National Institute of Mental Health (NIMH) and Christopher M. Jones, PharmD., M.P.H., CAPT, U.S. Public Health Service, Director, National Mental Health and Substance Use Policy Laboratory*

**3:15 p.m. Comprehensive Inventory of Federal Activities that Affect the Provision of Services for People with SMI and SED. (Recommendation 1.3).**

*CAPT, David Morrissette, Ph.D., LCSW, ISMICC Coordinator*

**3:40 p.m. Communication Strategy**

*Brian Robertson, Acting Director, Office of Communication, SAMHSA and CAPT, David Morrissette, Ph.D., LCSW, ISMICC Coordinator*

**4:00 p.m. The Way Forward: National Participation in ISMICC**

*Facilitators: Anita Everett, M.D., CMO, SAMHSA and CAPT, David Morrissette, Ph.D., LCSW, ISMICC Coordinator*

**5:00 p.m. Adjourn**

# Appendix B

## Official List of Meeting Participants

**US Department of Health and Human Services  
Interdepartmental Serious Mental Illness Coordinating Committee Meeting  
Friday, June 8, 2018  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 800  
Washington, DC 20201**

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