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

Thursday, December 14, 2017
10:30 a.m. to 12:00 p.m. (EST)

Hubert H. Humphrey Building - Studio
200 Independence Avenue, S.W.
Washington, DC 20201

Opening by the Designated Federal Official and the Roll Call

Pamela Foote, the Designated Federal Official (DFO), welcomed participants and called to order the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). Roll call followed to ensure a quorum.

Federal ISMICC Members or Designates Present

- Eric D. Hargan, J.D., The Acting Secretary, Department of Health and Human Services (HHS);
- Elinore F. McCance-Katz, M.D., Ph.D., The 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);
- John McCarthy, Ph.D., M.P.H., Director, Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC), for the Secretary of the Department of Veterans Affairs (VA);
- Ralph Gaines, M.B.A., Principal Deputy Assistant Secretary for Community Planning and Development, for the Secretary of the Department of Housing and Urban Development (HUD);
- Alexandra O. Hudson, Policy Advisor to the Assistant Secretary, Office of Special Education and Rehabilitative Services, for the Department of Education (ED);
- Jennifer Sheehy, M.B.A., Deputy Assistant Secretary, Office of Disability Employment Policy (ODEP), for the Secretary of the Department of Labor (DOL);
- Kimberly Brandt, J.D., Principal Deputy Administrator for Operations, for the Administrator of the Centers for Medicare and Medicaid Services (CMS);

Federal ISMICC Members or Designates Not Present

- 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;
- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, St. Joseph-Hoag Health;
- 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, Peer Support Provider and Manager, Collaborative Support Programs of New Jersey;
- Kenneth Minkoff, M.D., Zia Partners;
- 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.

Non-Federal ISMICC Members Not Present

- Ron Bruno, Founding Board Member and Second Vice President, CIT International;
- David Covington, L.P.C., M.B.A., CEO/President, RI International;
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court.

Guests

- Kara Townsend, M.P.H., Deputy Assistant Secretary for Planning and Evaluation (ASPE), HHS;
- Anita Everett, M.D., Office of the Chief Medical Officer (OCMO), SAMHSA;
- CAPT David Morrissette, Ph.D., LCSW, U.S. Public Health Service, ISMICC Coordinator, OCMO, SAMHSA;
- Paolo del Vecchio, M.S.W., Director, Center for Mental Health Services (CMHS), SAMHSA;
- Pamela Foote, Designated Federal Official, CMHS, SAMHSA.

Ms. Foote verified the quorum and turned the meeting over to Dr. McCance-Katz, Assistant Secretary for Mental Health and Substance Use, SAMHSA.

Welcome and Introductions

Dr. McCance-Katz introduced Acting HHS Secretary, Eric D. Hargan, J.D., who was sworn into office as Deputy Secretary on October 6, 2017, and appointed as Acting Secretary of HHS on October 10, 2017 by President Trump. Previously, Mr. Hargan was an attorney specializing in transactions, health care regulations, and government relations. During 2003 to 2007, Mr. Hargan served at HHS in a variety of capacities and worked with the State Department's Bureau of Arms Control to advance bio-security in developing nations. He also initiated and led the HHS team that developed the first responses to international food safety and importation issues in 2007, as well as being a member of the U.S. Government team at the inaugural U.S.-China strategic economic dialog in Beijing in 2006 and 2007. More recently during the transition, Mr. Hargan served as the lead co-chair for Illinois Governor Rauner's Health Care and Human Services Committee and taught at Loyola Law School, focusing on administrative law and health care regulations.

Mr. Hargan thanked the ISMICC for their commitment, specifically the considerable contribution of non-federal committee members. Addressing the federal members of the committee, Mr. Hargan added that he looks forward to hearing about current efforts and priorities and working with them to make a difference in the lives of people with serious mental illness (SMI) and serious emotional disturbance (SED).

Mr. Hargan explained that the partnership of the federal and non-federal members of the committee presents a unique opportunity to better understand and address the challenges faced by those with SMI and SED. Challenges such as education, employment, housing, and accessing coordinated health and behavioral health services can lead to social disconnection, involvement with the criminal justice system, homelessness, and a range of other tragic outcomes. Mr. Hargan added that these challenges should be viewed more as a public health problem than as a public safety problem. Mr. Hargan expressed that HHS is committed to partnering with and advancing the work of the committee and thanked them again for their work.

Dr. McCance-Katz thanked the committee and stated that this second meeting of the ISMICC would focus on the current and planned activities of the federal members and provide an opportunity to hear from the public. Dr. McCance-Katz explained that the committee would need to build upon the first report to Congress from the ISMICC, "The Way Forward," to enhance coordination across federal agencies and to improve service access and delivery of care for people living with and families affected by SMI and SED.

Dr. McCance-Katz shared that many people with SMI and SED do not receive the treatment and support they need. Fragmented systems too often provide incomplete services that do not draw on the best available evidence. The result is needless suffering for individuals and families, and increased risk of jail and prison, homelessness, disability, poor physical and mental health, and even early death. Dr. McCance-Katz explained that over the next five years, ISMICC can help improve the coordination of services, increase the use of research based effective practices, and guide the work of the departments and agencies represented on the committee.

Dr. McCance-Katz added that the first report to Congress provided a broad overview of issues that need to be addressed. The report also identified an initial set of advances and strategies that hold promise for improving care and support for people living with these disorders. Further, initial steps have been taken to evaluate the federal system of services and supports for people

with these conditions, guided by a strong set of recommendations from non-federal committee members.

Before turning the meeting over to the federal partners, Dr. McCance-Katz introduced and thanked CAPT David Morissette, U.S. Public Health Service, who will serve as the dedicated ISMICC Coordinator from SAMHSA, partnering with SAMHSA's Chief Medical Officer, Dr. Anita Everett. As a Public Health Officer, CAPT Morrissette coordinated the design of the Services' Mental Health Team Disaster Response Model, and has deployed numerous times to states and tribes in leadership roles. Since 2001, he has worked in SAMHSA's Center for Mental Health Services, Community Support Programs Branch in a variety of roles, including Acting Branch Chief and Lead on justice related programs. In addition, he helped implement the Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program, provided behavioral health services to military members and their families at Walter Reed National Military Medical Center, and taught as an Adjunct Professor at the School of Social Work at Catholic University.

Dr. McCance-Katz introduced each of the following federal partners who provided an update to the committee.

Deputy Assistant Secretary for Planning and Evaluation (ASPE)
Kara Townsend, Deputy Assistant Secretary

ASPE is a staff division within the Office of the Secretary focused on advising the Secretary of HHS on the development of sound policy through policy focused research and evaluation. To that end, ASPE recently inventoried current HHS programs and activities that target SMI across the age span and found over 100 distinct services that either directly or indirectly target SMI, including programs that aim to reduce suicidal behavior. These efforts span thirteen operating and staff divisions of HHS that are making diverse contributions in this area. Further, the recent departmental draft strategic plan which ASPE develops and oversees, reflects this commitment and includes an objective that focuses on reducing the impact of mental health and substance use disorders through prevention, early intervention, treatment, and recovery support.

The Office of the Secretary is particularly interested in advancing the ISMICC focus on strengthening federal coordination to improve care. Several notable HHS collaborative efforts are currently underway in this domain:

- Partnering with the Departments of Labor and Treasury to improve mental health and substance use disorder parity implementation and enhance parity compliance and enforcement. Revisions are underway on an action plan that will be used to guide federal efforts on parity moving forward.

- Broad coordination across HHS to implement and track progress on the implementation of the 21st Century Cures Act including working with SAMHSA on a provision in the 21st Century Cures Act (henceforth, Cures Act) that directs initiation of a study on the formulas of distributing the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, and the Projects for Assistance from Homelessness Funds. This study is scheduled to be completed at the end of 2018.

- Several large-scale evaluation projects in collaboration with many other federal partners

to complete grant evaluations that focus on early intervention, integrated and coordinated care, and ways to better engage individuals with SMI in care.

- Conducting an evaluation of the two-year demonstration of Certified Community Behavioral Health Clinics in eight states including many individuals with SMI, which was recommended by the non-federal committee members. This project will be complete in December of 2021.

- Evaluating a four-year pilot program that establishes new Assisted Outpatient Treatment services for individuals with SMI. Evaluation efforts are underway, and the final evaluation report for the project is due September of 2020.

- Collaborating with SAMHSA on the Cures Act distribution of block grant funds.

Department of Justice
Tracey Trautman, Office of the Attorney General, BJA

The BJA supports communities through a grant called the Justice Mental Health Collaboration Program, which provides multiple opportunities for states and counties across the country to collaborate on mental health issues. There are currently 135 open competitive grants for $26 million across 41 states. Ms. Trautman shared the following examples:

- The Superior Court of Fulton County, Georgia was awarded $250,000 and is leading the Fulton Mental Health Task Force, which includes local and state partners. This task force is responsible for creating a data driven action plan with recommendations that improve the use of public safety and behavioral health resources, maximizing impact, and measurably improving outcomes for people with mental health conditions in the justice system.

- Boulder County, Colorado was awarded $200,000 to enhance its existing program called Project Edge, which is a law enforcement response program that diverts individuals with a behavioral health issue from the criminal justice system before arrest. Through this program, emergency psychiatric clinicians accompany law enforcement officers in response to community calls which involve an individual with suspected or diagnosed behavioral health conditions. Further, in collaboration with other law enforcement partners, the Boulder County Sheriff's Department is using these funds for quality improvement efforts to ensure appropriate allocation of resources and to maximize their response capacity throughout Boulder County.

Another program run by BJA is the Stepping Up Initiative, which includes over 400 counties that have passed resolutions to reduce the prevalence of people with mental illness in their jails. In addition, a police mental health collaboration toolkit, currently a web-based resource, provides different examples for training and six different learning sites across the country that will help others to start a program. Those learning sites are Houston, Texas; Los Angeles, California; Madison, Wisconsin; Portland, Maine; Salt Lake City, Utah; and the University of Florida Police Department. BJA will also be launching a companion training and technical assistance effort this year called the National Training and Technical Assistance Center to improve law enforcement

responses to people with SMI and intellectual and developmental disabilities (IDD).

Finally, BJA has supported the development of a National Crisis Intervention Team training that will include a technical assistance component and be available to those who want to implement crisis intervention activities.

Department of Veterans Affairs
John McCarthy, SMITREC, Office of Mental Health and Suicide Prevention

SMITREC is a program evaluation center within the VA, Office of Mental Health and Suicide Prevention. The Veterans Health Administration provides mental health care to over 1.6 million veterans and serves over 200,000 patients annually who have a diagnosis of schizophrenia, bipolar disorder, or other psychosis.

The risk of suicide among VA patients with SMI is particularly high. Further, the prevalence of bipolar disorder is rising dramatically and this population has the highest rates of suicide among VA patients with any mental health conditions.

The VA has prioritized the integration of care and coordination across facilities within the VA as well as between the VA and other agencies. The VA is actively coordinating with the Department of Defense (DOD) to ensure that mental health condition and treatment information for individuals who are separating from the military is available so that providers can be as responsive as possible.

The VA is also actively engaged in first episode psychosis care, and is developing education and guidance for facilities while looking for coordination opportunities. The ReachVet Program, the Recovery, Engagement, and Coordination for Health, and the Veterans Enhanced Treatment Program, are efforts within the VA to develop innovative services for individuals who are identified as particularly high risk for suicide. These programs target individuals in the top 0.1 percent of predicted risk for suicide and substantially represents individuals with bipolar disorder and schizophrenia. Early evaluations suggest that the program effects are positive and represents an opportunity to inform suicide prevention for individuals with SMI, both within and outside of the VA.

Department of Housing and Urban Development
Ralph Gaines, Principal Deputy Assistant Secretary of Community Planning and Development

The intersection for HUD and SMI centers on those experiencing chronic homelessness. This population is made up of people that have experienced homelessness for a year, or have been homeless for a year over the course of three years. HUD addresses SMI and SED within the Continuum of Care Program, administered by the Special Needs Assistance Program Office that is designed to do the following:

- Promote a community-wide commitment to end homelessness;
- Provide funding for efforts by our non-profit providers and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities;

- Promote access to and effect utilization of mainstream programs by homeless individuals and families; and

- Optimize self-sufficiency among individuals and families experiencing homelessness.

Mr. Gaines explained that chronically homeless individuals and families are the most likely to experience SMI and SED and require permanent supported housing. In fact, HUD's Continuum of Care Program served approximately 110,000 individuals during 2017. In the coming year, the program will continue to support the Continuum partners in their efforts to provide housing with treatment, and plans to implement a "move on" strategy enabling homeless people in permanent supportive housing to move to lower cost mainstream housing programs. Further, HUD is committed to assuring efficiency and coordination of services at the local level. For example, HUD will create an unsheltered-homeless strategy that targets technical assistance and other resources to communities with large increases in unsheltered homelessness, such as those on the West Coast.

Health and housing go hand in hand. Therefore, HUD will also be developing Envision Centers, which are premised on the notion that financial support alone is insufficient to solve the problem of poverty and homelessness. Intentional and collective efforts across a diverse set of organizations are needed to implement a holistic approach to foster long lasting self-sufficiency. Health services, including mental health, will serve as one of the four pillars of the Envision Centers designed to improve access to health outcomes by individuals and families residing in HUD assisted housing.

Department of Labor
Jennifer Sheehy, Deputy Assistant Secretary, Office of Disability Employment Policy

The DOL believes that employment is a necessary recovery strategy for someone to be independent and enjoy a meaningful life. DOL looks across all federal programs to increase employment for people with disabilities, to make recommendations to streamline and improve policies and to increase employment outcomes, wages, and individual choices regarding employment decisions. To accomplish this, DOL works with federal and state partners to identify successful practices to support employment for people with all disabilities including those with serious and significant disabilities like SMI or SED. In addition, DOL works with employers by providing technical assistance and promoting policies and practices among employers that are successful as well as research and evidence based.

Ms. Sheehy outlined two DOL initiatives: Employment First State Leadership Mentoring Program and Stay at Work/Return to Work grant program.

Working with the Administration for Community Living at HHS, DOL's Employment First State Leadership Mentoring Program provides intense technical assistance to states that want to institute policies for Employment First. In this program, subject matter experts work closely with officials from state agencies, such as vocational rehabilitation, the workforce, developmental disabilities agencies, mental health services, and others to make sure that public funding can be blended or braided together to support competitive, integrated employment.

In future ISMICC meetings, DOL would like to highlight success stories by bringing in subject

matter experts, employers and employers with SMI to share success stories from their states and discuss their model. Further, they plan to provide the committee with information on the technical assistance tools that are available to employers on how to hire and support people with SMI and then engage with federal colleagues and non-federal members on how best to support and ensure widespread use of these initiatives.

DOL collaborated with SSA, ED, and HHS on another initiative called the Stay at Work/Return to Work grant program, which is appropriated in the President's 2018 budget. These grants will allow states to provide coordinated services as early as possible when someone experiences illness, injury, or mental illness on the job, so that the individual can get back to work as soon as medically feasible.

Center for Medicare and Medicaid Services
Kim Brandt, Principal Deputy Administrator for Operations

Kim Brandt explained that the work of the committee has given CMS an opportunity to look at how to better serve their clients especially those who have SMI and SED. Ms. Brandt thanked the non-federal partners for their enthusiasm and input and highlighted ways that CMS has implemented numerous recommendations outlined in the draft report.

Recommendation 1.6 addresses the use of data to improve quality of care and outcomes, to review and improve federal and national data sets relevant to the lives of people with SMI and SED, and to incorporate tracking of information and outcomes. CMS has an initiative that will be finalized in March of 2018, called the Medicaid and Children's Health Insurance Program (CHIP) Scorecard, which will support continued improvement in health outcomes for beneficiaries by promoting transparency and accountability about program administration and outcomes. Performance measures in the scorecard will be monitored and used to help state and federal officials drive improvements and increase accountability in health outcomes and program administration. The scorecard will span the spectrum of services by including state and federally reported measures in three areas: state health systems performance, state administrative accountability, and federal administrative accountability. Further, CMS expects to update the scorecard periodically, keeping a portion of the same measures from year to year, to allow for analyses of trends. However, other measures in the scorecard may be replaced as more outcome focused measures become available, and to address areas of emphasis in the Medicaid and CHIP programs and recommendations from groups such as this one.

Recommendation 2.10 addresses the expectation that SMI and SED screening to occur in all primary care settings, which means to expand access and facilitate early initiation of treatment for people with SMI and SED through identification and engagement in primary care settings. In accordance with Section 12003 of the Cures Act, CMS is currently finalizing a State Medicaid Director Letter which was developed with the help of the committee and will highlight strategies that states should use to improve integration in primary and behavioral health care, early identification, engagement, and treatment.

Recommendation 3.9 addresses making integrated services readily available to people with co-occurring mental illnesses and substance use disorders, including Medication Assisted Treatment (MAT) for opioid use disorders. CMS has been working on Section 223 of the Protecting Access to Medicare Act, which authorized a demonstration to look at Certified Community Behavioral Health Clinics (CCBHCs). This program is a model for providing comprehensive community

based behavioral health care to meet the needs of individuals with serious mental health conditions, including integrated mental health, substance use disorder, and primary care. At the end of 2016, CMS partnered with SAMHSA to implement this demonstration whereby the eight participating states, (Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania), began receiving an enhanced federal Medicaid match for services provided in CCBHCs spanning two years.

Recommendation 5.5 addresses parity in that payment for psychiatric and other behavioral health services should be equivalent to other health care services. Reimbursement by public programs for mental health services is lower as a percentage of cost than reimbursement for other health services, forcing providers to offer critical services at a loss. As a result, many mental health service providers do not participate in public programs, leading to widespread mental health workforce shortages. However, Medicare and Medicaid, and other benefit programs need to provide adequate reimbursement for a full range of services needed by people with SMI and SED, at rates equivalent to those paid for other types of health care services.

In the final rule recently issued, CMS pointed out that parity requires use of comparable methodology in setting reimbursement rates for behavioral health providers, as is used in setting rates for medical providers, forcing them to review comparative data and assess whether there is true parity. Ongoing technical assistance will continue to be provided to states as they work through parity compliance for Medicaid managed care organizations, Medicaid alternative benefits plans, and CHIP.

Dr. Everett added that developing a communication strategy to ensure that the ISMICC community is engaged with the CMS initiatives would be helpful. Ms. Brandt stated such a strategy would be welcomed.

The Department of Education
Alexandra O. Hudson, Policy Advisor to the Assistant Secretary, Office of Special Education and Rehabilitative Services

For the record, Ms. Hudson, a designee for ED, was on the line, but was not able to speak due to her line being muted.

Social Security Administration and Department of Defense

Dr. Everett asked if the Social Security Administration was on the call; they were not. She then stated that though the Department of Defense (DOD) was not in attendance, she would read a statement from the DOD summarizing their position and contribution to the ISMICC.

Though the required parity between mental health and substance use disorder benefits and medical surgical benefits and plan benefit provisions do not apply to Tri-Care programs, DOD fully supports and is working toward the principle of mental health parity. The National Defense Authorization Act for fiscal year 2015, signed into law on December 19, 2014, removed Tri-Care statutory limitations and inpatient mental health services for adults, and residential treatment care, center care, for children. DOD published a final rule in the Federal Register that contained comprehensive revisions to the Tri-Care regulation as follows:

1. To reduce administrative barriers;

2. To access mental health benefit coverage; and

3. To improve access to substance abuse treatment for Tri-Care beneficiaries, consistent with current standards of practice.

To improve access and reduce barriers to mental health and substance use disorder (SUD) care, this final rule has four main objectives:

1. Eliminate unnecessary quantitative and non-quantitative treatment limitations on mental health and SUD care;

2. Expand covered mental health and SUD treatment under Tri-Care to include coverage of Intensive Outpatient Programs (IOPs) and venues for medication assisted treatment for opioid use disorder;

3. Streamline the requirements for mental health and SUD institutional providers to become Tri-Care authorized providers; and

4. Develop Tri-Care reimbursement methodologies for newly recognized mental health and SUD/IOPs and opioid treatment programs.

The implementation for most of the regulatory changes began October 2, 2016. Over 60 Tri-Care manual sections have been revised to implement these changes. The following benefits became effective in July of 2017, once the revised Tri-Care Manuals were published in June of 2017:

- Outpatient treatment of opioid use disorder with MAT by qualified opioid treatment programs

- Intensive outpatient programs for mental health and substance use disorder treatment.

- Streamlined requirements for institutional providers of health care to become Tri-Care authorized providers.

- Expansion of approved accrediting bodies for institutional providers of mental health and SUD treatment with flexibility to add additional organizations as they develop.

- Removal of the requirement for referral and prior authorization following the office-based outpatient mental health treatment for non-active duty Tri-Care primary beneficiaries.

Dr. Everett opened the floor for comments from Mr. Peter Earley, and the other non-federal members. Mr. Earley expressed concern over the absence of ED given the importance of involving schools and early screening. Dr. Everett thanked him for calling attention to the absence and assured him that they would be contacted. She once again extended an invitation for comments or reactions from the public ISMICC members or anyone else present before the public comment component of the meeting. When no callers replied, Dr. Everett called on Mr.

Paolo del Vecchio.

Center for Mental Health Services, SAMHSA
Paolo del Vecchio, M.S.W., Director

Mr. del Vecchio gave an update on CMHS efforts for fiscal year 2018 that intersect with the ISMICC agenda. First, in collaboration with the National Institute for Mental Health (NIMH), CMHS has launched roughly 250 programs around the nation to help individuals experiencing first episode psychosis. As previously mentioned, CMHS is working on an evaluation with ASPE to look at both fidelity and outcomes associated with these programs. Second, regarding workforce, there is currently a grant announcement for the Minority Fellowship Program. In addition, CMHS has plans to initiate grant announcements for family networks and consumer networks.

Regarding suicide prevention, for the first time the National Suicide Prevention Lifeline responded to over two million calls in 2017. CMHS is also working closely with NIMH and VA in looking at Zero Suicide efforts to work with primary and behavioral health care systems to help implement evidence-based suicide prevention efforts.

Mr. del Vecchio noted appreciation for the collaboration with HUD and stated that CMHS plans to issue another grant announcement around supported housing, particularly for people with SMI.

The Cures Act gave CMHS new authority to expand its initiatives in many areas. The Garrett Lee Smith Program will expand college mental health initiatives beyond suicide prevention and address treatment, education, and other activities, and a grant announcement is expected to be forthcoming. Regarding integrated care, there is a current grant announcement focused on the Minority AIDS Initiative for the SMI population. CMHS hopes to award more integrated care grants in 2018 through the bi-directional integration allowed for in the Cures Act and to provide technical assistance on integrated care through a continued collaboration with Health Resources and Services Administration (HRSA) on the Center for Integrated Health Solutions.

Mr. del Vecchio closed out his presentation with appreciation for the partnership with DOJ, noting CAPT Morrissette's leadership and desire to increase the number of mental health courts and to provide ongoing technical assistance to develop the needed range of supports to keep people out of jails and prisons.

Dr. Everett thanked Mr. del Vecchio and SAMHSA’s continued contribution over the next five years before calling on Mr. Peter Earley.

Mr. Earley thanked the federal agencies, especially HUD for understanding that mental health and housing are inexorably linked. An IG report in 2017 took the Bureau of Prisons to task for how it treated the 22,000 people with SMI, some being held in solitary or in isolation cells on an average of four years, and releasing 13 percent to the public from isolation cells without treatment. He stated that to be a model, and stress the importance of helping people in jails and prisons, the Federal Bureau of Prisons should be stepping up and be part of the discussions. Mr. Earley strongly urged DOJ to use their authority to ensure that the justice involved SMI population have someone to represent them and to explain to the committee what the Bureau of Prisons is doing with these individuals.

Dr. Everett thanked Mr. Earley for his input, stating his concerns will be addressed in the future,

perhaps in a themed meeting, and then called for comments or questions from anyone on the phone. Denise Byrd, a caller from New Jersey, suggested student loan forgiveness programs for those who are training to be mental health professionals. She also suggested the inclusion of and training of families whose loved ones have a mental illness in order to help rather than exacerbate the problems. Finally, Ms. Byrd stated that housing for those incapacitated by mental illness and for people in recovery would be helpful.

Another non-federal committee member, Kenneth Minkoff, M.D., Zia Partners, expressed his appreciation for the reports from the federal department participants and the demonstration that the report is starting to influence the way the individual departments think and respond to the issue of SMI. He added that it is important to keep in mind that the vision for ISMICC is extremely ambitious and requires the collective dedicated efforts to achieve that vision.

Dr. Minkoff asked federal members to share practical approaches to increase collaboration and implementation in 2018. In response, Dr. McCance-Katz stated that CAPT Morrissette will be monitoring the process to ensure collaboration is taking place and that the process is moving forward. She added that one of the major keys is to develop a national system of integrated care for people with SMI. Once in place, the system could bring in other needed resources to accomplish the vision. To that end, a demonstration program supported by CMS is currently underway and is being closely monitored.

Dr. McCance-Katz explained that once information comes back regarding CCBHCs in mid-2018, talk of a national platform would be more realistic. It is expected that stakeholder groups will help, thereby incorporating the issue of parity. She added that the recommendations of the public members align with the ongoing work that she hopes will expand beyond a few states to a national approach that includes housing services and the school system.

Dr. Everett called on Mr. John Snook, Esq., Executive Director, Treatment Advocacy Center, who stated that the report is a "new day for the treatment for SMI." States across the country are now either being sued, or leading officials are being held in contempt of court, because people are being trapped in jails rather than treatment beds. With serious opportunities as well as risks, he asked everyone to carefully read through the recommendations which are out of the norm for federal committees.

Mary Giliberti, J.D., Chief Executive Officer, National Alliance on Mental Illness, stated that those who are not tracking this process will want concrete facts on how the lives of those with SMI will be improved. As a former federal worker, she noted the challenge will be in communicating and demonstrating how programs are impacting things for the better.

Elena Kravitz, Peer Support Provider and Manager, Collaborative Support Programs of NJ, Inc., acknowledged the diligent and rapid work of the committee and the many recommendations that have been implemented, leading the way for even more improvement after the five-year appointment of ISMICC. Though it may require many incentives for everyone to come to the table, it is necessary to move the agenda forward.

Dr. Everett opened the floor for the comments of two individuals that registered in advance: Katrina Velasquez and Darlema Bey.

Katrina Velasquez, Policy Director of the Eating Disorders Coalition (EDC), spoke first,

thanking the committee for their work. The EDC is a non-partisan national advocacy organization comprised of treatment providers, researchers, advocacy organizations, and families and individuals affected by the serious mental illness of eating disorders. Ms. Velasquez addressed two areas of concern: enforcement of mental health parity and workforce training issues.

Ms. Velasquez encouraged everyone to think of eating disorders as SMI because they are serious and complex biologically-based mental illnesses, affecting over 30 million Americans during their lifetime. Eating disorders have the highest mortality rate of any psychiatric illness, with one person dying every 52 minutes as a direct result of an eating disorder. While eating disorders can be successfully treated with interventions of the appropriate durations and levels of care, only one third of those with eating disorders receive any medical, psychiatric, or therapeutic care. Further, 50 percent of people with eating disorders have co-occurring substance use disorder. Eighty-one percent of people with binge eating disorders are clinically overweight or have obesity. However, they often go undetected by medical professionals due to stigma and a lack of training and resources.

Ms. Velasquez pointed out that the Cures Act includes provisions to increase access to eating disorders treatment through mental health parity and to coordinate early detection and intervention. She called on the committee to ensure their recommendations also respect the Congressional intent to save lives, as every second counts to people struggling with this SMI

After sharing an example of a teenage girl diagnosed with anorexia nervosa and her encounter with an uninformed physician, she pointed out that one study of 637 medical residency programs showed that only 20 percent of medical graduate programs offer elective rotations on eating disorders. She urged the committee to include a recognition that eating disorders are a SMI and to encourage further implementation of life saving provisions within the Cures Act, including section 13005, 13006, and 13007.

Darlema Bey, an advocate and a caregiver from New Jersey with a professional background in cardiac angioplasty and electrophysiology, shared the story of her sister suffering from Post-Traumatic Stress Disorder after being attacked and beaten. Additionally, her heart is failing while other organ systems are declining from the side effects of treatment. Ms. Bey described her experience as an advocate and hopes that the SMI population will one day have access to the most modern health care, safe housing, access to holistic healthy food, and be allowed to flourish.

Ms. Bey began advocating for mental health care reform when caring for her sister became increasingly difficult. She shared her research on psychological conditions, medications, side effects, treatments, and holistic healing with local, state, and federal law makers, families, and health care providers to collaborate and improve the mental health care system. Her meetings on Capitol Hill brought to light that the concerns of caregivers are not being included in the new legislation though the struggles are universal.

Ms. Bey shared the following list of caregiver concerns and priorities because research shows that people with mental illness have shorter life spans of at least 20 years, and it is vital that this population gets proper care.

1. Currently, doctors and staff are limited to offering outdated care practices to Medicaid

patients. Modern, holistic, alternative care practices must be offered and covered under Medicaid and at community mental health care program facilities.

2. Mental health care policies need to be implemented and include adjustments to primary HIPAA laws, allowing caregivers and families to be part of and privy to the treatment plans, regardless of signed releases. HR-2646, the HIPAA amendment on protection and advocacy, needs to include family caregivers in the treatment and discharge plan. This can be accomplished by emulating what Ohio is doing to include caregivers, preventing the system from being financially drained.

3. New specialized and supervised housing is needed, (i.e., apartments), with onsite managers and medical staff on duty to monitor clients for medications, meals, social activities, supervised sports, shopping, and treatment services rather than placing patients in private homes or commercial properties that do not have the client's best interests as a priority. In fact, these “homes” are rarely available, are in extremely poor and unhealthy condition, and are in existence to collect the client's check. They constitute a dangerous and subhuman existence.

4. Supportive treatments like Eye Movement Desensitization and Reprocessing, Magnetic Brain Stem, psychotherapy, pharmacognosy, orthomolecular psychiatry, and personalized genetic medicine are needed as modern-day alternatives to harsh, debilitating drugs that cause many organ systems to become diseased and/or fail. These treatments need to be covered by Medicaid and Medicare.

5. Families should have the ability to access a state funded program to help patients and families deal with the lack of understanding and compassionate treatment they face in the community.

6. New innovative programs must be developed and funded to change the mindset of society about those with mental health issues. For example, the New Jersey State Office of Mental Health Stigma is so poorly funded that as of 2012 it was a one-woman office with no budget.

Ms. Bey concluded by saying that she believes advocates must work at the local, state, and federal levels, and can only do so with a seat at the table. She applauded ISMICC for allowing the public and the caregivers that are in the trenches to be at the table.

Dr. Everett thanked Ms. Bey and was followed by Ms. Kravitz, who thanked the callers for their advocacy. Ms. Kravitz added that advocates are increasingly well-educated and have combined forces to create a growing movement over the last 10 years.

Dr. Everett concluded the public segment of the ISMICC meeting, explained that after lunch the committee would reconvene for a work group in Room 705A at 1:00 p.m., and thanked all participants.