



**Minutes of the First Meeting
of the
Interdepartmental Serious Mental Illness
Coordinating Committee**

Thursday, August 31, 2017
9:00 a.m. to 5:00 p.m. (EST)

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

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Interdepartmental Serious Mental Illness Coordinating Committee Meeting

August 31, 2017

Hubert H. Humphrey Building, Washington, DC

Opening by the Designated Federal Official and the Roll Call

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

Federal members or their designees present:

- Tom Price, M.D., Secretary, Department of Health and Human Services (HHS); Chair, ISMICC;
- Elinore McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, SAMHSA;
- Terry Adirim, M.D., M.P.H., FAAP, Deputy Assistant Secretary of Defense for Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs, DOD;
- Jason Botel, M.Ed., M.A., Acting Assistant Secretary of Elementary and Secondary Education, ED;
- Kimberly Brandt, J.D., Principal Deputy Administrator for Operations, CMS;
- Ben Carson, M.D., Secretary, Department of Housing and Urban Development (HUD);
- Stephen Cox, J.D., Deputy Associate Attorney General, DOJ;
- John McCarthy, Ph.D., M.P.H., Director, SMITREC, VA;
- Jennifer Sheehy, M.B.A., Deputy Assistant Secretary, Office of Disability Employment Policy (ODEP), DOL;
- Melissa Spencer, Deputy Associate Commissioner, Office of Disability Policy, SSA.

Non-federal public 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, 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;
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court; and
- Conni Wells, Owner/Manager, Axis Group, LLC.

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

Welcome, Opening Remarks, Charge to the Committee, and Introductions

Dr. McCance-Katz introduced Dr. Tom Price, Secretary of HHS, citing highlights from his career. Dr. Price has spent his career advocating for a patient-centered health care system that adheres to principles of affordability, accessibility, quality, choices, innovation, and responsiveness. Dr. Price has made SMI one of his top three priorities.

Secretary Price's Introductory Remarks

Dr. Price greeted ISMICC members, and specifically thanked Dr. Carson as well as all of the representatives for their participation. Dr. Price noted that Dr. Carson's presence demonstrated the commitment of President Trump and the administration to addressing the challenge of SMI in America. He gave special thanks to Kana Enomoto, Acting Deputy Assistant Secretary at SAMHSA, and her team for their work in establishing the ISMICC.

The work of the ISMICC is timely, given the need for a fresh examination of how we treat SMI in America. HHS has identified three clinical priorities: the opioid crisis, childhood obesity, and severe mental illness, each presenting a complicated challenge. Policies are coming up short, and real progress would be a victory for the health and well-being of the American people.

According to the latest data from SAMHSA, 10 million Americans in a given year live with SMI, defined as a diagnosable mental illness of sufficient duration, resulting in serious functional impairment that interferes with or limits one or more major life activities. The term generally encompasses schizophrenia, bipolar disorder, and severe depression. The health care system and current policies fail to serve adequately many of these 10 million Americans. One third of those 10 million received no treatment in the past year, far from the standard of care we would demand for other serious diseases.

SAMHSA estimates that Americans with SMI are likely to live lives that are 8 to 10 years shorter in duration than the general population; depending on how you measure that number, it may be as high as 25 years. These diseases are generally incurable, yet they are treatable, and recovery is the expectation. Letting an SMI go untreated has devastating consequences.

According to one report, 10 times more Americans with SMI are in prison than in psychiatric facilities, hospitals, or institutions, depriving many Americans of the treatment that they need and leading to tragic consequences. The imperfect and sometimes cruel system of institutionalization has been replaced with a system that in many cases is more cruel and fails to equip families and health care providers with solutions.

Americans don't know these statistics, nor many others such as the rates of severe mental and physical comorbidities that Americans with SMI have, or the share of Americans with SMI who face homelessness. Americans with SMI have struggled in relative silence for decades, despite the efforts of those who have suffered and of the families who face the challenges. Many ISMICC members have helped raise awareness about the challenges of SMI.

Dr. Price thanked Peter Earley, author of "Crazy: A Father's Search Through America's Mental Health Madness," for his attendance and for representing parents of individuals who struggle with schizophrenia. He then related a personal story with a tragic ending, involving family friends with a son diagnosed with schizophrenia and the family's struggle to get him the right kind of treatment.

Understanding how and why we have failed people with SMI will require not just raising awareness, but defeating the prejudice and apathy that weaken the way that we treat these individuals, understanding why our policies and practices have been failing, and replacing them with better ones.

Dr. Price noted that Dr. McCance-Katz is America's first Assistant Secretary for Mental Health and Substance Use, a position created by the 21st Century Cures Act. This is not the first presidential commission to consider the problem of SMI in America, he said, recalling President Jimmy Carter's Commission on Mental Health, and George W. Bush's New Freedom Commission. However, this historic commission is the first standing committee created to address this topic that is required to report to Congress on the federal government's handling of SMI. Dr. McCance-Katz brings a new level of authority to this issue, along with her own deep experience and expertise. The first psychiatrist ever appointed to head SAMHSA, she will be charged with working across the department and the federal government so that Americans with SMI receive the highest possible standard of care—care that is deeply informed by our knowledge of science and medicine.

The ISMICC's charge is threefold: (1) report on the advances we are making in SMI treatment, recovery, and prevention; (2) provide rigorous assessment of where we are in the fight to help Americans with SMI live longer, healthier, and more productive lives; and (3) make specific recommendations about policy reforms that can produce better treatments and outcomes for Americans with these diseases.

Policies and practices need improving, because mental health care, in particular care for SMI, does not receive the emphasis or the resources it needs. Improvement will come not just through the provision of more health care services, but also through a more holistic approach, a true continuum of care that makes sense for each unique patient. Achieving that requires regular

assessment of what we can do from an inpatient standpoint and an outpatient standpoint, with input from people on the front lines, families, local government officials, health care providers, and ISMICC members. The vision of SAMHSA is essential: “Behavioral health is essential to health. Prevention works, treatment is effective, and people recover.”

Dr. Price encouraged ISMICC members to “Dream of a country where we treat serious mental illness with the same expertise and commitment with which we treat cancer and heart disease, where individuals and families facing serious mental illness feel no shame in their struggle, but receive the sympathy, support, and the love they need. For it is love that is going to be the motivating force in making that dream a reality.” Dr. Price said that love, compassion, and policies, along with the work of the ISMICC, will make this endeavor a success, because love is what drives care and change.

Dr. Price thanked Dr. McCance-Katz for her compassion and clarity in approaching the work ahead, then yielded the chair. Dr. McCance-Katz then introduced Dr. Carson.

Secretary Carson’s Introductory Remarks

Dr. Ben Carson, Secretary, HUD

Dr. McCance-Katz introduced Secretary Ben Carson from HUD. Dr. Carson said his goal at HUD was to develop the holistic approach to each housing resident, an approach that includes mental health. He noted that his career as a neurosurgeon grew from his early interest in mental health and psychiatry, which he developed in his youth as a result of his mother’s struggle with depression.

Dr. Carson emphasized the trauma and serious issues that confront the homeless and the residents in public housing, who have experienced a lot of trauma in their lives and often struggle with substance use, memory disorders, and other mental health conditions. Places of intersection are places for intervention, he noted. For instance, shelter is an important point of contact, based on estimates that 26 percent of all sheltered homeless people have a significant mental illness. Staff must learn to recognize and deal with mental illness and disabilities. A comprehensive approach is the best.

HUD has been aggressive in addressing chronic homelessness. On July 14, 2017, HUD announced \$2 billion to support thousands of local homeless assistance programs nationwide. Of that amount, \$750 million serves people experiencing chronic homelessness. Local applicants are encouraged to use a “housing first” approach, so individuals and families can move quickly into permanent housing. The goal is to get people off the streets and into a supportive shelter or housing. Expanding on that concept, Dr. Carson said that addressing homelessness should involve a “housing first, housing second, and housing third” approach: “Housing first: We get them off the street. Housing second: We diagnose the reason that they’re on the street. And housing third: We address it.”

Dr. Carson said he was pleased that veterans’ homelessness is down, and that some areas—such

as Akron, Ohio, and Bergen County, New Jersey—have announced that homelessness is gone altogether. Based on such significant progress, he expressed his belief that we can eliminate homelessness in this country.

Public housing authorities and other agencies are encouraged to identify mental health problems or other disabilities, contact those who provide appropriate services, and enter into agreements with social services agencies to help provide mental health treatment for affected residents. Local authorities must establish linkages with local services. When mental health problems require intervention, public housing authorities should move tenants quickly, but temporarily, so they can receive treatment without jeopardizing their lease. Social service providers should work with property managers to identify lease violations and intervene with a remediation program without eviction, or before eviction proceedings are started.

The Fair Housing Act and other anti-discriminatory legislation should be fully and comprehensively enforced. Neighbors sometimes have legitimate safety concerns. However, the vast majority of people with mental illness are not violent, and it's important to differentiate between populations in order to avoid discrimination against people who need our help the most. We should prioritize people with the highest level of need for housing and housing assistance programs, so as to be ready if someone has an issue. We want an alert, medically sound, compassionate, and rapid process to take care of the issues that people face, such as the emotional and stressful fallout in Texas from Hurricane Harvey. HUD staff will be strong advocates for mental health identification and treatment, and will look for ways to do even more.

Dr. Carson thanked the ISMICC for its work, adding that he looked forward to future cooperation and performance to address these important issues.

Dr. McCance-Katz proceeded with introductions, noting that the ISMICC includes 10 federal members and 14 members from the public. In addition to the ISMICC members identified during the roll call, additional federal officials and speakers also introduced themselves and gave brief introductory remarks, including:

Other federal attendees:

- Paolo del Vecchio, M.S.W., Director, CMHS, SAMHSA
- Captain Robert DeMartino, M.D., Lead Medical Officer, Office of Health Services Policy and Oversight, DoD
- Thomas McCaffery, M.P.P., Deputy Assistant Secretary of Defense for Health Affairs, DoD
- Ruby Qazilbash, M.P.A., Associate Deputy Director, BJA, DOJ
- Shannon Royce, Director, Center for Faith-based and Neighborhood Partnerships, HHS

Other non-federal attendees:

- Sergio Aguilar-Gaxiola, M.D., Ph.D., Professor of Clinical Internal Medicine, University of California, Davis
- Lisa Dixon, M.D., M.P.H., Professor of Psychiatry, Columbia University

- Lynda Gargan, Ph.D., Executive Director, National Federation of Families for Children's Mental Health
- Joseph Parks, M.D., Medical Director, National Council for Behavioral Health

Dr. McCance-Katz thanked all participants and proposed that the ISMICC's work would be different than previous efforts under President Carter and President Bush. She welcomed feedback and noted everyone's determination to change how the seriously mental ill are served.

Justice Department Program Overview

General Stephen Cox, Deputy Associate Attorney General, DOJ

Dr. McCance-Katz introduced Mr. Cox, who helps oversee the Office of Justice Programs (OJP) within DOJ to provide grants and technical assistance, some of which focus on the intersection of criminal justice and mental health. He noted that his colleague, Tracey Trautman, representing BJA, would elaborate on its programs that provide training and tools to law enforcement agencies to help them deal with individuals with mental disorders, as well as its partnering with mental health and substance abuse service providers and its funding for publications on recidivism and recovery. Moreover, the Bureau of Justice Statistics (BJS), the National Institute of Justice (NIJ), and the Office for Victims of Crime (OVC) fund national studies on mental illness in jails, prisons, and the general population; innovative research and development efforts; and efforts to improve mental health services for victims of crime.

In her presentation, Ms. Trautman noted that OJP is one of three grant-making components within the DOJ that seek to help communities improve their services for people involved with criminal justice who have mental illnesses and substance use disorders. NIJ is partnering with the NIMH to pilot a jail suicide risk screening instrument and to test an intervention program through a randomized control trial to reduce the likelihood of post-release suicide. BJS is monitoring surveys on the prevalence of SMI in jails and prisons, rates that far exceed those of the general population. OVC provides training and technical assistance to assist victims' assistance advocates, including resources for providers who serve crime victims who have SMI. BJA administers the Justice and Mental Health Collaboration Program, a grant program that has awarded roughly \$70 million in recent years for state, local, and tribal entities. The grants cover a broad spectrum of interventions as well as partnerships between criminal justice agencies. In 2016, the bureau funded a police and mental health collaboration tool kit for building and sustaining a program, and \$2.5 million is budgeted in 2017 to operationalize the tool kit. For 2018, a national crisis intervention team curriculum will be available to law enforcement agencies. The Office of Community Oriented Policing Services is publishing information on officer safety and working with people with mental illness. The BJA and the National Institute of Corrections (NIC) support a Stepping Up initiative, through which 384 counties have passed resolutions committing to reduce the prevalence of people with SMI in their jails; some technical assistance will be available to participating sites.

Department of Labor (DOL) Program Overview

Jennifer Sheehy, Deputy Assistant Secretary, DOL

Dr. McCance-Katz introduced Ms. Sheehy, who said that people with disabilities must be considered in all labor policy, and noted that employment is a key component of mental health recovery and improved health outcomes. Ms. Sheehy discussed efforts at DOL to serve people with mental illness.

Working with states and federal entities, ODEP develops policy for programs, services, laws, and regulations that benefit people with disabilities in employment. This office also provides technical assistance to employers through an Employer Technical Assistance Center, looking for promising practices to share with employers. For example, companies such as Unilever, EY (formerly Ernst & Young), and Aetna are driving leadership in their industries by addressing mental health and wellness among their employees and offering supports that help someone sustain a job.

DOL's Job Accommodation Network offers confidential one-on-one advice on accommodations for employers, managers, and employees with disabilities, including tools for people experiencing mental health conditions in the workplace. Further, the Campaign for Disability Employment is a public outreach campaign to destigmatize people with disabilities, including those with SMI. Another critical initiative called Employment First funds technical assistance experts who work with state agencies to show them how to support integrated employment for people with disabilities, including SMI.

Ms. Sheehy also highlighted the Employee Benefits Security Administration (EBSA) that, along with other federal agencies, helps enforce and administer the Mental Health Parity and Addiction Equity Act. EBSA works with employers' insurance companies, assesses gaps in service, levies penalties or sanctions, and ensures that disparities are corrected. New enforcement data will be released January 2018.

Finally, Ms. Sheehy said that the president's first budget supports a large state grants program for stay-at-work and return-to-work programs, although these are not yet funded.

Department of Defense (DoD) Program Overview

Terry Adirim, Deputy Assistant Secretary of Defense for Health Services Policy and Oversight, DoD

Dr. McCance-Katz introduced Dr. Adirim, who thanked Dr. Price and HHS for making this effort a national priority, as well as SAMHSA for leading the effort.

DoD seeks to ensure that beneficiaries receive needed care while dealing with the social determinants of health, health disparities, and geographic disparities, including lack of providers. Dr. Adirim said that reducing stigma from the public and from providers is a personal goal.

The military health system, one of the largest integrated health care systems, includes direct care military hospitals and clinics, and a health plan called TRICARE. DoD serves 9.5 million beneficiaries, including approximately 1.3 million active duty and over 2 million dependent children, many being seen for outpatient mental health visits. In 2016, there were over 1.2 million visits at military treatment facilities and over 2.5 million at civilian network facilities. Inpatient visits in 2016 included over 5,000 at military facilities and over 32,000 at network facilities.

DoD is effective in identifying and treating mental health conditions, implementing ongoing intensive efforts to improve access to mental health services, and working with SAMHSA on data sets to understand our population with regard to mental health conditions. DoD invites independent and public examination of this work to benefit service members and families, and recognizes areas that need improvement.

In 2016, DoD made mental health parity a reality for DoD beneficiaries by eliminating unnecessary treatment limitations on treatments for mental health and substance use disorders, expanding coverage to include intensive outpatient programs and medication-assisted treatment for opioid use disorder, and streamlining requirements for institutional mental health and substance use disorder care providers to become authorized DoD providers. Preliminary data suggests that implementing mental health parity resulted in a 50 percent increase in outpatient psychotherapy services provided to DoD beneficiaries.

DoD's efforts in the area of SMI are not identical to those in the civilian sector. Dr. Adirim outlined the path for those identified with SMI on active duty, based on the epidemiology of SMI. Psychiatrists are deployed in boot camps and austere contingency areas to triage SMI in these settings. When a medical evaluation board determines that an active duty member should be separated from service due to SMI, military benefits include annuity payments and health care. Dr. Adirim offered more information to interested participants and closed by adding that DoD looks forward to contributing to the ISMICC's efforts.

Department of Veterans Affairs (VA) Program Overview

John McCarthy, Director, SMITREC, VA

Dr. McCance-Katz introduced Dr. McCarthy, who said that the VA has long recognized the importance of meeting the needs of veterans, including those with SMI. As the largest integrated health system in the United States, the VA has programs with heavy investments to improve care for individuals with SMI. For example, excess mortality among individuals with schizophrenia is lower in the VA than in other care settings. Further, the rate of suicide is elevated among veterans and veterans coming to the VA for care, and that is a major public and VA concern that is being addressed. Dr. McCarthy emphasized that the VA can't do it alone, especially because most veterans do not come to the VA for health services. Even if everything were perfect within the Veterans Health Administration (VHA), that wouldn't be sufficient. Much more needs to be done.

Social Security Administration (SSA) Program Overview

Melissa Spencer, Deputy Assistant Commissioner, SSA

Dr. McCance-Katz introduced Ms. Spencer, who noted that the SSA process is complicated, especially for the most vulnerable, who benefit from having a family member or an advocate to help with the application process for Supplemental Security Income or Social Security. Online services have improved, yet SSA wants to have a community presence for individuals who need face-to-face interaction to file for benefits or get information about their claim. Over 10 percent of claims now have evidence obtained via health information technology, which speeds the disability claim review process. Among people applying for disability benefits, 70 percent get approved within a few months of application. Overall, approximately 32 percent who apply for a mental impairment benefit get allowed; the rate is 51 percent for schizophrenia and 15 percent for depression and bipolar disorder.

About 44 percent of children with alleged disability based on a mental impairment get allowed, and most have comorbid impairments. SSA is required by law to re-adjudicate every child's claim when they reach age 18. When a child's benefits cease at age 18, the young adult's work prospects are not good. Ms. Spencer noted the partnership with DOL to promote work activity and prevent disability applications, as well as demonstration projects aimed at youth in transition. The Promoting Readiness of Minors in SSI program is in effect in several states, focusing on children in school and older teenagers, exposing them to success in the work environment before the age of redetermination. Research partnerships with the National Academy of Sciences investigate issues for individuals with mental health disorders, including children with medical impairments; these studies help SSA assess a person's ability to function in the workplace.

In partnership with the Supplemental Security Income/Social Security Disability Insurance Outreach Access and Recovery (SOAR) organization, SSA is exploring how the SOAR representative can obtain all the information needed to evaluate individual claims, mostly for people with schizophrenia who experience homelessness. Policy changes include working with non-medical sources, including parents, family members, community organizations, and non-physicians, to better understand the severity of an individual's medical condition.

Centers for Medicare & Medicaid Services (CMS) Program Overview

Kimberly Brandt, Principle Deputy Administrator for Operations, CMS

Dr. McCance-Katz introduced Ms. Brandt, who noted that CMS has over 130 million covered lives across four programs, with a wide array of programs that address SMI for adults and children, and with a focus on innovative service delivery. CMS has been working with state and local partners to provide care where people need it in their communities, rather than just addressing care at the federal level.

As one of the largest payers for mental health services in the United States, including for

Medicaid and the Children's Health Insurance Program (CHIP), CMS plays a critical role in providing behavioral health care. CMS works with states to ensure implementation of mental health parity requirements, and evaluation of the impact of those requirements on access to quality care for Medicaid and CHIP. CMS also offers technical support to states to use data analytics to assess the needs of populations with SMI, and to develop work plans to improve service delivery. CMS has been working to modernize computer systems and remedy the lack of reliable, consistent data across the states so they can better target services.

Under the 21st Century Cures Act, CMS was directed to issue a State Medicaid Director Letter regarding opportunities to design innovative service delivery systems, including systems for providing community-based services for adults with an SMI or children with SED. States can use the Medicaid Innovation Accelerator Program to optimize identification of beneficiaries who have an SMI. The program will provide technical support and tools to help states perform data analytics, improve services, and examine the distribution of opioid use disorder and medication-assisted treatment in their Medicaid programs. By looking at prescribing patterns, states can identify over prescribers and address program integrity, fraud, and abuse.

CMS is working to measure and improve the quality of health care for children and adults by making sure that quality measures include five adult and two child core set measures for behavioral health. For example, in the last fiscal year available, 2015, 72 percent of children ages 6 to 20 had a follow-up visit with a mental health provider within 30 days of hospital discharge for a mental illness, and 34 states voluntarily reported on that measure. Also, 74 percent of adults who were current smokers or tobacco users were advised to quit.

In partnership with SAMHSA, the Assistant Secretary for Planning and Evaluation (ASPE), and other partners, CMS has awarded \$22.9 million to support 24 states to improve behavioral health care by providing community-based mental and substance use disorder treatment grants. Eight grantee states are participating in a two-year demonstration project that started in 2017.

CMS will hold a public meeting on September 8, 2017, to discuss ideas for a potential behavioral health care payment model to improve health care access and quality while lowering the cost of care for beneficiaries, particularly those with behavioral health conditions.

For fee-for-service care, the Medicare program has a wide range of options for mental health services, including outpatient visits with mental health care professionals, intensive outpatient care with multiple treatments provided in a single day, partial hospitalization, and inpatient care. Expanding access to behavioral health care services by physicians and other providers has been a major focus, leading in 2017 to a separate payment to physicians for models of care that incorporate behavioral health treatment in the primary care setting, thereby promoting inter-professional collaboration in treating mental illness.

Finally, the current proposed fee schedule adds psychotherapy for crisis to the list of eligible Medicare telehealth services, particularly in rural areas where telehealth is critical. Also, CMS is proposing to improve payments for office-based behavioral health services, including therapy and counseling for individuals with SMI and SED.

Department of Education (ED) Program Overview

Jason Botel, Acting Assistant Secretary for Elementary and Secondary Education, ED

Dr. McCance-Katz introduced Mr. Botel, who noted that the ED works closely with other federal agencies to maximize the use of evidence-based interventions that have been developed in whole or in part with federal research investments. The department has many programs and resources that help school districts meet the needs of students with SMI. Through its technical assistance centers, the department provides school districts with access to subject matter experts along with a system for implementing evidence-based interventions.

The department's programs that address SMI include School Climate Transformation Grants. In 2014, five-year grant awards totaling approximately \$180 million were made to 71 school districts in 23 states, Washington, D.C., and the U.S. Virgin Islands. School districts use the funds to develop, enhance, and expand systems of support for implementing evidence-based, multi-tiered behavioral frameworks for improving behavioral outcomes and learning conditions for students. Many of the grantees also receive assistance from SAMHSA programs.

Another ED initiative, Project SERV, funds short- and long-term education-related services for local educational agencies and institutions of higher education, to help them recover from and prevent a violent or traumatic event, such as student suicide clusters.

In fiscal year 2017, through the new Student Support and Academic Enrichment Formula Grant program, state education agencies received \$400 million in federal grants to assist local school districts with mental health and other activities. The grants include support for school-based mental health services and high-quality training for school personnel in the areas of suicide prevention and trauma-informed practices in classroom management.

Within the Elementary and Secondary School Counseling program, active grants through April 2019 provide funding to local educational agencies to establish or expand elementary and secondary school counseling programs. These projects use a developmental preventive approach, expand the inventory of effective counseling programs, include in-service training, and involve parents and community groups.

Finally, the Youth Suicide Prevention Fact Sheet, a resource for schools, assists schools in addressing suicide, including links to many resources.

Questions and Issues for Committee Discussion

Dr. McCance-Katz noted that the majority of SAMHSA's programs fund services and programs for those with SMI and/or children with SED, ranging from mental health block grants to a wide range of discretionary grants that support programs for the homeless, jail diversion, and supported employment. She then posed the following questions to stimulate ISMICC input:

- How do we move medical treatment of SMI out of jails and prisons and back to communities and community mental health programs?
- How can we make better use of evidence-based treatment, such as assertive community treatment, assisted outpatient treatment, and linkages with peers to support recovery?
- How might civil commitment laws be appropriately used to assist a person with preventing relapse to psychosis, and are there ways the federal government can assist?
- What should be done to improve access to care and recovery support services when the National Survey on Drug Use and Health estimates that 35 percent of Americans with SMI get no treatment at all?
- What are the current needs in the United States for resources to address mental health needs such as hospital beds, acute care versus longer-term needs, crisis intervention services, and additional levels of caring communities?
- What can be done to more effectively engage people in care?

Further, Dr. McCance-Katz encouraged discussion on the following issues:

- Issues surrounding the use of psychotropic medications, particularly for those who experience psychosis; effectiveness of medication treatments, including expanded use of long-acting formulations that have been shown to be effective; the use of clozapine for treatment-resistant schizophrenia; and monitoring for and addressing side effects of psychotropic medications.
- Recovery supports and their evidence base; areas where federal agencies could better collaborate; how to protect privacy rights while considering the concerns of family.
- Major workforce issues, in terms of numbers of behavioral health care staff, geographic distribution of those staff, and preparation of providers to provide evidence-based interventions.
- Integration of behavioral and physical health care and the ability of behavioral health clinicians to address co-occurring mental and substance use disorders.
- Issues and mechanisms to extend the reach of providers through innovative approaches.

- More effective partnerships at the federal level, so services and systems will be less disjointed for individuals, families, and providers at the local level.

Panel Presentation on Federal Advances to Address Challenges in SMI and SED

Dr. McCance-Katz introduced the first panel, focusing on “Federal Advances to Address Challenges in SMI and SED” and providing a summary of federal advances, challenges, and recommendations in SMI and SED research. The panelists included Joshua A. Gordon, M.D., Ph.D., Director, NIMH; Paolo del Vecchio, M.S.W., Director, CMHS, SAMHSA; John McCarthy, Ph.D., M.P.H., Director, SMITREC, Office of Mental Health and Suicide Prevention, VA; and Ruby Qazilbash, M.P.A., Associate Deputy Director, BJA, DOJ. The discussant for this panel was Melissa Spencer, Deputy Associate Commissioner, Office of Disability Policy, SSA, and an ISMICC member.

Joshua A. Gordon, Director, National Institute of Mental Health (NIMH)

Dr. Gordon noted that NIMH balances its research portfolio to address current and future needs and thereby to achieve near-, medium-, and long-term impact. A long-term view of SMI requires an understanding across the entire cycle of development, including disease origins, progression, and recovery. Dr. Gordon cited four NIMH focus areas: (1) identify risk and enhance our ability to predict the development of SMI, (2) identify biomarkers that help predict risk and follow the course of disease, (3) chart the illness throughout development, and (4) develop personalized interventions.

In terms of predicting risk, the growth of genetic knowledge provides many clues, as evidenced by the identification of more than 180 places in the genome that confer risk for schizophrenia. However, genetic risk is only part of the story. We also need to understand the environmental factors and developmental factors that play a role in the development of SMI.

Biomarkers make it possible to chart the course of the illness. To accelerate progress, NIMH avoids studying simple individual diagnoses, and instead aims to pool data on individuals with SMI across diagnostic domains. Through “deep phenotyping” that includes measurement of behavior, brain activity, and symptoms, researchers seek to group individuals with psychosis according to types that may better predict their disease course.

Longitudinal studies with multiple modalities—including neuroimaging and neuropsychological measures—allow the development of predictive tools and methods for charting the course of individuals as their illnesses progress. A collaboration between SAMHSA and NIMH studied integrated care for patients with a first episode of psychosis, including psychotherapy, family education and support, supported employment, education, and medication. Patients who received early coordinated treatment had better outcomes. Several NIMH research efforts aim to reduce treatment delays in first-episode psychosis by identifying individuals at high risk, improve the care of those high-risk individuals in community mental health centers, and develop novel approaches to treating youth and adults.

Because diagnoses aren't necessarily good predictors of treatment, it's important to develop a more individualized approach. Understanding the relationship between patterns of brain activity and treatment will help develop novel treatments aimed at patterns of dysfunctional brain activity. If we can identify what makes individuals responsive to particular treatments, we can make a difference in the medium term.

Finally, the rise in suicide rates has been inexorable, particularly in youth and middle-aged men, despite many efforts to counter it. NIMH is focused on predicting which individuals are at high risk of suicide, and what to do once they are identified. In collaboration with the DOJ and others, NIMH is studying individuals who are particularly at high risk for suicide in the year following release from prison. Through a better understanding of mortality outcomes and the use of data sets, researchers hope to better identify those at risk and counter that risk.

Paolo Del Vecchio, Director, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA)

Mr. del Vecchio said he would focus on the central issue of access to evidence-based treatments. Data from 2016 show that most individuals who receive public mental health services for SMI or SED do not receive evidence-based practices, even regarding medication management. For other evidence-based practices—such as family psycho-education, assertive community treatments, and supported employment—only one to two percent of people with SMI or SED receive such services.

Research shows that the most effective way to provide services is through comprehensive, coordinated, and collaborative care. Meeting the complex needs of people with SMI and SED requires a multidisciplinary approach that includes medication, therapy, and community recovery supports. There is a need for a toolbox of medications, therapy, and recovery supports to assist people on their journeys of recovery.

Regarding medications, the introduction of second-generation atypical antipsychotics appeared to help in addressing symptomology. For instance, clozapine may be one of the most effective agents. However, access to such medications is far too limited. Though there are not a lot of new medications in the pipeline, promising new approaches include deep brain stimulation, repurposing ketamine, and exploring the intersection between inflammation and SMI.

As for therapeutic approaches, only two percent of public mental health clients have access to cognitive behavioral therapy (CBT), a treatment that is supported by evidence from many studies. Exciting new work by the Beck Institute for Cognitive Behavior Therapy in Bala Cynwyd, Pennsylvania, is looking at recovery-oriented CBT therapy and finding promising outcomes, including in the long-term institutionalized population. Moreover, far too few people are receiving evidence-based approaches such as dialectical behavior therapy, cognitive remediation therapy that helps people with decision-making and motivational interviewing that helps to engage and activate clients in care.

Recovery supports address issues of social determinants and patient-centered care. However, of the 70 percent of people with SMI who are unemployed and want to work, only two percent receive supported employment. Providing people with housing reduces symptoms, decreases criminal justice involvement, and increases employment. Jail diversion is also effective. Evidence shows that peer specialists are as effective as other providers. Major advances have been made in recent decades, with 40 states billing Medicaid for peer and family supports. Complementary integrated approaches that look promising include exercise, mindfulness, and diet.

Coordinated care approaches are critical. In partnerships with CMS and ASPE, 70 clinics in eight states are now providing comprehensive care through enhanced Medicaid revenues, an approach that has great potential for improving community mental health. Efforts are underway in 17 communities to identify what works best in providing assisted outpatient treatment.

Adverse childhood experiences too often are a common denominator in SMI and SED, with 50 percent of mental illness onset happening before age 15 and 75 percent before age 25. However, far too few students receive school-based services such as the evidence-based “Good Behavior Game.” Additionally, we need to look upstream to infant and early childhood mental health consultation models.

We need a continuum approach for acute crisis care services, from prevention to intervention to post-intervention, including hotlines, mobile crisis teams, inpatient care, alternatives to emergency room use, and follow-up care. Again, few people get connected to ongoing services after inpatient care, which often results in the “revolving door” syndrome.

With suicide rates increasing, Zero Suicide provides opportunities to apply a comprehensive public health framework. We are now preparing people for a life of recovery, not a life of disability. Questions abound, such as: How do we focus on starting early, increasing access, and assuring quality? How do we make sure that every individual and family and every community has access to evidence-based practices?

Across the federal government, we’re defining SMI differently, so there is a critical need for standardized data collection. We also have to address privacy rights and offer protections against the abuse and neglect that continue for this vulnerable population.

Finally, the need for ongoing engagement is critical; 50 percent of clients stop engaging in treatment in the first six months. People must be activated in their care, and it’s critical to develop individualized and personalized approaches that address culture, age, sexual orientation, and geography. Forming relationships is critical, because people don’t recover alone, but rather with support from providers, family members, peers, and others.

John McCarthy, Director, Serious mental Illness Treatment Resource and Evaluation Center (SMITREC), VA

Dr. McCarthy noted that although the number of U.S. veterans has decreased, the number who

received VHA services increased by 24 percent from 2005 to 2016. During that same period, the number of individuals treated in VHA outpatient mental health settings increased by 85 percent. Accordingly, the VA has substantially increased its capacity to meet the needs of veterans with mental health conditions. VHA users with schizophrenia and bipolar disorder constitute a small proportion of the patient population, yet they generate disproportionate expenditures and service utilization. In response, the VA established the National Psychosis Registry in 1999, generating data about patients with schizophrenia, bipolar disorder, or other psychoses, including the annual incidence of suicide attempts. The VA's SMI Re-Engage Initiative identifies individuals with an SMI who have a gap in VHA services lasting a year or more, then provide outreach in an effort to bring them back into VHA care.

Dr. McCarthy cited information on the number of VHA patients from 1999 through 2016 with schizophrenia, bipolar disorder, or other psychoses. The number of individuals receiving care for bipolar disorder has steadily increased, whereas there has been an ongoing decrease in care for those with schizophrenia. A drop from 2015 to 2016 seems to reflect the change from ICD-9 to ICD-10 diagnosis coding.

Individuals with SMI receive substantial services. From 1999 through 2016, the percentage of VHA patients receiving inpatient psychiatric care has decreased, whereas receipt of non-psychiatric inpatient care has been relatively stable. This may reflect changes in morbidity among individuals receiving care, and for those with SMI, it may reflect changes in treatment practices and the success of programs such as the Mental Health Intensive Case Management Program. Regarding outpatient utilization among individuals with SMI, there are more encounters in non-mental health clinic settings than in mental health settings.

The VA has done comprehensive suicide monitoring and analysis. Among individuals with schizophrenia and bipolar disorder who received VHA care in 1999, suicide rates through 2006 were elevated, with the highest rates among those with bipolar disorder. Among VHA patients from 2001 through 2014, suicide rates have stayed high among individuals with bipolar disorder, despite VA efforts such as the Mental Health Enhancement Initiative and the development of suicide prevention coordinators on the crisis line. However, suicide rates have decreased somewhat for VHA users with schizophrenia and overall among individuals with mental health or substance abuse disorders.

Suicide risks are particularly high after inpatient discharges, especially among individuals with depressive disorder, followed by bipolar disorder and schizophrenia. This means that suicide prevention for individuals coming to the VA with SMI is an important priority. Strategic partnerships are critical, given the substantial numbers of individuals who die of suicide and who are not recent users of VHA care or otherwise connected with the VA. Suicide prevention coordinators and SAMHSA have recognized VA efforts to understand and act on suicide risk among veterans and VA patients, including those who call the Veterans Crisis Line. Recovery Engagement and Coordination for Health—Vets Enhanced Treatment uses a suicide predictive model based on information in the VA's electronic health record system to identify and engage veterans at high risk for suicide, particularly among those with SMI.

Dr. McCarthy closed by noting that part of the mission of the ISMICC is to review access to and effectiveness of such programs, and to consider what additional programs should be developed.

**Ruby Qazilbash, Associate Deputy Director, Bureau of Justice Assistance (BJA),
Department of Justice (DOJ)**

Ms. Qazilbash provided data and experience from the perspective of the criminal justice practitioner and policymaker. National Survey on Drug Use and Health studies show that the prevalence of SMI in the general population is four percent, while this rate is four times greater among the jail population. The most rigorous study to date on the jail population (by Steadman, Osher, and others), based on structured clinical interviews, found that the SMI rate in the jail population is 17 percent; other research points to 72 percent of that subpopulation having a co-occurring substance abuse disorder. BJA self-report surveys of people under correctional control reveal a 26 percent prevalence of SMI among jail inmates and a 14 percent rate among prisoners.

With close to 11 million people being processed through jails each year, compared with a little over 625,000 being admitted into the nation's prisons, jails house the majority of the inmate population with SMI. BJA policy focuses on helping local jails to use validated screening instruments consistently in order to understand and address SMI prevalence rates within a jurisdiction, and to ensure that those people who are cycling in and out of jails are connected to services within the community.

Law enforcement agencies and officers have become first responders for people in mental health crises, as well as for their family members. The volume of calls to law enforcement involving people with SMI appears to be increasing, with one Florida report showing us that one in 10 calls for service is mental health related. Similarly, law enforcement agencies in Deschutes County, Oregon, have reported sharp increases in recent years in mental health-related service calls. Moreover, service calls involving mental health generally take much longer to resolve than other calls.

BJA surveys show that approximately one-third of inmates with a mental health indicator are receiving treatment, and that people with mental illnesses tend to stay longer in jail. For example, in a study conducted in New York City, the average length of stay for people awaiting trial who have a mental health indicator was almost twice as long as for those without such an indicator; the increase was approximately 35 percent in the sentenced population. The disparity occurred across various demographic subgroups.

More treatment services should be focused in the community, Ms. Qazilbash said. Research shows that providing connections to community-based services, particularly community-based case management services, reduces the length of time to a person's re-arrest. Yet only a fraction of people who should be connected to care—at the point of court, jail diversion, or reentry from the jail or prison back into the community—are getting connected to that care. For instance, in the Franklin County, Ohio, jail population, out of 10,523 bookings into the jail, 969 people were flagged with an SMI, and of those, only 609 received follow-up treatment in the community. According to the national estimates previously mentioned, as many as 1,700 people in that study

were not connected to community treatment, but likely needed it. Of those not connected to services, estimates suggest that more than half are at moderate to high risk for reoffending.

BJA has been working with counties and cities, looking at their responses across the criminal justice continuum. There are many opportunities to build diversions when appropriate, and to connect inmates to a spectrum of care that includes crisis services as well as longer-term supports and services. In 2012, BJA and the Council of State Governments Justice Center released a shared framework for reducing recidivism and promoting recovery for adults with behavioral health needs who are under correctional supervision. The framework reflects a consensus with SAMHSA, the NIC, and major associations representing state directors of corrections, probations and parole offices, substance use services, and mental health services. The outcome was that there is a need for risk and needs assessments for people under correctional control who have behavioral health needs. People with low criminogenic risk need to be connected to community services and medical care. People with moderate to high criminogenic risk need intensive supervision with a combination of supports. Communities need to do a better job of allocating resources, Ms. Qazilbash said, pointing to studies showing that combining low- and high-risk criminal justice populations in programming can increase recidivism for the low-risk population. The shared framework is part of the Justice and Mental Health Collaboration Program, which is adding 55 new grantees in 2017.

Ms. Qazilbash revisited the previously discussed Stepping Up initiative, which aims to reduce the prevalence of people with mental illnesses within jail populations. To date, at least 384 county boards (representing 115 million people) have passed resolutions committing to the initiative. Stepping Up resources are available to practitioners, executives, and stakeholders who are working together with those counties. For example, the initiative's "Six Questions" document asks counties to answer key questions and track four measures: (1) the percent of people within the jail population who have an SMI that necessitates screening and assessment, (2) the average length of stay in jail for those individuals, compared to the general jail population, (3) the rate of connection to care upon release, and (4) the recidivism rate for this population, compared to a general release cohort.

Also of note is the Police and Mental Health Collaboration Toolkit launched by the International Association of Chiefs of Police and BJA. It provides information about how to build a police and mental health collaboration, provide training, track data and outcome measures, and evaluate progress. The toolkit features six learning sites, their policies, and memoranda of understanding. The sites accept site visits and are on call to help other jurisdictions. A 2017 congressional appropriation to Stand Up will operationalize more supports to law enforcement agencies.

Discussant: Melissa Spencer, Deputy Associate Commissioner, Office of Disability Policy, SSA

Ms. Spencer spoke on common themes across the presentations regarding how to be more effective, help people to receive treatment, and implement policy reforms that lead to better outcomes. We want to listen to families, people on the frontlines, and providers. We have a vision that prevention works, that treatment is effective, and that people can recover.

Although early care can lead to better outcomes, and coordinated care is the best treatment approach for individuals with SMI, the central problem is very limited access to evidence-based care.

Concerns include (1) keeping individuals with SMI in care, (2) ensuring that there is a mechanism to bring individuals back to care, (3) addressing the increased risk of suicide, and (4) recognizing the need for standard data, data analytics, and identification of projects where we can use data analytics to improve the lives of individuals with mental impairments. Ms. Spencer added that she recognizes the theme of hope that can lead to a life of recovery, and the need to serve more people by expanding the use of approaches that we know are effective.

Dr. McCance-Katz reviewed the schedule and called for commentary.

Pete Earley asked for metrics on the Stepping Up program and inquired whether county commissioners could be required to implement the program when it costs them money. Addressing stigma, he cited the example of a background check where federal employees ask someone with no qualifications to give a judgement about a neighbor's mental health. Regarding Social Security and public housing, he said that a jail in Virginia releases every inmate with a mental illness on their personal recognizance, because they can't afford medications for the people in those jails and prisons, and they're afraid people who are jailed will lose their Social Security disability benefits. Pointing to another issue, he said that when inmates are released in New York, they're not allowed to go into public housing. Finally, Mr. Earley asked whether biomarkers for SMI risk have actually been found after the millions of dollars spent in that arena.

Conni Wells said she had hoped to hear during the meeting not just an overview of what we are doing, but also a discussion of what we know isn't working, the tough question of why it isn't working, and the need to stop wasting money and time on activities that are not working. She also expressed disappointment that there had been little discussion about children, even though some of the programs being discussed do serve children and families.

Maryann Davis said there is little evidence about what works specifically with transition age youth. In a 2015 report, the Institute of Medicine (now the National Academy of Medicine) recommended more research to establish an evidence base for improving the health and well-being of young adults. We can't improve access to programs that don't yet exist. She emphasized the importance of service delivery system for transition age youth, noting that SAMHSA and CMHS have supported some programs for this population. Mental health services have to be well designed for those who are involved with the justice system, instead of sending them to typical outpatient services and expecting the therapist to know how to work effectively with that population.

Clayton Chau added that reverse disparity is an issue. If you belong to a family that has Medicaid coverage, there are plenty of available programs. However, transitional youth or children whose parents can afford commercial insurance do not have access to these programs.

John Snook noted that a system that says we're not going to provide you treatment unless you

can participate voluntarily or you're dangerous, is always going to be stigmatizing. Spending money on care and effective treatment will prevent stigma.

Kenneth Minkoff said a coherent national, federal strategy is needed for implementing a successful system of SMI services across the nation, with funding streams and payers that support a common delivery system for people living in a community.

David Covington said law enforcement does not have the time to take people to a hospital for a medical clearance when they are fielding calls for many other issues that require their quick response. Often, if they do go to the hospital, they are asked to stay as long as four to eight hours because the staff is not equipped or prepared. Officers have a job to do and they're going to do what is easiest to do. If we in mental health defer to law enforcement, or hospitals, to do our job for us, they will figure it out the best they can, such as by filing nuisance complaint and putting a person in jail. In Phoenix, Arizona, however, the expectation of the state medical authority and the health plan is that crisis facilities must accept an immediate drop-off by law enforcement.

Incarceration, lifespan, healthy life with comorbid medical conditions, and issues of unemployment are important, but, as Dr. Price noted, the issue of friends is critical. A 2010 meta-analysis of 150 studies of health outcomes found that the most powerful factor to improve health is to improve one's social supports network. Loneliness is a 30 percent contributor to early mortality, yet there is almost no data on this for the SMI community. Implementing evidence-based practices such as Zero Suicide and building on the housing first approach for employment is crucial.

Mary Giliberti said we need to focus on a continuum of care, including medication, supported employment, supported education, as well as financing and sustainability. Effective services are difficult to finance, while the things that are less difficult to finance are not necessarily recovery oriented. Money should follow the best practices that people are talking about. She also addressed the need for standard nationwide data collection to make progress.

Ron Bruno shared an example of a community that did a great job in implementing the Sequential Intercept Model, trying to fill every gap with crisis intervention team officers, mobile crisis outreach teams, a dedicated receiving center, a wellness center, and a 16-bed unit where people could stay for a longer time, if necessary, rather than going to the emergency department. Though there are programs that work, law enforcement is taking it upon themselves, including hiring their own psychiatric teams to be part of their personnel to go out and do a cold response. The mental health system needs to take responsibility through programs such as Mobile Crisis Assessment Team teams, where a mental health professional is teamed with a peer specialist, but funding is the issue.

Elena Kravitz shared her personal interest in the issues raised. She explained that her agency, Collaborative Support Programs of New Jersey, is a peer-led, recovery-focused organization. The substance abuse communities report that peer involvement is very effective at bedside as well, when people come in on overdoses. She stated that she represents the voice of many people in sharing her comments, including the following:

- Physical health was absent from the list of public health outcomes in the charter itself, when integration of health services across the board should be a large focus.
- Poverty is a documented determinant of health, mental health, and physical health. Employment provides an important avenue for financial stability, but existing disincentives inherent in federal disability benefits impede asset accumulation.
- In addition to documenting and addressing employment, enrollment, and education, community integration service outcomes need to include independent living, and safe and affordable housing.
- To deal with stigma, also known as discrimination, language must be addressed. The language in the charter is to be commended, but all reports need to follow the model to address discrimination.

Kenneth Minkoff recalled Dr. Price’s use of the term epidemic when talking about SMI. The Centers for Disease Control and Prevention (CDC) has expertise in using advanced public health strategies to identify factors to recognize and address an epidemic across a broad population. Applying those strategies, or that knowledge base, to the issue of SMI could be helpful. As a public health epidemic, just like the opioid epidemic is, SMI must be thought of in terms of early detection of people at risk, prioritizing engagement and intervention over time, and ensuring that every community participates. The CDC doesn’t restrict itself just to thinking about infectious disease; it has potential to be available in this area as well.

He also noted the importance of designing the delivery system from the perspective of people, as opposed to the list of programs, services, and evidence-based practices. He likened the current approach of asking about insurance when someone calls to being asked if you have fire insurance when you call in a fire. In contrast, people with mental health crisis need to be helped like those with a medical crisis: as quickly as possible, as easy as possible, with as few barriers as possible, and with comprehensive treatment and myriad care teams to help, such as when there is a cancer diagnosis.

Dr. Minkoff added that it is imperative to understand that most people with SMI have co-occurring substance issues, and design services accordingly. The work of Jeffrey Brenner speaks to designing systems, outcomes, and metrics based on complexity; that is one example affecting all of the accountable care work.

Pete Earley stated the need to design a system where everybody works together while keeping in mind the finances. One of the reasons the jail in Virginia was releasing people with mental health issues, beyond paying the costs to hold them, was that they received only \$32 per day per person, versus \$52 per day for illegal immigrants.

Dr. McCance-Katz dismissed the participants for the lunch break.

Non-Federal Advances to Address Challenges in SMI and SED

Dr. McCance-Katz reconvened the meeting and introduced the second panel on “Advances to Address Challenges in SMI and SED,” aimed at providing a summary of select advances, challenges, and recommendations regarding SMI and SED research.

Panelists included Lynda Gargan, Ph.D., Executive Director, National Federation of Families for Children’s Mental Health; Lisa Dixon, M.D., M.P.H., Professor of Psychiatry, Columbia University Medical Center, and Director, Division of Behavioral Health Services and Policy Research; Sergio Aguilar-Gaxiola, M.D., Ph.D., Professor of Clinical Internal Medicine at the University of California, Davis, and Director, Center for Reducing Health Disparities, and Director, Community Engagement Program, Clinical and Translational Science Center; and Joseph Parks, M.D., Medical Director, National Council for Behavioral Health. The discussant for this panel was 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, and ISMICC member.

Lynda Gargan, Executive Director, National Federation of Families for Children’s Mental Health

Dr. Gargan explained that the National Federation of Families for Children’s Mental Health is the national advocacy organization for children and youth experiencing behavioral health challenges and their families. She noted the Masai warrior greeting, “How are the children?” to emphasize that the future depends on the health of children.

Prevalence data show that approximately 20 percent of the nation’s 74 million children under age 18 will have a significant mental health issue sometime in life—almost 15 million children. Suicide is the second leading cause of death for young people ages 15 to 24, following closely behind homicides, with 90 percent of children who complete a suicide having a mental illness diagnosis. However, we still are grappling with treatment, research, and funding. Children are not little adults, so data cannot be extrapolated from what works for adults. She noted the example of medications that are dispensed to children without longitudinal data about their use in children.

Dr. Gargan shared her personal story of her son, who was “born with all the framework for success” but who was traumatized by multiple crises and tragedies involving family and friends. He took psychotropic medications and did well in college. Wanting to be a Navy SEAL, he was advised by recruiters to quit and/or lie about his medications. Describing his current success, she urged everyone to listen to the children about what works for them and what doesn’t.

Dr. Gargan emphasized that stigma is real, and compared the way that communities rally around families whose children develop catastrophic diseases with the silence and prejudice surrounding mental illness. To help our children and their families, we must reject stigma, identify children’s behavioral health as a public health crisis, and stop expecting teachers to do everything and instead create systems for children and families that will help our teachers teach. Prescriptions

should not be the first line of response. We need to provide culturally responsive supports.

Dr. Gargan noted that her organization is the only organization in the country that has a national certification for parent and family peer support. The organization is working to pair the “Good Behavior Game” with parent peer support. She challenged the ISMICC to create a responsive system that says, “Our children are well.”

Lisa Dixon, Professor of Psychiatry, Columbia University Medical Center; Director, Division of Behavioral Health Services and Policy Research

Dr. Dixon emphasized the need for partnerships of the federal, state, local, and private sectors to achieve progress. Nothing we do will work without ongoing attention to engagement. Effective practices also require a continuum of integrated care that includes evidence-based pharmacologic treatment and a person-centered approach.

For individuals with schizophrenia, research shows improved outcomes from shortening the duration of untreated psychosis to three months or less and providing a set of team-based interventions called Coordinated Specialty Care. Coordinated Specialty Care is an evidence-based package of interventions adapted for transition-age youth.

Dr. Dixon described advances from research to practice with the mental health block grant and the contributions of states and localities. In New York State, they have enrolled over 800 young adults across 20 sites, and achieved dramatic reductions in hospitalization. The commissioner is committed to trying to make this service available to everyone who is eligible, regardless of payer, and thereby shorten the duration of untreated psychosis.

About 40 percent of our young people are in work or school, with the rate increasing to 72 percent at the last or most recent follow-up. In the Recovery After an Initial Schizophrenia Episode study, young people were asked about their most important treatment goal, which was staying in and doing well in work and school. Regarding supported employment, most people want to work, seeing it as an essential part of recovery. A no-exclusion, integrated approach to supported employment with competitive employment (not sheltered work) is more effective than traditional vocational rehabilitation and other rehabilitative approaches.

Peer support is another important intervention, in which individuals with lived experience of mental illness contribute to treatment and care. Inclusion of peers has an emerging evidence base demonstrating reduced use of acute services, decreased substance abuse, decreased depression, and increased engagement with care.

On the topic of suicide, we know we can do safety planning prior to discharge, conduct follow-up outreach, and provide suicide-specific psychotherapies. Yet health care systems do not routinely apply available knowledge about detecting and treating suicidality.

People with SMI die 10 to 25 years earlier than their age-matched counterparts who do not have SMI, due to medical causes. We need to address this with strategic care integration, attention to

health behaviors such as smoking and physical inactivity, and high-quality services in integrated care settings.

Sergio Aguilar-Gaxiola, Professor of Clinical Internal Medicine, University of California, Davis; Director, Center for Reducing Health Disparities; Director, Community Engagement Program, Clinical and Translational Science Center

Dr. Aguilar-Gaxiola focused on disparities in access to mental health care, especially for traditionally underserved populations, as well as the issue of comorbidities. Regarding the social determinants of health, the significant burden of mental health needs among diverse populations translates into illness, premature death, diminished productivity and social potential, wasted resources, and suffering for individuals, families, and communities.

National data on the treatment gap reveals that 50 to 90 percent of those in need of mental health services are not receiving services. For instance, a study that Dr. Aguilar-Gaxiola conducted in the mid-1990s in California's Central Valley showed that only one out of six people of Mexican origin had access to care, with less than one in 10 consistently employed migrant workers having access to care. Factors that contribute to the treatment gap include systemic barriers, stigma, a lack of individual engagement in behavioral health care, and a lack of culturally and linguistically appropriate services.

Advocacy is important because it is so difficult to navigate the health care system. Public health interventions should include audiovisual tools and social marketing campaigns to reduce stigma, evidence-based treatment approaches, and community-defined evidence. To promote trust, we need to work with community-based organizations on practices and programs they are already using with people where they live. An experiment in California called the Mental Health Services Act generated over \$2 billion for services last year, especially for those experiencing disparities. Other examples include the statewide stigma reduction campaign called Each Mind Matters that includes materials tailored to diverse communities, and the California Reducing Disparities Project focused on reducing stigma and discrimination.

Dr. Aguilar-Gaxiola posed the following questions for consideration by the ISMICC as it develops its recommendations:

1. How can we identify patients' non-medical health needs as part of their overall care?
2. How can we connect patients to local services and resources that help them avoid getting sick in the first place or better manage illness, including mental health needs?
3. How can we be a strong leader and champion to collaborate with other sectors to improve health?
4. How can we connect community residents to jobs in the health care sector, one of the largest employers?

Joseph Parks, Medical Director, National Council for Behavioral Health

Dr. Parks said a lot of good services are available for people with SMI. Peer support services

and population health management services are especially important. The problem is a lack of access to effective treatments. He noted that people with SMI have approximately three or four behavioral health disorders and three or four physical health disorders. They often have deficits in memory, concentration, executive ability, and ability to organize information. Yet these individuals are expected to figure out what they need and when they need it, and this leads to high costs and poor outcomes. We don't require that cognitive supports be in place, yet when they are implemented, outcomes are much better.

Community mental health center health homes in Missouri actually outperform primary care on reducing hemoglobin A1c, controlling blood pressure, and controlling dyslipidemia, and save \$31 million more than they cost. Unfortunately, the private sector is failing in this area, and to get things done and achieve better outcomes, more regulation is required, not less.

The psychiatry shortage is particularly severe, with 40 percent of psychiatrists in cash-only practice. In a 2016 survey, 70 percent of community health centers reported that they lose money on psychiatric services. Reports abound of hospitals closing beds and not providing care, because hospitals have to subsidize part of the professional cost of psychiatric care, and they lose money on inpatient psychiatric care. Community providers can't get reimbursement for many effective new practices that are not reflected in the Current Procedural Terminology coding and not covered by Medicare or other available billing streams, except for Medicaid.

A substantial number of people with SMI are still uninsured. Disability rates are much lower in the states that have expanded their coverage than in those that have not. For example, Ohio reported an 80 percent reduction in disability applications six months following their expansion.

Quality control is also a problem, because we fail to measure or we use too many different measures. A recent report identified 1,483 different performance measures for behavioral health in 42 unique categories. We must mandate how things are measured and the measurements that are acceptable, honing them down to a small set.

Reimbursement rates are a parity issue. We have to make sure that payments for behavioral health services are actuarially sound—meaning the amount of the payment is sufficient to cover the actual cost of what is done plus a reasonable profit. We will not achieve adequate access to psychiatric service until the rate disparity is addressed.

Many components of new effective care approaches are not directly reimbursable. Dr. Parks told of a patient who was intermittently homeless with self-injury behaviors and intermittently suicidal. She responded to treatment, and once in recovery, she became a peer case manager and then a peer supervisor, effectively engaging people and helping them stay in treatment. Despite such success, reimbursement for peer services is available only through Medicaid. We need to assess parity adequacy by comparing payment rates in behavioral health compare to the rates in general medical care, as well as by assessing the adequacy of provider panels by secret shopper to see if someone answers the phone and if appointments are available.

Dr. Parks noted that these issues will be improved by the New Certified Community Behavioral

Health Center (CCBHC) demonstration program. However, he said that demonstration projects demonstrate a lack of commitment, and added that changes need to be broadly implemented. The CCBHC program covers the full range of evidence-based services, but it remains a demonstration program operating in only eight states and limited to just two years.

The psychiatric bed crisis also must be addressed, but as yet there is not a good measurement of the number of beds of all types that are available. Another issue with the bed crisis is that current level of care instruments do not allow adequate length of stay because they do not score for social determinants. After Missouri required the use of LOCUS (Level of Care Utilization System) and CALOCUS (Child and Adolescent Level of Care Utilization System), which do assess housing and other social determinants, insurers offered much better coverage for effective services. He said that the same could be done nationally.

Dr. Parks outlined technical ways to address psychiatric service shortages such as revising the Conrad 30 Waiver Program so waivers provided to psychiatrists do not count toward the ceiling of 30 slots, revising the Group on Educational Affairs (Association of American Medical Colleges) graduate medical education calculation for supporting psychiatry residents to be the same as for OB/GYN or primary care, revising redistribution requirements for unused Medicare direct graduate medical education training slots so the psychiatry slots cannot be reduced, and removing regulatory barriers to tele psychiatry. Success will largely be a question of willingness to exert executive powers in areas such as payments rates and performance measurement.

Discussant: Elyn Saks, Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences, University of Southern California Gould School of Law

Dr. Saks commented on the presentations and offered suggestions in the area of mental health law and policy at the state level:

- Dr. Gargan's presentation raised important concerns, such as: If there's a conflict between the child, the family, and the state, who gets to decide? At what age do children get to decide? Would they be the primary decision-makers, even though we know they are mentally ill, and children's brains develop into their late 20's or maybe even longer than that?
- Dr. Dixon's presentation focused on engagement, the cost of integrated care, evidence-based pharmacology, and a person-centered approach. Citing her personal experiences, Dr. Saks highlighted the importance of employment for recovery, and inquired about the reasons for the value of peer support.
- Dr. Aguilar-Gaxiola's report on disparities and treatment gaps led Dr. Saks to question if the situation is different for mental illness and physical illness. If so, is that because of stigma, or because treatment costs for mental illness may continue throughout life?

- Dr. Parks’ presentation on parity issues is critical, because people with SMI can live up to their pre-illness potential if they receive appropriate support and access to care. However, we need to be thoughtful about the use of coercion and involuntary treatment, and we should encourage people with SMI to make their own choices.
- Stigma has many manifestations, causes, and effects, the worst of which is that it deters people from getting care. Combating discrimination and removing barriers in employment is necessary, as well as advocating the full implementation of parity.

Comments and Open Discussion

Dr. McCance-Katz called for comments.

Linda Beaver: Unlike other illnesses, SMI impinges on perception, reasoning, self-regulatory processes, and decisional capacities. Sometimes the only thing that encourages people to access and remain engaged in treatment is trust coming from a person-to-person bond. A set of specialized interpersonal skills should be put in the hands of everyone who comes in contact with people who have an SMI or SED.

Conni Wells said the process of trying to control an epidemic begins with inoculating our children. She described living in a very small community in the Appalachian Mountains, where there is a 70 percent no-show rate for children and their families who come into town for services. Stigma is the number one reason they report for not getting services. She also pointed out that these families often don’t understand the terms and titles used in this field. Further challenges include that people tend to only come to town once a month, generally after they receive their benefits. We need to provide services and programs that are practical and relatable to the people we serve.

Clayton Chou agreed that language is important in reducing stigma. For example, the term “behavioral health” often is misunderstood when translated into several other languages common in the populations we serve, implying that a person’s behavior is the source of the problem. Language can play a powerful in stigmatizing people.

Sergio Aguilar-Gaxiola cited two recent studies relevant to the Hispanic community, both demonstrating that adherence to mental health care is much better when delivered either in the primary care setting or in the school setting. If Appalachian children were seen in the schools, access and engagement might increase. Similarly, if Hispanic individuals are seen in the primary care setting, they don’t have to be seen going in and out of the building that says “psychiatry” or otherwise differentiate between medical and behavioral care.

Joseph Parks agreed, noting that he first practiced in psychiatric clinics but now practices in a primary care center where he is better able to offer services. Patients are more willing to come, and when they don’t, primary care physicians can redirect them back to him. Arizona Medicaid pays a higher rate for integrated care settings based on their effectiveness in engaging patients.

Kenneth Minkoff commented that the people who need us the most, need to be treated as priority customers, even if they are challenging. All systems must be designed so that the people with the greatest need are welcomed exactly as they are, wherever they show up, an approach that is not normally incorporated into the way we design our delivery systems. Studies show that stigma against people with mental illness is greatest among mental health professionals. Moreover, efforts to educate professionals about mental illness sometimes results in more knowledge and more stigma at the same time, as seen in a study showing that as psychiatry trainees went through residency, they had progressively worse attitudes toward people with co-occurring mental health and substance use disorders.

Regarding parity, people who have had a stroke or serious car accident receive physical rehabilitation services and work with a multidisciplinary team in multiple levels of care. People with SMI should have comparable access to the ongoing rehabilitation they need. Another barrier to care is requiring different prior authorizations and treatment planning documentation requirements if you're delivering a service as a psychiatrist in a mental health center. If you're treating depression in a primary care environment, you don't have to have a written treatment plan for Medicaid every three months with 16 different pages; you're able to simply treat people.

Dr. Minkoff pointed to Dr. Parks as an expert in operationalizing a vision-driven system of care at the state level. It's important to have people in leadership positions who are committed and able to do this work, and are accountable at the population level.

Sergio Aguilar-Gaxiola stressed the critical importance of the social determinants of health, adding that there are no significant federal investments in this area. However, Dignity Health in California has invested \$100 million to address social determinants of health; United Healthcare focused \$350 million on six million Medicaid members; Trinity Health and Bon Secours each focused \$70 million; Cincinnati Children's Hospital focused \$10 million to support development in a specific community; Provident St. Joseph also spent \$130 million in this area.

Clayton Chou pointed out that federal agencies spend money in silos rather than in a coordinated fashion; what's needed instead is a collective strategy to create a system that's easy for people to access and use.

David Covington referenced Thomas Joiner's work on the interpersonal model of suicide, which suggests that everyone who dies of suicide perceives themselves as a burden to others and feels lonely and disengaged. When those two factors are paired with capability, it's extraordinarily dangerous for the individual, and a contributor to early death.

Pete Earley said he spent three months doing research on the needs of people experiencing homelessness in Georgetown, but couldn't find a publisher interested in his findings. There was no engagement because there was no human connectivity. Without that, providing people with housing and assertive community treatment teams is not enough. He also cautioned that the notion that "everyone can recover" is insulting to parents who have lost a child to suicide.

Linda Beeber shared her concern that while the ISMICC is addressing the charge to gather

evidence, it looks like there are a lot of wonderful things out there that work, and that's not the problem. It's the problem of getting people to both access and engage in care long enough to get the benefit out of it.

Maryann Davis concurred, and stressed the importance of addressing the unique needs of transition-age youth, and the problem of losing access to services solely because of an arbitrary birthday. The definitions differ across agencies as to when a child transitions to adulthood, and a child can lose services simply because of a birthday rather than a change in life circumstances. This is confusing for young people and their families. Helping them negotiate the transition and prepare for it well in advance is imperative. As for the question of whether to extend the children system up to age 21, 26, and even 30, would that be merely delaying the transition? The problem remains that the adult system doesn't offer developmentally appropriate services for transition-age youth. She suggested that if a person develops an SMI at age 19, maybe they should enter the adult system, but that approach hasn't been examined. She also noted the absence of juvenile justice and child welfare representatives at the meeting.

Few evidence-based practices have been established for transition-age youth, although coordinated specialty care is making progress. Evidence shows that young adults benefit from individualized placement supports, one of the few adult interventions that clinical trials have shown to be effective for young adults. This is a reminder that clinical trials and service demonstrations for adults should conduct separate analyses to see how well the interventions apply to young adults. However, although the use of individualized placement supports is the strongest evidence-based practice for adults with mental illness, most individuals who do get jobs receive extremely low wages. Young adults also fear losing their benefits if they work more than 20 hours a week, Dr. Davis said.

Finally, youth in transition often don't access care on their own, and tend to quickly drop out of services. These youth are in a new social network that may or may not include their families as much as we might hope. They are negotiating adult skills at an inexperienced stage. If we don't make our services easy to access, really appealing, and developmentally appropriate, and relevant to what they care about—employment and going to school—we're not going to successfully engage a population at this critical stage in life.

Clayton Chou said the amount of paperwork to apply for services is burdensome—especially for services for mental health, physical health, housing, and social services—and this discourages engagement.

Paolo del Vecchio mentioned that results from his household survey show that when people need help, they engage with family and friends, family physicians, and faith communities. He asked Shannon Royce, Director of the HHS Center for Faith-based and Neighborhood Partnerships, to comment.

Shannon Royce referred to a recent study from the Southern Baptist Convention about the importance of the faith community, which isn't particularly equipped to deal with these issues but often is one of the first places a family will go when in crisis. Although we don't expect

them to be the psychiatrist or the counselor, pastors, rabbis, and imams need to know how to help people access services while providing spiritual support to families.

Lisa Dixon said engaging people requires offering them services they want, not selling them something they don't want, and helping them make that connection. People don't wake up in the morning and say, "I want to go get treatment for my schizophrenia." We should listen to what they want, and then say, "You're having some trouble with your friends. Or, you're having some trouble in school. Well, we actually have someone who can help with that."

She added that while we have some very good services for young adults, some of them do not return to school or work, and have significant cognitive impairments or substance use problems. In order to have credibility, we must acknowledge that lots of work must be done to improve outcomes, and that treatments may not make people feel like they did before they got ill.

Lynda Gargan responded to Dr. Minkoff's point that as providers gain knowledge about people with co-occurring mental health and substance use issues, their enthusiasm may decrease. She said that experiencing disparaging comments and disrespectful attitudes from office staff was discouraging for her son and delayed his engagement with treatment.

Conni Wells spoke about "shameless environments," a concept that includes how to set up the environment, from setting up the chairs to how the community sees the outside of the building, as well as how families or consumers feel when they go into the building, and not hearing staff talk about the previous patient. This approach can help reduce the 70 percent no-show rate. She added that addressing the what, where, why, and how of program effectiveness must be part of the solution to allocating limited resources and achieving the best outcomes in different settings.

Joseph Parks emphasized that determining what works requires effective measurement that uses the same methodology to obtain comparable results. He urged federal agency representatives to develop a smaller and more consistent set of measures for evaluating programs. He also suggested that the DOL might identify typical market rates for key behavioral health services, so that ISMICC members could better assess reimbursement for psychologists, psychiatrists, in the cash sector, in commercial insurance, and in Medicare and Medicaid.

David Covington emphasized the need to use available technologies to ensure that providers and administrators have access to the data and safety mechanisms involved in providing effective psychiatric crisis care. We should use LOCUS or CALOCUS so we have data that providers can use to match individuals to the appropriate level of service that will meet their needs. We need to marry sound clinical interventions with basic workforce and workflow management tools. Also, parity for evidence is important; we have better evidence of the effectiveness of interventions such as DBT and CBT than for medical treatments such as statins for heart disease.

Pete Earley asked the ISMICC to consider that the broken medical system is even more problematic in jails and prisons; in half of the jails in Virginia, staff don't even do a mental health assessment when someone comes in. Standardization of assessment and integration of services are needed. For example, the Arizona Medical Authority requires that when a person

with SMI enters the jail system, within minutes the behavioral health system knows and is responding. However, those are resources that we don't track, and mental health costs can end up being borne by another department...

Kenneth Minkoff asked for comments from federal agency representatives about policy issues.

Ralph Gaines, Principal Deputy Assistant Secretary in Community Planning and Development at HUD, said that Dr. Carson and senior leadership have taken an internal approach to evaluate the agency and how services are delivered. Mr. Gaines said that he met with staff at every level of the agency, and invited grantees to share their experiences, to assess what is working and what is not. HUD aims to help build up urban and rural communities, and to create partnerships with stakeholders to provide sustainable services that can move in new directions.

John McCarthy: We don't have all of the information that we need. We really have a patchwork of information for a subset of individuals with SMI. The VA urgently wants to improve care for veterans, including those with SMI, and to improve suicide prevention. My immediate focus is on coordination with DoD, and learning about opportunities to coordinate with other agencies in this work.

Kimberly Brandt of CMS mentioned a program called Money Follows the Person that helps provide community-based long-term care for Medicaid beneficiaries. The program has been successful in meeting needs for housing, social supports, and health care. As a result, Congress is considering moving the program from a demonstration project to a national model, as well as looking at new models from the payment delivery side and provision of services to fill the gaps. We could learn a lot from that.

Kenneth Minkoff said the idea of the money following people as they move from institutional care to the community is one of the things that was proposed to the Carter Commission.

Kimberly Brandt mentioned a public meeting planned for September 8, 2017, where CMS will get input on new models for service delivery and payment, and how to fill the gaps.

Elinore McCance-Katz emphasized that employment is a key component of recovery. She expressed hope that new partnerships can be established between ISMICC members with the goal of expanding effective programs. Behavioral health centers need higher payments that create an incentive to treat people with SMI, rather than pushing them into the criminal justice system. Achieving that will require work with Medicaid as well as commercial insurers.

She cited Rhode Island as an example of a revolving door, because there is no incentive on the outpatient side to serve the most challenging patients, or to send a doctor to court as required by law. When care providers don't go to court, people with SMI relapse and go back into the criminal justice system. Sometimes people who can't access needed behavioral health programs seek to gain access by getting arrested. Rhode Island addressed the issue of stigma by working with a private program that made it easier for patients with SMI who are leaving the state hospital to obtain community services. Rhode Island also set up a medication clinic at the state

hospital to ensure that lack of medication wasn't a barrier that prevented patients with SMI from returning to the community. The state has started setting up crisis centers and encouraging law enforcement to bring people there instead of the emergency department, with the goal of reducing hospitalizations and facilitating access to community behavioral health providers.

Elyn Saks addressed the issue of the criminalization and incarceration of people with SMI. She suggested that in cases of misdemeanors and nonviolent felonies, mental health courts should allow people with SMI to receive care instead of being punished for something that they may not be that responsible for.

Rathelia Stroud said Georgia plans to expand access to accountability courts, nontraditional in their operation, to address the needs of people with SMI who are thrust into the criminal justice system, be it for misdemeanors or felonies, or for juveniles. Crisis intervention team training has improved interactions between law enforcement and people with SMI. The goal is to get participants engaged with a mental health care provider, and to ensure that they have a day structure involving work or school. After successful completion, participants' cases are dismissed and their records are restricted. Judge Stroud said this "therapeutic jurisprudence" has been successful; the most recent evaluation of the accountability court that she presides over showed an eight percent recidivism rate.

Paul Emrich noted that the federal government has treaty obligations to provide health care to federally recognized tribes. Under an agreement with the federal government, the Chickasaw Nation operates its own health care system that encourages input from patients and providers. Practice-based evidence can be developed in a unique local context and then replicated elsewhere. The ISMICC should be pay attention to archaic rules and regulations that hinder progress toward more effective coordination of services.

Dr. McCance-Katz thanked everyone for their input and encouraged further input from participants before closing the session.

Operational Issues – Report Structure, Future Meetings, and Workgroups

Dr. McCance-Katz explained the logistics of how the ISMICC will operate. The first report to Congress is due by December 13, 2017. The report will include a summary of advances in SMI and SED; an evaluation of federal programs related to SMI and SED and their effects on public health; and specific recommendations for actions that agencies can take to better coordinate mental health services for adults with SMI or children with SED. SAMHSA is compiling an inventory for the ISMICC of the federal programs that are currently in place. The timeline for the report is as follows: (1) In mid-September, an outline of the report will be sent to members for feedback, (2) A first draft of the report will be completed by October 15 and sent to members for feedback within one week, (3) In mid-November, a second draft of the report, modified based on member feedback from the first draft, will be sent to members for feedback within 1 week.

Dr. McCance-Katz said work groups are allowed if members think that having them would

facilitate prompt feedback about the drafts of the report to Congress. The work groups, to be composed of ISMICC members (federal and non-federal) or their designees, may hold meetings as necessary. Work groups will be established by the parent ISMICC with the approval of the Secretary of HHS. Work groups will send their recommendations to the ISMICC, not to HHS. If members decide to establish work groups, the DFO must be informed about the work group's name, members of the work group, and how they will meet. Work groups should designate one person who communicates with the DFO.

Dr. McCance-Katz also explained that there will be two ISMICC reports: The 21st Century Cures Act requires an initial report in December 2017 and a second report five years later. ISMICC member terms are for three years. There will be at least two meetings per year, one in person and one virtual, with the timing based on important federal activities such as the proposed budget and the end of the fiscal year.

Pete Early suggested forming a work group to focus on jails and prisons, a second group to focus on payment issues, and a third group to focus on coordination of housing, employment, and related issues.

David Covington noted that the New Freedom Commission had 15 work groups, then read his notes on 10 priorities he gleaned from the discussion: "Jails and prisons, therapeutic relationship, evidence-based practices like ACT [acceptance and commitment therapy], AOT [assisted outpatient treatment], and linkages to peers. How do we improve civil commitment? How do we improve access to care, especially given that 35 percent receive no treatment at all, crisis care, long waits in ERs? How do we improve recovery supports and ensure better evidence? How do we protect privacy rights? How do we address workforce deficits including the number and geographic distribution? And how do we increase the skills around co-occurring substance use services?"

Dr. McCance-Katz agreed that priorities could be assigned to work groups, allowing members to choose a group, but noted that members may provide feedback on any priority. She suggested that work groups combine priorities covered during today's meeting in order to limit the number of work groups, noting that limited staff will be available to support the work groups.

Kenneth Minkoff suggested forming a group that creates an overall federal vision for serving the SMI and SED populations, and linking it to state and local efforts. Another group could look at alignment of funding policies. A third group could focus on children and youth, criminal justice, housing, employment, and recovery supports. And finally, a group could identify the low-hanging fruit of addressing regulatory barriers, so people could celebrate early success.

Conni Wells suggested developing a glossary with brief definitions of key terms as a way to facilitate discussion and promote consistency.

Mary Giliberti mentioned the issues of refining data collection, promoting engagement, and providing recovery supports.

Dr. McCance-Katz noted that SAMHSA is currently examining its data collection approach to determine if it should be changed. Any members who have been SAMHSA grantees are already familiar with the data that SAMHSA requires be reported (the National Outcome Measures System and Government Performance Reporting Act data).

Kenneth Minkoff emphasized that implementation begins at the first meeting. He urged ISMICC members to think about how their work will lead to specific actions, and achieve a sustainable, meaningful impact nationwide during the next few years. Ideally, the first report will include immediate action steps, with recommendations for doing more work over the next year.

John Snook asked about how specific the recommendations might be. For example, might we recommend elimination of the Institution for Mental Disease exclusion under Medicaid?

Dr. McCance-Katz noted that some programs are congressionally mandated, and during work group discussions, federal members of the ISMICC may need to cite statutory requirements.

Linda Beeber asked about the responsibility of Congress.

Dr. McCance-Katz said congressional representatives had the wisdom and foresight to establish the 21st Century Cures Act that called for development of the ISMICC, presumably based on suggestions from non-federal constituents in the mental health field. She encouraged constituents to contact their congressional representatives, who will hold the ISMICC and federal agencies accountable for their efforts to better serve people with SMI and SED.

Joseph Parks mentioned that federal departments have extensive budgets and authorities, and suggested that each department list what is feasible using its internal authorities and resources.

Dr. McCance-Katz noted that there is a formal process for recommending changes. Everything must go through legal counsel for review, but not every change requires legislation.

Clayton Chou said the outline for the ISMICC report would be important as a way to focus the recommendations. He noted that the New Freedom Commission came up with so many recommendations that people found it hard to decide where to start.

Maryanne Davis expressed concern that each work group must be prepared to address how its recommendations (on topics such as crisis response, justice system involvement, and recovery supports) would apply to children and youth.

David Covington mentioned the analog with development of the National Action Lines for Suicide Prevention, formed in 2010. Each of the 14 taskforces was led by public and private members of the executive committee, similar to the ISMICC. Taskforce members were all additional people from the field who were brought in. As a result, hundreds of people were engaged in the process.

Dr. McCance-Katz said that it should be possible to bring in a limited number of experts if the recommendation is made by the ISMICC. However, it might be best for work groups to consult with experts as needed and incorporate their input into the ongoing work of ISMICC members during their three-year appointments.

Conni Wells said she would be facilitating calls with peers to reflect the voice of families, hoping to infuse their input into the review of the draft report to Congress.

There was a general consensus to move forward with work groups.

Dr. McCance-Katz said that by the following week, ISMICC members will be contacted and asked to volunteer for specific work groups, each of which will be assigned a SAMHSA facilitator. Everyone will receive the entire draft of the report. She suggested immediately setting up a meeting of the work group to discuss each individual's modifications of the draft report, and then each work group will submit its combined input. She then reiterated the flow and the timeline leading up to a virtual meeting around December 13, 2017.

She also mentioned an idea discussed within SAMHSA of visiting other agency sites at various times during the next three years to conduct a one- or two-hour listening sessions and thereby obtain public feedback. ISMICC members may be invited to those sessions. Regarding state engagement (such as state Medicaid directors and county behavioral health providers), she pointed out that one of the roles of an ISMICC member is to explore individual connections and affiliations with state agencies and other organizations, and then to share their input about how to improve mental health services.

Joseph Parks encouraged sharing of the draft report to Congress with some of the state agencies and organizations to help build support for the recommendations.

Kenneth Minkoff said that outreach to state agencies and organizations should include both federal and non-federal representatives who serve on the ISMICC.

Dr. McCance-Katz said a public SAMHSA announcement will go out about this meeting, and it will mention the ISMICC's interest in having stakeholder groups be involved. She added that other federal agencies may be putting out information about the ISMICC in an effort to alert the public and perhaps to connect organizations with work groups. She assured ISMICC members that announcements about their involvement in work groups would not go out without member approval.

Linda Beeber suggested that it is important when addressing treatment issues to look also at prevention, intergenerational issues, and social determinants, in order to cut across silos.

Dr. McCance-Katz summarized how work groups will be established and the timeline for commenting on drafts of the report to Congress, including the initial outline, the first draft in October, and the second draft in November, followed by release of the final document in December. She mentioned again the plan to have a virtual meeting in December in connection

with the report's release, to have ISMICC meetings in early 2018 (potentially in February) and in mid-2018, and perhaps to conduct some listening sessions.

Public Comment

Dr. McCance-Katz asked for public comment. Note: Public comments are not included in this summary. Afterward, she asked for any further comment from ISMICC members.

Subsequent Discussion

Based on public comments, a discussion ensued about SMI and violence.

John McCarthy said that his understanding of the literature is that mental illness is not associated with greater risk of violence to others, although it is associated with greater risk of violence to self.

Dr. McCance-Katz responded by saying that although it is true that the vast majority of people with mental illnesses are not violent, it is important to acknowledge that people who have untreated SMI often have histories of violence to themselves or others.

Jennifer Sheehy added that in her experience people with mental illness tend to be victims of violence much more often than perpetrators of violence.

Elena Kravitz said that when people don't feel pressured to be in an environment and they come in voluntarily, they do not react violently.

Maryann Davis pointed to the findings of the MacArthur Violence Risk Assessment Study, that after controlling for other factors that contribute to violence such as environment, the increase in violence related to mental illness is very small and related to substance use, and that the vast majority of people with mental illness do not engage in violence against others.

John Snook said that people with untreated SMI have a higher rate of violence, especially inter-familial violence. We need to recognize the reality and respond by providing the care people need.

Elena Kravitz expressed concern about criminalizing people with SMI as a result of their violent behavior.

Pete Earley added that too often in Virginia, the only way someone gets treatment is to be violent. In Pennsylvania, people can't get care unless they are a clear and present danger, which is not the case with other medical conditions.

Linda Beeber reframed the discussion in terms of prevention. When people are left alone without the structures in place to recognize it, to intervene, to offer the care that's needed, then violence escalates. She added that most people with SMI are not harmful to others, and the focus should be on the potential for recovery.

David Covington noted the opportunity to make a difference in urgent situations where people are engaged in actions that hurt themselves or others.

Jennifer Sheehy added that employers did not come to the table for a long time because of the perception that people with any mental illness are dangerous. In recent years, however, employers are opening up, offering wellness and mindfulness and employee assistance programs, and advertising the support they offer to their employees and their families.

Kenneth Minkoff shifted the discussion and expressed hope that the ISMICC would be proactive in helping define the report to Congress. He questioned how the ISMICC will make decisions or recommendations and suggested developing a mission statement or vision statement that the group could agree on.

Dr. McCance-Katz said that although the ISMICC does not vote on recommendations, various ideas could be captured in the report.

Pete Earley expressed concern about barriers to receiving services, such as needing to be in imminent danger of harm to self or others before being admitted.

Kenneth Minkoff suggested it should be illegal to turn people away who need help but are not a threat. He noted that regulatory actions can be taken when people are inappropriately denied care.

David Covington added that some communities are realizing it's more humane and effective to have crisis intervention resources. Crisis intervention was one of the pillars of the original Community Mental Health Act but eventually only received a small amount of funding. Over time, that turned around. The governor of Colorado put over \$100 million in state funding to develop crisis services. California put in a similar amount of funding and Georgia and Delaware began to fund it. In Washington, the courts are mandating greater efforts to reduce psychiatric boarding in emergency departments.

Clayton Chou said that, in reality, communities often don't want crisis centers to be established in their backyards.

Pete Earley reiterated the issue of funding obstacles, citing Virginia as an example, where it costs \$50,000 per year to keep one person in jail. It would be much less expensive to provide housing and an assertive community treatment team, but the issue is, who will pay for it?

Dr. McCance-Katz opened the floor for further public comment. There was none.

Joseph Parks commented that one of the advantages of CCBHC are the requirements to take everybody regardless of payer status, have 24/7 crisis services, and have extended evening and weekend hours, which are more welcoming than just business hours. Centers are given a funding method that ensures they have the adequate rates to pay for those services.

John Snook noted that the issue is not just at the provider level but the administrative level as well. Some systems are divided, where one entity is responsible for the outpatient and one is responsible for the inpatient, without an integrative approach.

Joseph Parks described achieving some improvement by using the CALOCUS to increase motivation to start funding the middle structures between inpatient and outpatient services. This must be implemented by the state and the Medicaid managed care contract and then enforced.

John Snook pointed out that many jails are building hospitals and treatment facilities. Once that money is spent, it is no longer available. This must be solved quickly.

Kenneth Minkoff said that the strategic approach of thinking about how to have impact across states and counties is important and timely. In Texas, the Meadows Mental Health Policy Institute is working with local communities to get themselves organized into a behavioral health leadership team so that the responsibility for that community is shared across multiple entities.

He expressed optimism that the ISMICC can move in that direction.

Mary Giliberti emphasized the urgent need to address issues related to the criminal justice system and orienting the system to focus on early intervention for SMI.

Dr. McCance-Katz thanked all members for their participation and input.

Meeting Adjourned

Pamela Foote, DFO, adjourned the meeting at 4:53 p.m.