

U.S. Department of Health and Human Services

Minutes of the Interdepartmental Serious Mental Illness Coordinating Committee Eighth Full Committee Meeting

August 27, 2021, 1:00 p.m. to 5:00 p.m. (Eastern Time)
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane
Rockville, Maryland 20857

/Miriam Delphin-Rittmon, Ph.D./

signed 10/19/2021

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Call to Order/Committee Roll Call

Pamela Foote, Designated Federal Official, ISMICC

Ms. Pamela Foote, Designated Federal Official, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), called the meeting to order at 1:00 p.m. and a quorum was established.

Federal ISMICC Members or Designees Present

- Judith Dey, Ph.D., Economist, Designee, Office of Behavioral Health, Disability, and Aging Policy, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
- Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Abuse, Substance Abuse and Mental Health Services Administration
- Maria Fryer, M.S., Designee, The Attorney General, Department of Justice
- Sandy Resnick, Ph.D., Designee, Deputy Director, Northeast Program Evaluation Center (NEPEC), Office of Mental Health and Suicide Prevention, Virginia Central Office (VACO), Department of Veterans Affairs (VA)
- CDR Kenneth Richter, Secretary of Defense
- Taryn Williams, M.Ed., Secretary, Department of Labor
- Christy Kavulic, Ph.D., Designee, Department of Education, Office of Special Education Programs
- Judith Cash, Designee, Administrator of the Centers for Medicare and Medicaid Services, Acting Deputy Director, Center for Medicaid and CHIP Services
- Marion (Taffy) McCoy, Ph.D., The Commissioner of the Social Security Administration

Federal ISMICC Members Not Present

- Secretary of Housing and Urban Development or its designee

Non-Federal ISMICC Members Present

- Trinidad de Jesus Arguello, Ph.D., LCSW, PMHRN-BC, Director, Compostela Community and Family Cultural Institute
- Yasmine Brown, M.S., CEO, Hope Restored Suicide Prevention Project, LLC
- Ron Bruno, Founding Board Member and Second Vice President, Crisis Intervention Team (CIT) International
- David Covington, LPC, MBA, CEO and President, Recovery Innovations (RI) International
- Pete Earley, Author
- Dainery Fuentes, Ph.D., School Psychologist, Polk County School Board, Lakeland, Florida

- Brian Hepburn, M.D., Exec. Director, National Association of State Mental Health Program Directors (NASMHPD)
- Jennifer Higgins, Ph.D., CCRP, Owner, Commonwealth GrantWorks
- Johanna Kandel, Founder and CEO, The Alliance for Eating Disorders
- Steven Leifman, J.D., Assoc. Administrative Judge, Miami-Dade County Court, Eleventh Judicial Circuit of Florida
- Adrienne Lightfoot, Peer Program Coordinator, DC Department of Behavioral Health
- Amanda Lipp, Director and Filmmaker, Lipp Studios
- Winola Sprague, DNP, CNS-BC, Medical Director, Children's Advantage
- Rhathelia Stroud, JD, Presiding Judge, DeKalb County Misdemeanor Mental Health Court, DeKalb County Magistrate Court
- Katherine Warburton Williams, D.O., Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals

Welcome and Introductions

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

Dr. Delphin-Rittmon thanked Ms. Foote and greeted and thanked participants. She explained that in year three of a six-year commission, ISMICC has a unique and critical opportunity to serve those with serious mental illness (SMI) and their families, particularly in light of the COVID-19 pandemic and she looks forward to working with ISMICC members.

As a White House appointee, Dr. Delphin-Rittmon was a senior policy adviser to the administrator at the Substance Use and Mental Health Services Administration (SAMHSA) in 2012 to 2014. During that time, she had the opportunity to work on workforce development, health care reform, and with the Office of Behavioral Health Equity. Most recently, she served six years as commissioner of the Connecticut Department of Mental Health and Addiction Services leading a full continuum of prevention and treatment recovery services, and support. Prior to that, she served as the deputy commissioner and senior policy advisor. She also has served as faculty at Yale Department of Psychiatry for the past 20 years.

Dr. Delphin-Rittmon asked her team members to introduce themselves. Mr. Tom Coderre, who served as the Acting Assistant Secretary during the transition, now serves as Acting Deputy Assistant Secretary. Sonia Chessen, Chief of Staff, formerly worked as the Assistant Secretary for Planning and Evaluation Office (ASPE) and is happy to be returning to Health and Human Services (HHS). After introductions, Dr. Delphin-Rittmon overviewed near-term priorities, cross cutting issues, and recent funding to address COVID-19 and funding provided through the American Rescue Plan Act (ARPA).

Established in 1992, SAMSHA sets the nation's behavioral health agenda by providing leadership and resources to decrease the impact of substance use and mental illness on American communities. Through cross-cutting strategies, SAMHSA focuses on data and equity to improve access to, use of, and outcomes from SAMHSA-funded services. To fulfill the mission of

reducing impact, it is imperative to revitalize and re-energize SAMSHA staff, as well as fill the 183 vacancies out of 664 full-time positions.

With a budget request of \$9.7 billion for fiscal year (FY) 2022, SAMHSA has identified five core near-term priorities:

1. Preventing overdose
2. Enhancing access to suicide prevention and crisis care
3. Promoting children and youth behavioral health, particularly in light of the pandemic.
4. Integrating primary care and behavioral health care through initiatives, such as Certified Community Behavioral Health Centers (CCBHC)
5. Using performance measures, data, and evaluation of funding streams

SAMHSA's four cross-cutting principles of equity, workforce, financing and recovery are the foundation for their work and align with the priorities of the Biden/Harris administration. Dr. Delphin-Rittmon explained that SAMHSA's Office of Behavioral Health Equity, formed in 2010, is one demonstration of the importance of equity in the behavioral health system. Further, building a workforce is now more important than ever to address the ripple effects and impacts of the pandemic.

Dr. Delphin-Rittmon expressed appreciation for the resources that President Biden put forward to address behavioral health, increase access to mental health and substance use services, and establish an equitable system. With an additional \$4.25 billion in COVID funding and total appropriation of \$6.1 billion in FY2021, SAMHSA provided grants for suicide prevention, emergency response, Project AWARE, and the National Child Traumatic Stress Network, as well as 100 additional CCBHCs, adding to the current 340 centers. This boosted SAMHSA's budget by \$3.56 billion and expanded funding for Block Grants for community mental health services and substance use prevention and treatment, community-based funding for local behavioral and substance use disorder (SUD) services, the National Traumatic Stress Network, Project AWARE, youth suicide prevention grants, and CCBHCs. For FY2022, SAMHSA requested \$9.7 billion for mental health, substance use prevention, substance use treatment and health surveillance, and program support. Dr. Delphin-Rittmon shared the table below to demonstrate how SAMHSA's programs and priorities are managed:

SAMHSA's Programs Aligned to Emerging Priorities

	1. Preventing overdose	2. Promoting children and youth BH	3. Integrating primary and behavioral health care	4. Using performance measures, data and evaluation	5. Enhancing access to suicide prevention & crisis care
Center for Substance Abuse Treatment <ul style="list-style-type: none"> • SBIRT • State Opioid Response Program • Certification of Opioid Treatment Programs 	✓		✓	✓	✓
Center for Mental Health Services <ul style="list-style-type: none"> • 988 • Certified Community BH Clinics Expansion Grant • Project AWARE 		✓	✓	✓	✓
Center for Substance Use Prevention <ul style="list-style-type: none"> • STOP Act grants • Harm reduction • Overdose prevention strategy 	✓	✓		✓	
Center for Behavioral Health Statistics and Quality <ul style="list-style-type: none"> • Disparity impact statement (in partnership with OBHE) • National population surveys (e.g., NSDUH, BHSIS) 				✓	

Dr. Delphin-Rittmon explained that SAMHSA is reconvening the Behavioral Health Coordinating Council (BHCC), a cross-departmental council she co-chairs with Dr. Rachel Levine, Assistant Secretary for Health, HHS. The BHCC shares the same priorities of suicide prevention, overdose prevention, children and youth behavioral health, integration, and performance and evaluation. She then turned the meeting over to Anita Everett, MD, DFAPA, Director of Center for Mental Health Services (CMHS), who provided a history and context for the meeting.

The ISMICC was authorized in the 21st Cures Act in response to the 2014 Government Accountability Office (GAO) Report noting that HHS leadership needed to coordinate federal efforts related to SMI and SED. On March 15, 2017, ISMICC was certified and began its six-year commission, ending March 2023. The statute requires that ISMICC include 10 federal agencies along with non-federal members, hold two bi-annual meetings, and submit two reports to Congress. The first report, entitled *The Way Forward*, received hundreds of comments, many expressing relief that improving services and funding for individuals with SMI and SED was being addressed at this level. The report contains 45 recommendations across five focal areas: data, access, treatment and recovery, justice, and finance. Having reached the mid-point of its commission, ISMICC will meet again in December 2021 and submit its final report in April of 2022 and, according to the statute, will include:

1. A summary of advances in treatment and recovery.
2. An evaluation of federal programs addressing suicide, employment and recovery supports, and recommendations for actions agencies can take to better coordinate the administration of services for those with SMI and SED.
3. A recommendation regarding ending or continuing with ISMICC.

To that end, the goal of this meeting is to demonstrate and update members on various SAMHSA programs connected to or influenced by the report and to hear from federal ISMICC partners about their work. The meeting will also provide a time for public comment and discussion on the future of ISMICC.

Consideration of Minutes

Pamela Foote, Designated Federal Official, ISMICC

Ms. Foote allowed for a time of questions and comments before entertaining a motion to accept the September 29, 2020 meeting minutes, which were accepted.

Advances in Services for Serious Mental Illness (SMI) and Serious Emotional Disturbances SMI Advisor

Amy N. Cohen, Ph.D., Director, SMI Adviser, Division of Education, American Psychiatric Association

Dr. Everett introduced the next topic by sharing how a colleague related their positive experience with the SMI Adviser and called on Dr. Amy Cohen, Director, SMI Adviser, Division of Education, American Psychiatric Association to present.

The SMI Adviser, also known as the clinical support system for SMI, is in year four of a five-year initiative funded by SAMHSA and implemented by the American Psychiatric Association. The vision for the SMI Adviser is to transform care for people who have SMI so they can live their best lives. The SMI Adviser is led by a clinical expert team supported by content experts and an advisory board. SMI Adviser offers support and technical assistance to clinicians including physicians, nurses, psychologists, national certified peer supports, social workers and it provides information for families and those living with an SMI, through education on evidence-based practices, direct consultations to clinicians, and vetted evidence-based resources. Anyone can access all resources through the app or on the web.

Over the last three years, more than 1,046,341 people accessed the website at smiadviser.org. The app, with over 15,000 downloads, is available on both the Android and the iPhone platforms and allows access to everything on the website along with several assessments, such as the PHQ-9 (Patient Health Questionnaire-9). Clinicians can use the assessments, score each item, and receive the scores and interpretation of those scores at the time of the visit. Developers are continually working on improving visibility through search engine optimization for the website.

Based on ISMICC's 2017 report, the creators built a taxonomy, or classification, of needs for the SMI population. For instance, based on the psychotherapies listed in the report, SMI Adviser incorporates cognitive behavioral therapy (CBT), trauma-focused CBT, motivational interviewing, and problem-solving therapy, among others. Dr. Cohen emphasized that everything in SMI Adviser ties back to the taxonomy while the data collection reveals gaps where more information is needed.

SMI Adviser provides many opportunities to improve the knowledge and skills of those working with the SMI population. Educational opportunities are accessible through a calendar of upcoming webinars and a catalog of all presentations. With at least 200 webinars, over 42,000 clinicians have been trained and earned continuing medical education units. Further, they are starting the application for joint accreditation, which will bring all the requirements into

alignment to provide continuing education credits for psychologists, social workers, and pharmacists.

Virtual learning collaboratives are also offered by the SMI Adviser. In the third year of the initiative, they offered 20 collaboratives that provided hands-on, in-depth learning from subject matter experts. During each 12-week course, participants work on a project they can take back to their site, such as developing a position description and supervision for peers and developing nursing assessments.

In November 2020, with expert consultation from the Psychosis-Risk and Early Psychosis Program Network (PEPPNET) and National Institute for Mental Health (NIMH), SMI Adviser held the Third National Conference on Advancing Early Psychosis Care: Addressing Inequities – Race, Culture, and COVID-19. The free two-day event provided 20 sessions addressing system-level improvements, culturally informed care, the new normal, and the human experience (4 tracks). Attendance increased seven-fold compared to the second national conference. All conference sessions were recorded and continue to be offered in SMI Adviser’s Education Catalog as accredited on-demand activities (www.SMIadviser.org/fep-session).

All resources offered on the site are independently reviewed and rated by two clinical experts for its evidence-base and applicability to the SMI population and frontline clinicians. Only those with a high rating in all three areas are included in the knowledge base where a search by category or keyword will provide the user with a concise summary and link to the resource. The resource base has and will continue to expand thanks to an ongoing inventory of the taxonomy. Recent additions include a suicide and SMI resource developed with the Suicide Prevention Resource Center and a series of four myth and fact sheets on psychopharmacology, using technology, misconceptions about SMI, and evidence-based practices. A tip sheet is also available on how to prepare for a virtual appointment and is available in Spanish.

When complex clinical challenges arise, Dr. Cohen explained that SMI Adviser is very responsive, providing a continuum of consultations, from a brief email to an in-depth, live discussion with an expert. They have also worked with sites to close a gap in care that requires some reorganization. Requesting a consultation on the website is easy and receives a response within one business day. Excluding implementation sites, they have provided over 2,000 consultations on a variety of topics, (e.g., psychopharmacology, service delivery, Clozapine, schizophrenia, family involvement, and collaborative and integrated care).

SMI Adviser has also developed micro sites to contain all of the education, tools, tips, and console in one place. For example, the Clozapine Center of Excellence (COE), led by Robert Cotes, M.D., and in collaboration with the National Association of State Mental Health Program Directors (NASMHPD), is focused on increasing and improving the use of clozapine and treatment refractory schizophrenia. They also have a Long-Acting Injectable COE that provides resources, education, and consultation led by Dr. Robert Cotes in conjunction with Donna Roland, Ph.D., APRN, from the University of Texas at Austin. Together, the two COEs have a moderated listserv called the Center of Excellence Exchange with over 480 clinician subscribers who share ideas and engage with peers across the country. An outgrowth of the listserv is a monthly virtual forum on a hot topic attended by over 50 participants. Further, the COVID-19

micro-site provides clinical tips, guidelines, tools, and handouts to help clinicians talk to their patients while another micro-site offers a newly developed guide for reopening a mental health practice.

In fall 2019, SAMHSA provided a supplemental award to SMI Adviser with the goal of improving the use of Psychiatric Advance Directives (PADs). Within six months, they launched an app available for both iPhone and Android called My Mental Health Crisis Plan, (visit SMIadviser.org/padapp). The app empowers individuals to create and share a PAD pertaining to themselves or someone else. Dr. Cohen noted the app is so named because many people feel comfortable talking about a crisis plan, and less comfortable talking about a PAD. The last step of the app allows the user to pick the state that they live in and view the necessary steps for turning the crisis plan into a legal document, (i.e., PAD), if desired. A facilitator guide is also available to help others make a PAD. Other benefits of the app include being able to designate treatment preferences and appoint someone to make legal decisions on their behalf. The PAD can be accessed and updated at any time while a QR code allows users yet another way to share it with family members, friends, or their clinical team. Users can also print out a PDF and email the PAD all within the app.

SMI Adviser has many dashboards. Dr. Cohen highlighted the Education Engagement Metrics, which displays the map of the United States. By clicking on color-coded regions and topics, the user can see exact metrics, including how many users are from urban, mid, and rural sites, types of engagements, number of learners, types of professions, and credits earned by certificate type and learning format. To date, there are:

- 1,046,341 website users.
- Almost 2.5 million-page views.
- Almost 22,500 app downloads across my Mental Health Crisis Plan and the SMI Adviser app.
- Over 113,000 total registrations for learning with over 50,000 credits issued to almost 43,000 learners.

Though SMI Adviser does not have a large social media presence, everything is tagged, and the work is award winning, including:

Aster Awards

- SILVER Award, #MissionforBetter campaign
- GOLD Award, SMI Adviser Newsletter

dotCOMM Awards

- GOLD Award, *How to Talk About the COVID-19 Vaccine with People Who Have SMI*
- GOLD Award, *Third National Conference on Advancing First- Episode Psychosis Virtual Event*
- GOLD Award, *My Mental Health Crisis Plan app*
- Honorable Mention, SMI Adviser website
- Honorable Mention, *The Data on Serious Mental Illness* video

In closing, Dr. Cohen stated that in addition to the three licensed school resources, educational opportunities, and consultations, a Digital Health Navigator will be introduced in year four into year five. This individual will connect with clients prior to their telepsychiatry visits to help with technology problems and assist colleagues in finding appropriate apps. The long-term goal is to collect enough data to have this role be a reimbursable part of the team. Other goals center around the implementation of 988 and supporting rural care teams. Lastly, Dr. Cohen is looking forward to what ISMICC will be focusing on in the coming years.

Dr. Delphin-Rittmon thanked Dr. Cohen and introduced David DeVoursney, Director, Division of Service and Systems Improvement, Center for Mental Health Services (CMHS) to present.

Certified Community Behavioral Health Clinics (CCBHC)

David DeVoursney, Director, Division of Service and Systems Improvement, Center for Mental Health Services (CMHS)

Mr. DeVoursney thanked Dr. Cohen and expressed appreciation for the work of the SMI Adviser as well as for the work of the ISMICC. He began with an overview of the Certified Community Behavioral Health Clinic (CCBHC) model.

The CCBHC model brings together a comprehensive range of services while incorporating evidence-based practices and other supports based on a community needs assessment. Minimum standards for services and access to services, (e.g., increased resources for people experiencing a mental health or SUD crisis), are part of the model and fall under certification criteria developed by HHS.

Clinics can become a CCBHC in three ways: as part of the original Medicaid demonstration, as part of SAMHSA's CCBHC expansion grant program, or as an independent state program. Additionally, clinics can participate in any category though there are significant differences between categories.

In the Medicaid demonstration, CCBHCs receive a payment for Medicaid enrollees based on the Prospective Payment System (PPS), which reimburses them based on their cost for providing services. Under the SAMHSA expansion grant program, CCBHCs receive \$2 million for two years in grant funding while independent state programs vary. For example, Texas decided to develop an independent program when they were not chosen to be a part of the Medicaid demonstration in 2017 and worked with their managed care plans to provide for CCBHCs to be certified independently in their state.

Out of 24 states that submitted proposals, eight states were chosen to participate in the Medicaid demonstration which was originally slated for the time period of 2017 to 2019 and has now been extended through 2023. SAMHSA handles the programmatic aspects and execution of the expansion grants while the Centers for Medicaid and Medicare Services handles payment for the demonstration CCBHCs. To become a CCBHC, programs must meet specific certification criteria which were developed by HHS in 2014 under the Protecting Access to Medicare Act. Six program requirements correspond to language in the Protecting Access to Medicare Act 2014:

1. Staffing – Staffing plan driven by local needs assessment, licensing, and training to support service delivery
2. Availability and Accessibility of Services – Standards for timely and meaningful access to services, outreach and engagement, 24/7 access to crisis services, treatment planning, and acceptance of all patients regardless of ability to pay or place of residence
3. Care Coordination – Care coordinate agreements across services and providers (e.g., FQHCs, inpatient and acute care), defining accountable treatment team, health information technology, and care transitions
4. Scope of Services – Nine required services, as well as person-centered, family-centered, and recovery-oriented care
5. Quality and Other Reporting – 21 quality measures, a plan for quality improvement, and tracking of other program requirements
6. Organizational Authority and Governance – Consumer representation in governance, appropriate state accreditation and meaningful participation from consumers and family members in their governance structure.

CCBHCs are required to provide nine clinical services: screening, assessment, diagnosis and risk assessment, treatment planning, outpatient mental and co-occurring mental and SUD services, crisis services. If there is a state sanctioned mobile crisis network already in their area, they can connect through a designated collaborating organization (DCO) to provide the services. However, since the CCBHC must maintain clinical and financial responsibility for the services, they must be extremely engaged in the oversight and delivery of those services. Five other required services that CCBHCs can provide directly or through a DCO include targeted case management, outpatient primary care screening and monitoring, community-based mental health care for veterans, family support and counselor services, and psychiatric rehabilitation services.

Though the original demonstration included 66 clinics across eight states, in 2019, Pennsylvania left the federal demonstration, decreasing the number of clinics to 50 across seven states. However, Michigan and Kentucky will soon be joining the demonstration. SAMHSA's expansion grants are also building the program and making it possible for 100 new CCBHCs in the coming weeks. With 52 centers in 2018, the rapid growth to 400 sites is due to increases in annual appropriations together with supplementary funds from COVID-19 Relief and ARPA.

Discussion

Dr. Jennifer Higgins inquired about the expectation of increasing CCBHCs in the future. Mr. DeVoursney explained that of the newest cohort of 100, 70 CCBHCs are drawing on ARPA and COVID-19 funds. In addition, the administration has requested an additional \$125 million in FY2022 to develop more CCBHC expansion grants. He also noted that Kansas and Illinois recently passed legislation to expand their own state based CCBHC programs. Further, adding Michigan and Kentucky to the Medicaid demonstration and the growth of independent programs bodes well for the future.

Steven Leifman, J.D., expressed support of CCBHCs and added that both the civil and criminal courts would like a more formal relationship with and access to CCBHCs, particularly since they are likely the largest referral service for CCBHCs. Mr. DeVoursney concurred about the referral comment and added that approximately 40% of those within the Medicaid demonstration are

providing direct outreach in criminal justice settings. Yet, communities have the flexibility to decide how they want to incorporate community outreach and other required activities. He encouraged everyone that has a CCBHC in their area to foster that relationship. Mr. Leifman would like a stronger stance, noting that he has worked very closely with the Conference of Chief Justices and court administrators while meeting with SAMHSA regional directors to make this happen. Mr. DeVoursney stated that with funding in the next month for a new Technical Assistance Center for expansion grants, community partnerships could be a focus. Dr Everett added that the requirements for continuity of care through case management and rapid access, (i.e., seeing a patient within a short period of time), could be advantageous.

Dr. Delphin-Rittmon thanked Mr. DeVoursney and introduced Dr. Melinda Baldwin to present on Project AWARE.

Project AWARE: School-Based Mental Health Care

Melinda Baldwin, Ph.D., LCSW, Director, Prevention, Traumatic Stress and Special Programs Division, CMHS

Dr. Melinda Baldwin informed the Council that Project AWARE (Advancing Wellness and Resiliency in Education) is designed to build or expand the capacity of State Educational Agencies (SEA) in partnership with State Mental Health Agencies (SMHAs) in overseeing school-aged youth. The program aims to advance wellness and resiliency in education by increasing mental health awareness in schools across states, territories, and tribal communities. Specifically, the purpose of Project AWARE is to:

- increase awareness of mental health challenges that school-aged youth may experience.
- provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health challenges.
- connect school-aged youth, who may present with behavioral health challenges and their families to needed services.

Project AWARE began in 1999 as the Safe Schools/Healthy Students program. With the 2012 school shooting in Sandy Hook, it evolved into the “Now Is The Time” program and quickly grew into the program it is today with 44 grants, five of which are disseminated to tribes, and new grants will be awarded in the next couple of weeks. Since states receive and implement the grant in only three local education agencies (LEA), SAMHSA is considering sustainability when the federal funding is exhausted.

Dr. Baldwin highlighted three infrastructure development indicators used for data collection: policy development, workforce development, and partnership/collaboration. Notably, grantees far exceeded expectations by 169%, 263%, and 183% respectively. Similarly, prevention and mental health promotion indicators of training, screening, referral, and access showed even greater over-achievement with outpacing the goals by 703%, 261 %, 206%, and 75% respectively.

Dr. Baldwin reported the following successes of Project AWARE:

- Ensuring cultural relevance for program activities
- Collaborations
- Building rapport, trust, and relationships
- Increase in mental health literacy
- Removing barriers to care and increasing access
- Implementation of universal screening
- Ability to pivot during the pandemic
- Workforce training
- Interdisciplinary team approach
- Continuous focus on improving school climate

Project AWARE faces many challenges, including a lack of mental health providers available for hire, stigma, prioritizing mental health at the state level, and the COVID-19 pandemic. COVID-19 has decreased the amount of time to provide services while increasing responsibility, restricting travel, contributing to teacher burnout, and complicating lesson delivery, (e.g., hybrid versus in-person). Other challenges include technology, increased anxiety for staff and students, and dealing with loss and grief. However, with the increase of mental health literacy training, many teachers and school personnel are able to recognize the signs of emotional disturbance and help students.

988 Crisis Services

Richard McKeon, Ph.D., Chief, Suicide Prevention Branch, CMHS, SAMHSA

Dr. Richard McKeon, Suicide Prevention Branch Chief, CMHS, stated that the implementation of 988 will help transform mental health crisis services through increased access to the National Suicide Prevention Lifeline (Lifeline). Preliminary data from the Center for Disease Control and Prevention reveal an estimated 45,000 suicides occurred in 2020. Of the 51 million people with mental illness in 2019, 26% perceived that their need for services went unmet. For those with SMI, nearly 48% perceived their needs were unmet. With significant gaps in the system of care, including crisis care, an over reliance on the criminal justice system to handle mental health emergencies has brought us to the current state of affairs.

To improve outcomes, crisis care must evolve beyond the current fragmented system to a coordinated system as described in SAMHSA’s national guidelines for behavioral crisis care. In a coordinated system with maximum access to crisis lines through 988, best estimates show that about 80% of the needs can be resolved over the phone without needing police response or other services. For those who need an in-person response, typically a two-person mobile crisis team handles the crisis without the need for the police or other services for 70% of callers. Further, if a person needs a place to go, crisis stabilization facilities provide an alternative to emergency rooms and a place where police are incentivized to not take someone to jail.

Dr. McKeon outlined the structure of the current National Suicide Prevention Lifeline. When calling the Lifeline, callers are given options to “Press 1” to reach the Veterans Crisis Line or “Press 2” to speak to crisis counselors that are fluent in Spanish. When no option is chosen, the call is automatically routed to the closest local crisis center based on the area code of the

caller. If the local crisis center does not answer quickly, the call goes to a backup center. When a person accesses the Lifeline by chat or text, it goes to a sub-network of the 33 centers out of the total 184 centers who provide chat and text response. Dr. McKeon explained that a series of SAMHSA-funded evaluation studies conducted by Madeline Gould from Columbia University reveal that when callers who are suicidal access the Lifeline their intent to die is significantly reduced during the call, or on the chat. Similarly, follow-ups conducted by the centers show that 90% of suicidal callers report that the call kept them from killing themselves. For those using chat, 50% report a reduction in suicidal thoughts. Further, third-party callers, (e.g., family members), experience great value and help by calling the Lifeline about their loved one.

The Lifeline will face challenges in handling the volume of calls as the service grows. Currently, most of the volume is through phone calls, but this past year revealed a very significant chat and text volume, so the goal is to maximize the number of calls, chats, and texts that are answered. Verizon and T-Mobile customers can call 988, but texting is not yet an option. However, the Federal Communications Commission is looking at adding texting to 988 in addition to the calling feature.

The 988 will operate through the existing Lifeline. Further, since people should have a high quality, user experience, local 988 lifeline centers will need resources to increase staff. Access must be universal and equitable, and funding must be scaled through partnerships with the federal government, states, and localities. Lastly, parity is needed so that responsiveness for behavioral crisis services matches responsiveness for medical crisis and emergency services.

A sufficiently resourced 988 system will be a catalyst for behavioral health system transformation just as 911 changed emergency medical services in America over the last 50 years. With effective 988 implementation, millions of individuals in crisis can get the support and linkage to care they need resulting in decreased suicides, better engagement with services, and less interaction with law enforcement and correctional systems.

Dr. McKeon reiterated that the success of 988 will require federal investment and leadership to ensure adequate system capacity and to support coordinated, equitable person-centered design. He closed by recognizing the integral work of the ISMICC and its emphasis on crisis services in the initial report to Congress and thanked them for being a catalyst.

Discussion

Leith States, Chief Medical Officer, Assistant Secretary of Health's Office asked about interfacing with social media and the associated algorithms. Dr. McKeon stated that social media will play an important role in advertising the availability of 988. The current Lifeline works with several social media platforms, including Facebook; however, concerns remain about how the use of algorithms might lead to police intervention when it might not be required. Not everyone who thinks about suicide is necessarily at imminent risk, (i.e., in danger of immediate harm), but the Lifeline center staff are skilled and trained in working with callers who are. Further, SAMHSA evaluation studies show that working with callers collaboratively can avoid the need for police intervention. Therefore, continuing to work with platforms such as Facebook around their algorithm to try to minimize police interaction is important.

Mr. Leifman supports the process and questioned how the 9% of calls that do require police involvement, preferably by a Crisis Intervention Team (CIT), will be handled. He also inquired about capacity and expanding the 988 system to include immediate access to a virtual counselor.

Dr. McKeon explained that they anticipate there will be times that either Emergency Management Services (EMS) or the police will need to respond. However, even when a weapon is present, it doesn't mean that the police need to be called and Lifeline staff are trained to work with callers around access to lethal means. This points to the need for collaboration between 911 and 988 moving forward. As for capacity, SAMHSA is talking with numerous partners and was heartened that the President's budget includes enhanced funding for the Lifeline. They are also focusing on the needs of the local crisis centers for additional funding, which is critical to their mission. Regarding more immediate access to digital or virtual mental health services, Dr. McKeon supports exploring the idea and appreciated the suggestion.

Pete Early concurs that 988 is going to be a significant change but questions how it will be utilized in real-time when there is a staggering lack of available services. Dr. McKeon stated that the Behavioral Health Coordinating Committee's subcommittee on suicide prevention and crisis care is considering this crucial issue. He added that working with Federally Qualified Community Health Centers and CCBHCs is an important element and, since not every community has access to those centers, 988 will spotlight the waiting list for community mental health centers.

Mr. Early also noted that stigma is another obstacle and asked if it will be clear that 988 is a mental health crisis number and not just for suicide. Dr. McKeon stated that the law describes 988 as the national suicide prevention and mental health crisis hotline, so they are planning so that it will be available for a broad range of crises. Dr. Delphin-Rittmon added that a fairly significant public awareness campaign is planned to let people know 988 is available and to help them determine when it is best to call 988 or 911.

Mr. Covington described 988 as a radical revolution that will address many of the challenges in crisis care. He also noted the tremendous increase in funding in the block grants for mental health and for substance use and prevention. He added that 30 to 35% of mental health consumers are individuals with a substance use crisis. He emphasized that beyond providing core services, the inhumane treatment of keeping people in the emergency room for days must be addressed. Further, about 70% of those individuals are handcuffed and brought by police even though the vast majority are not involved in any overt criminal activity or pose an explicit threat to public safety. For example, in Phoenix only three to five percent of the 2,000 mobile crisis contacts by various providers per month require law enforcement. He believes that the framework and foundation being laid by SAMHSA and the implementation of 988 will address these issues.

Amanda Lipp emphasized that reaching youth through technology platforms is crucial. She added that Google is arguably the modern first responder of this generation since young people are googling to find help and hope, to build rapport, and to connect with people through storytelling. Further, research shows the effectiveness of digital referral advertising and using

digital ads to reach youth with psychosis and to reduce stigma with storytelling. Ms. Lipp added that she would appreciate further discussion about partnering with tech firms and social media influencers to strategically reach youth. Dr. McKeon welcomed future dialogue and will be connecting Ms. Lipp with those at the Lifeline working on this particular focus.

Report Outs from Federal Members

Dr. Everett introduced the federal report out session and Ms. Foote called on each of the federal members of ISMICC to report on their activities related to SMI.

Department of Labor

Taryn Williams, M.Ed., the Assistant Secretary for Disability Employment Policy with the US Department of Labor

Based on recommendations from ISMICC to improve federal coordination, the Department of Labor established a supported employment workgroup in fiscal year 2019 with representation from multiple federal agencies. The workgroup identified three target populations (i.e., youth, adults, and veterans), and three areas of focus (i.e., best practices and strategies, addressing barriers and benefits, and ongoing studies and outcomes). Led by Odette's Workforce Systems policy team, the workgroup continues to meet independently of ISMICC. In 2019, based on recommendations in ISMICC's report, Odette also launched the Visionary Opportunities to Increase Competitive Integrated Employment (VOICE) initiative to support states in increasing access to the Individual Placement of Supports (IPS) model of supported employment for people with mental health conditions. VOICE works in 11 states, including Alabama, Arkansas, Colorado, District of Columbia, Iowa, Kentucky, Louisiana, Michigan, Missouri, Utah, and Tennessee. In FY2020, Indiana, North Carolina, Virginia, and Wisconsin were added.

In March of FY2021, the Advancing State Policy Integration for Recovery and Employment (ASPIRE) initiative began to support states in aligning their policies, practices, and funding. The goal is to implement and scale evidence-based supported employment services for individuals with SMI. ASPIRE is working with Florida, Indiana, Iowa, Minnesota, Oklahoma, Virginia, and Wisconsin.

Department of Justice: Bureau of Justice Assistance

Maria Fryer, M.S., Policy Advisor, Department on the Bureau of Justice Assistance

The Bureau of Justice Assistance (BJA) is charged with helping communities across the country to improve their justice systems through program funding, grant administration, policy and resource development, and national training and technical assistance. A key focus area is to improve state and local responses to people experiencing SMI, SUD, co-occurring disorders, homelessness, and repeat contact with law enforcement. To that end, BJA helps communities learn to identify people in crisis, route calls to the appropriate people, increase and connect people to services, divert them from unnecessary arrest, and improve public safety through partnership. BJA aims to design programs that are responsive to real world challenges and provide maximum flexibility for local implementation. Ms. Fryer works with and oversees three programs to meet the needs of states, tribes, and local communities: Justice to Mental Health

Collaboration Program (JMHCP), Connect and Protect Behavioral Health Response, and Collaborative Crisis Response Training.

In FY2021, BJA determined to provide more resources to keep people with SMI out of the criminal justice system and to increase and improve connections to treatment in the community. Additionally, BJA explored more innovative ways to involve the community in the delivery of treatment options and to rethink the role of police responses to people with SMI. Community members are considering what public safety and what public health means to them. This includes considering what roles various entities, such as law enforcement, healthcare entities, and others, should play as well as how to deploy law enforcement more efficiently.

The JMHCP, which began in 2006, focused on jails, and beyond, to improve and enhance all the activities from pretrial services to court and ultimately supervised re-entry into the community and is now two distinct programs. The Connect and Protect: Law Enforcement Behavioral Health Response program launched this year created a solicitation as part of and funded through JMHCP. The goal is to target Intercept Zero through Intercept 1 in the sequential intercept model, to assist law enforcement through increased training in best practices. Some examples include co-responder teams, such as crisis response and intervention teams, mobile crisis outreach teams, case management teams or law enforcement mental health, and integrated 911. The Collaborative Crisis Response Training Program was also a new program this year. The goal is to provide funds so law enforcement and correctional agencies can implement BJA's new national crisis response training curriculum based on the Memphis Model Crisis Intervention Team Approach, available at the end of 2021 or early spring of 2022.

The number of BJA partners has almost tripled, providing more expert assistance to the field. For example, BJA has partnered with the University of Cincinnati (UC) to establish academic training and raise awareness in the policing community about the nature and needs of people with mental illness, co-occurring disorders, and intellectual and developmental disabilities. A partnership between BJA, UC and Policy Research Associates, ARC of the United States and many others provides evidence-informed training resources in crisis response.

BJA's training and technical assistance has expanded as well. In addition to direct funds, BJA has expanded support for free expert training consultation, including peer to peer exchanges with 14 law enforcement mental health learning sites. In May 2021, BJA launched five additional sites across the US to network with visiting agencies. Additional training and technical assistance will be available this fall.

The Center for Justice and Mental Health Partnerships offers free training and resources to communities to safely implement best practices that divert people away from the criminal justice system. These practices connect people to treatment and the support they need, such as housing, while also promoting public safety. The Police Mental Health Collaboration Toolkit is another resource for police and communities.

Upcoming events and national initiatives include Crisis Response for Rural Communities offered by the Academic Training Initiative, and Taking the Call presented on October 20th and 21st by

BJA, the Council of State Governments Justice Center, and UC to improve community health and lessen the burden of law enforcement and reduce unnecessary justice system contact.

Department of Justice: Bureau of Prisons

Allison Leukefeld, Ph.D., Administrator of Psychology Services Branch, Bureau of Prisons

Funding through the First Step Act allowed the Bureau of Prisons (BOP) to implement multiple projects in FY2021 for individuals with SMI. Specifically, BOP hospitals implemented changes to make inpatient units more inviting, and recovery oriented. They also fund life skills programs to help inmates care for themselves if they are conditionally released back to the community. Additionally, new residential programs were launched this year; five secure programs for inmates and patients with serious histories of violence and two that are open programs. BOP has contracted for vocational rehab assessments that will evolve into programs next year and allow them to screen and identify individuals that are appropriate for these programs.

BOP is in the process of developing a standardized professional peer support training program that will utilize curriculum and video to grow the current peer support program and accompanying apprenticeship. Other projects that support individuals with SMI include de-escalation training for staff and contracted evaluations of a number of programs, including drug programs, women's programs, anger management programs, and recidivism reduction programs.

Department of Veterans Affairs

Sandy Resnick Ph.D., Deputy Director, Northeast Evaluation Center, Office of Mental Health and Suicide Prevention, Department of Veteran Affairs

In October 2020, The Commander John Scott Hannan Veterans Mental Health Care Improvement Act of 2019 was signed into law. The Hannon Act states that the Department of Veterans Affairs (VA), in consultation with the Department of Defense (DOD), must establish clinical practice and treatment guidelines of SMI to include the following conditions: schizophrenia, schizoaffective affective disorder, and persistent mood disorder, including bipolar one and two. The guideline development process is currently underway with experts from a range of mental health and allied disciplines from both VA and DOD. The process is expected to last approximately 18 months and may include other federal agencies to provide comments. Much of the workgroup process is embargoed until completion, but updates will be forthcoming.

Department of Defense

No report

Department of Housing and Urban Development

No report

Department of Education

Christy Kavulic, Ph.D., Office of Special Education Programs

The Department of Education's (DOE) Office of Special Education Programs is focused on supporting school programs, families, educators, administrators, and children throughout the

pandemic in virtual education and reopening. Their Back-to-School Roadmap includes three priorities that school districts and communities are encouraged to focus on: prioritizing the health and safety of students, staff, and educators, building school communities, and supporting students' social, emotional, and mental health, and accelerating academic achievement. Resources for practitioners and parents in each of these areas will soon be released to highlight the use of innovative practices. The DOE has also worked to have a clearinghouse of best practices for safer schools and campuses available to communities, school educators, and families as schools reopen. One area of support the clearinghouse provides is regarding children's social, emotional, and mental health. Resources are submitted by practitioners and schools throughout the community and then reviewed prior to including them in the clearinghouse.

DOE also recently released guidance on the Individuals with Disabilities Education Act reiterating the department's commitment to ensuring that children with disabilities and their families have successful early intervention and educational experiences this upcoming year, which includes free appropriate public education and early intervention of social, emotional, and mental health services for infants and toddlers with disabilities and their families.

The department continues to fund technical assistance centers to support children's social, emotional, and mental health. These centers include the Center to Improve Social and Emotional Learning in School, Safety Technical Assistance Center, the National Center and Safe Supportive Learning Environments, the National Technical Assistance Center on Positive Behavior Intervention and Supports, and the National Center for Pyramid Model Innovations, which is a center for Positive Behavior Interventions and Supports with Young Children.

Centers for Medicare and Medicaid Services

Judith Cash, Acting Deputy Director for the Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services (CMS), one of the largest payers in the country for behavioral health services, is working with states to increase safe options for community-based and mobile crisis intervention services. With additional funding from ARPA, these options become available to states in 2022 for a five-year period, theoretically allowing them to provide rapid response, individual assessment, and crisis resolution outside of a hospital or other facility setting to individuals experiencing a mental health or SUD crisis.

States have multiple mechanisms for addressing SMI and SUD within the regular Medicaid state plan; however, new opportunities will help states expand services. In 2020, CMS and SAMHSA issued a joint informational bulletin to address how states can use Medicaid to provide SUD treatment to pregnant or postpartum women, parents, guardians, and children in a family-focused residential setting. The bulletin also addresses how states can coordinate multiple funding streams across Medicaid Title iv-e and other HHS programs to provide services for people experiencing a mental health crisis.

Other guidance to states came in the form of a State Medicaid Directorate regarding mandatory Medication Assisted Treatment (MAT) for individuals with opioid use disorder. Through Section 1115 demonstration authority, some states are also obtaining Medicaid funding to

provide residential treatment for individuals with SUD and SMI when they can demonstrate that it either has, or is on a defined path to having, a comprehensive community-based system of services to complement the residential treatment. Currently, 37 states participate in the SUD demonstrations and eight participate in the demonstrations for individuals with SMI.

Lastly, CMS is helping states to implement services that will help people being released from jail make a smooth transition back into the community.

Social Security Administration

Marion McCoy, Ph.D., Office of Research and Demonstration, Social Security Administration

Though they do not provide services, the Social Security Administration (SSA) runs the programs that most people with SMI and their families depend on, which is Social Security Income (SSI) Benefits and Social Security Disability Insurance (SSDI). SSA is congressionally mandated to provide research and evaluation on existing programs, run innovative demonstrations, collect evidence for interventions that assists people with SMI, especially those who want to return to work. Through the SSA program, people have roughly nine years to re-establish themselves in the employment market without being in danger of losing assistance.

The Office of Research and Demonstration solicits competitive proposals to have evaluations conducted on the services SSA provides to make sure they are helpful to people. For instance, for the 2004-2007 mental health treatment study that involved providing supported employment to people with SMI, the evaluation revealed that participants successfully improved their employment rates by 60%, and, most importantly, improved their quality of life, decreased mental health symptoms and the impairments accompanying those symptoms. This led SSA to a large demonstration on supported employment to help people before they need benefits. Participants in that study were people who were denied SSDI benefits in the previous 30 to 60 days. Lessons learned from this study are that people face multiple challenges that may not be recognized within the system, leading to a denial of services, even though the challenges are very disabling to finding competitive employment. In response, SSA is creating a new, more responsive listing to include the conditions that almost 65% of the participants live with, including anxiety, depression, PTSD symptoms, food disorders, and personality disorders. Part of the work includes training on how to best serve people with personality disorders and engage people who are reluctant to come to a mental health center. Other work focuses on supporting people who no longer need SSI or SSDI because they have medically improved or are aging out of the system, or who are re-entering the community following incarceration.

Health and Human Services

Judith Dey, Ph.D., Office of the Assistant Secretary for Planning and Evaluation, HHS

The Office of the Assistant Secretary for Planning and Evaluation (ASPE), a principal advisor to the Secretary of HHS, is continuing to study ways to improve access to treatment and quality of care for persons with SMI, especially in light of COVID-19. ASPE provides policy coordination, policy research, and evaluation functions and continues to lead the evaluation for the CCBHC Medicaid demonstration. Reports about the evaluation and early implementation findings are available on their website.

Informed by ISMICC's report to Congress, ASPE is conducting research in several areas that impact SMI, including monitoring tele-behavioral health policies and outcomes, improving the use of measurement-based care, measuring gaps in treatment assets and network adequacy, minimizing disparities and accessing treatment, understanding continuity of care after discharge from coordinated specialty care, and expanding access to evidence-based suicide prevention practices. As research is completed, it becomes available online. Reports currently available include: State Oversight of Residential Treatment for Behavioral Health Conditions, a new brief entitled Mental Health Consequences of COVID-19: The Role of Social Determinants of Health Research Brief, and a Chartbook on Behavioral Health Treatment Demand and Provider Capacity in the United States.

Public Comment

Pamela Foote, Designated Federal Official, ISMICC

Dr. Everett thanked ISMICC federal partners for their reports and moved to public comment, explaining that individuals who submitted public comments would be called on in the order that they were received and have up to three minutes to speak. Comments included stories of lived experience, urgent requests for alternatives to incarceration, particularly Assisted Outpatient Treatment (AOT) in every county, and reliable access to treatment for all. One caller stated that denying someone treatment because they are too sick to ask for it is a human rights issue and expecting someone to voluntarily seek treatment when they do not believe they are ill is unrealistic. At the close of public comment, Ms. Foote thanked everyone for their comments and explained all comments will be available in full as part of the written record of the meeting. Further, once the meeting minutes are approved, the comments will also be available in the minutes.

Next Steps/Report to Congress-Federal Partners

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

Dr. Everett expressed appreciation for the public comments, which are useful reminders of the severity of the circumstances faced by those with SMI and their families. She then opened the floor for discussion, particularly regarding suggestions from ISMICC members about moving forward.

Mr. Early asked how ISMICC can help SAMHSA revitalize and reorganize. He noted that efforts of ISMICC waned over time and wants to understand how the ISMICC will function going forward. Dr. Delphin-Rittmon stated she is open to the reconvening of subcommittees around key priorities and areas of interest. Email communication can also keep the conversation open and she hopes that efforts will expand beyond two meetings per year. Mr. Early expressed his excitement and appreciation for Dr. Delphin-Rittmon's reply.

Dr. Warburton also looks forward to increased involvement, stating that her reality echoes that of the public comments and the reality of those with SMI being caught up in the judicial system. She urges ISMICC to focus on the incarcerated population and diverting from jail. Dr. Delphin-

Rittmon noted that this focus would be well addressed in a sub-committee. Dr. Warburton volunteered to chair that subcommittee. Judge Rhathelia Stroud, presiding over a misdemeanor mental health court, noted the work of the GAINS (Gather, Assess, Integrate, Network, and Stimulate) Center with drug courts. She concurs that early intervention is crucial to improving the lives of those with SMI and would like to collaborate on the topic.

Dr. Everett invited discussion on whether the ISMICC should be reauthorized. Ron Bruno stated that non-federal members created the recommendations and that is where the collaboration ended. He hopes that in the future, they are better utilized and called upon for input about specific programs. Mr. Early added that even with the best of intentions, other federal agencies cannot be forced to implement the recommendations. He believes that relationships must be developed, and everyone needs the opportunity to collaborate. Dr. Delphin-Rittmon stated that relationships are quickly growing, and the time is ripe to advance key recommendations.

Dr. Everett stated that internally the original five focus areas are being considered. She then invited discussion on prioritizing a subcommittee on children. Ms. Higgins noted that some CCBHCs opt not to treat people 18 years of age and under. Mr. DeVoursney stated that CCBHCs are supposed to serve anyone regardless of ability to pay without any age restriction and will follow up with Ms. Higgins for further discussion.

Ms. Higgins found that the technical assistance of the Primary and Behavioral Health Care Integration (PBHCI) grant program offered through SAMHSA and its national partnership with the National Council on Behavioral Health to be very helpful. Dr. Everett explained that the program is an integrated care model where mental health needs are met in a healthcare setting.

Regarding recovery and resilience, Joanna Kandel stated that there is the belief that recovery from eating disorders is not possible and that shame and stigma perpetuate this notion. She pointed to the disparity of how people with a mental illness or disorder are treated compared with how people with medical issues are treated. She suggests that campaigns be developed to combat themes of no recovery and no hope. Dr. Delphin-Rittmon hopes to expand the efforts of the recovery movement especially through stories and by sharing recovery models across fields.

Dr. Everett closed out the discussion expressing appreciation for the meeting and excitement over the revitalization of ISMICC.

Final Comments/Adjourn

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

Dr. Delphin-Rittmon looks forward to the remaining three years of ISMICC and being part of the process now and in the future. She supports the idea of having a SAMHSA point person for subcommittees and noted the dynamic collaboration subcommittees can offer that will propel community health, funding, policy, and implementation of services.

Ms. Foote adjourned the meeting.