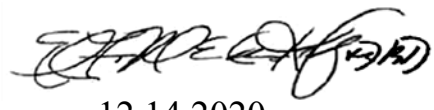
U.S. Department of Health and Human Services

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

September 29, 2020, 1:00 p.m. to 4:35 p.m. (Eastern Time Zone)
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Pavilions A and B, Rockville, Maryland 20857



12.14.2020

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Call to Order/Committee Roll Call

Pamela Foote, Designated Federal Official, Interdepartmental Serious Mental Illness Coordinating Committee

The meeting of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) was called to order at 1:30 p.m. and a quorum was established.

Federal ISMICC Members or Designees Present

- Elinore F. McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Use and Mental Health Services Administration (SAMHSA)
- Tracy Trautman, M.P.A., Acting Director, Bureau of Justice Assistance, Office of Justice Programs, Department of Justice (DoJ)
- Sandy Resnick, Ph.D., Deputy Director, Northeast Program Evaluation Center (NEPEC), Office of Mental Health and Suicide Prevention, Veterans Affairs Central Office
- Chad Bradford, CAPT, USN, MC, Director, Mental Health Policy and Oversite, Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs, Department of Defense (DoD)
- Laurie VanderPloeg, M.Ed., Director, Office of Special Education Programs (OSEP), Office of Special Education and Rehabilitative Services (OSERS), Department of Education
- Jennifer Sheehy, M.B.A., Deputy Assistant Secretary, Office of Disability Employment Policy (ODEP), Department of Labor (DOL)
- Kimberly Brandt, JD, M.A., Principal Deputy Administrator for Operations, Centers for Medicare and Medicaid Services (CMS)
- Joyce Nicholas, Social Science Research Analyst, Office of Retirement and Disability Policy, Social Security Administration (SSA)

Federal ISMICC Members Not Present

- Department of Housing and Urban Development

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., Chief Executive Officer, Hope Restored Suicide Prevention Project
- Ron Bruno, Founding Board Member and 2nd Vice President, CIT International
- David Covington, CEO/President, RI International
- Pete Earley, Author
- Dainery Fuentes, Ph.D., School Psychologist, Polk County School Board

- Brian Hepburn, M.D., Executive Director, National Association of State Mental Health Program Directors
- Jennifer Higgins, Ph.D., CCRP, Owner, CommonWealth GrantWorks
- Johanna Kandel, B.A., Founder and Chief Executive Officer, Alliance for Eating Disorders Awareness
- Steven Leifman, J.D., Associate Administrative Judge, Miami-Dade County Court, Eleventh Judicial Circuit of Florida
- Adrienne Lightfoot, Peer Program Coordinator, DC Department of Behavioral Health
- Amanda Lipp, B.S., Director and Filmmaker, Lipp Studios
- Winola Sprague, DNP, CNS-BC, Medical Director, Children's Advantage
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court
- Katherine Warburton, DO, Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals

Welcome/Consideration of Minutes
Elinore F. McCance-Katz, M.D., Ph.D., ISMICC Chair and Assistant Secretary for Mental Health and Substance Use

Ms. Foote submitted the minutes from the December 10, 2019, ISMICC meeting for consideration. A motion to accept the minutes was made by Rhathelia Stroud and seconded by Ron Bruno. The minutes were accepted.

Dr. Elinore McCance-Katz thanked members for attending the meeting and noted that there are several new members on the committee. She invited the members to introduce themselves.

ISMICC Overview
Deepa Avula, MPH, Chief of Staff and Director, Office of Financial Resources, SAMHSA

The ISMICC was authorized by the 21st Century Cures Act and the members represent different perspectives as required by the statute. The law designed ISMICC to be one group, composed of federal and non-federal members. Non-federal members bring information on what they see in the field or what they want considered in planning. Direction and authority come from Congress and the President and activities are funded by Congress through the Appropriations Committee. ISMICC activities are limited to what is included in the statute.

The meeting agenda was designed for all of the members to be able to provide input that SAMHSA can take into account when planning and developing products and activities.

Current National Landscape
Elinore F. McCance-Katz, M.D., Ph.D., ISMICC Chair and Assistant Secretary for Mental Health and Substance Use

SAMHSA's primary focus for the past seven months has been COVID-19 and behavioral health issues. Data from the 2019 National Survey on Drug Use and Health (NSDUH) were recently released. The results indicate 21 percent or 51.5 million Americans met the diagnostic criteria for a mental illness and 25 percent of those individuals have serious mental illness (SMI). Looking at substance use disorders (SUD), 7.7 percent, over 19 million Americans met diagnostic criteria for a SUD. Of those, 73 percent have alcohol use disorders, 39 percent have illicit drug use disorders, and 11.5 percent have both alcohol and an illicit drug use disorder. A total of 9.5 million people—3.8 percent of adults 18 and older—have a co-occurring disorder, the co-occurrence of mental and SUD.

In 2019 a total of 61.2 million Americans have a mental or SUD, which is a 5 percent increase from 2018. COVID-19 has changed the lives of Americans that have never been seen before, from social distancing, quarantining, forced isolation, unemployment, children out of school, parents home schooling children and lack of social support, which has negatively impacted the mental health of Americans. There is a whole literature that describes the effects of social isolation and forced quarantine. We see increases in mental illness and SUD and relapse for many people who were living in recovery from their SUD. People who make the decisions about how people live their lives generally have not been subject to those same decisions and, therefore, may not appreciate how the lockdowns have affected people.

Of the 61.2 million Americans with mental and SUD, only 10 percent receive treatment for SUDs and only 55 percent receive treatment for mental disorders. Thirty-four percent of individuals with SMI receive no treatment. Before the COVID-19 pandemic, more than 180,000 Americans died each year from drug overdoses, alcohol-associated deaths, and suicides, and it is known that substance use increases the risk for suicide.

Public opinion research indicates that people are very anxious about becoming infected or a loved one becoming infected with COVID-19. While the number of COVID-19 related deaths is tragic, millions of Americans have recovered. Dr. McCance-Katz is very concerned about the mental health impact of COVID-19 and the troubling statistics. For example, there has been a tenfold increase in the use of the Disaster Distress Helpline. All 50 states are applying for Crisis Counseling Program funds that SAMHSA administers for the Federal Emergency Management Agency (FEMA). We have also seen increased calls to suicide prevention lines and calls related to domestic and child abuse.

State health officials report a lack of services and providers because of the restrictions put in place. A large number of psychiatric units have been turned into COVID units and outpatient programs having difficulty reopening due to social distancing guidance. The Centers for Disease Control and Prevention (CDC) reports that emergency department (ED) visits for suicide attempts were higher in March and April when we had the stay at home order, relative to the same months in 2019. This is important because people feared going to the ED due to COVID;

suicide attempts resulting in an ED visit must have been very lethal attempts. As lockdowns were lifted in May and June, the proportion of ED visits for suicide attempts also went down.

Other research from CDC examined the adverse effects of COVID-19 on mental health. Forty-one percent of people answering an online survey said they had either anxiety, depression, or substance use issues. High rates of suicidality were seen, particularly in young adults 18 to 24 years old and among Hispanic Americans and African Americans.

When the COVID-19 public health crisis began in February, SAMHSA developed a four-point plan to address the needs of the public, those who have SMI and SUDs, practitioners and health care organizations, and a big focus on communication to get information out to the public and practitioners. SAMHSA has a website https://www.samhsa.gov/coronavirus, which provides information on issues related to service delivery and other pandemic considerations.

SAMHSA activities to address the pandemic include:

- Provided information to the general public, including Tips for Social Distancing.
- Worked with FEMA to get Crisis Counseling Programs in place.
- Increased resources to the Disaster Distress Helpline, Suicide Prevention Lifeline, and National Helpline.
- Increased use of telehealth and telemedicine, including use of telephone-based telemedicine since many households do not have internet access.
- Implemented a national training and technical assistance program on telehealth through the technology transfer centers. More than 300,000 people have participated in these trainings.
- Worked with the Office of Civil Rights to allow non-HIPAA-compliant resources for telemedicine.
- Partnered with the Federal Communications Commission to inform the public about extended cell phone minutes for those with SMI who may need telephone-based mental health services.
- Worked with the Drug Enforcement Administration to increase the availability of take-home medications (mainly in the form of methadone) for opioid treatment programs.
- Relaxed certain medication pickup and delivery, including flexibilities around prescribing and dispensing opioid therapies.
- The use of telehealth for opioid use disorder visits.
- Expanded the clinical role of mid-level practitioners such as nurse practitioners and physician assistants to address the shortage of physicians. Released guidance on alcohol withdrawal and made information available to recovery groups on setting up online meetings using no-cost resources.

Dr. McCance-Katz expressed her concerns about the survival of the mental health system. Data provided by the National Council indicates 93 percent of behavioral health organizations have

reduced their operations; 62 percent have closed their programs; 83 percent did not have enough personal protective equipment to last for 2 months; and 62 percent said they did not have financial resources to last 3 months. SAMHSA has worked hard to make it possible for behavioral health providers to participate in the Provider Relief Fund, but a lack of space to deliver services has made it difficult for many facilities to reopen.

SAMHSA received $425 million through the Coronavirus Aid, Relief, and Economic Security (CARES) Act. This funding has been used to expand the Certified Community Behavioral Health Clinic program by $250 million. These facilities provide integrated mental health, SUD, and general medical care, as well as 24/7 crisis intervention services. SAMHSA also provided $110 million to states to address their COVID issues related to individuals living with mental and SUD. This program included a set aside for health care providers who may be experiencing mental health issues related to working with patients stricken by the virus. Increased funding was provided to the Suicide Prevention Lifeline, Zero Suicide Programs, and community-based suicide prevention services. An additional $15 million was made available for tribal needs.

Moving forward, SAMHSA must continue communications with states and stakeholders and is reviewing the flexibilities put in place to determine what should be kept. SAMHSA is interested in committee members' thoughts on these issues. The agency is advocating to keep telemedicine and telehealth in place, while still reopening facilities. SAMHSA also wants to continue expansion of technical assistance and training to behavioral health providers. Other SAMHSA priorities include the growing stimulant problem, children's mental health and school-based services, establishment of 988 as the nationwide number for mental health crises, expansion of zero suicide programs, working with the VA on the PREVENTS effort, crisis intervention services, assertive community treatment and assisted outpatient treatment, a new psychiatric advanced directive app, and increasing the number of behavioral health providers.

Dr. McCance-Katz highlighted that mental health block grant funds can be used within jails and prisons, when services are delivered by community providers while people are incarcerated.

Discussion

Dr. McCance-Katz invited comments and questions on her presentation.

One point of discussion was around a possible link between major pandemics and schizophrenia. Dr. McCance-Katz has not seen literature on this possible link but would not be surprised. Schizophrenia is a neurobiological-based disorder with a strong genetic component. People who are vulnerable might express the illness under the circumstances of a pandemic. SAMHSA is not a research organization although we do collect data on SMI from NSDUH and we will be watching those numbers.

There was a comment about the new 988-crisis number and whether it will be framed as a crisis line. The new number is to be rolled out over the next two years and the rollout plan is not

ready, but is meant to be mainly for suicide prevention; and it would not be surprising to see it used for other types of emergencies such as mental health crises. The number will need to be monitored to see the types of resources needed to address the types of calls it receives.

Also discussed was the question of how SAMHSA can become involved in developing partnerships between behavioral health professionals and law enforcement. SAMHSA does have a diversion program with a number of grantees that have co-response agreements with law enforcement. It is important that people with mental health crises get care and treatment from those who understand the issues. That is why SAMHSA is advocating for crisis services and Certified Community Behavioral Health Clinics, with a goal of reducing the involvement of law enforcement in mental health crisis intervention.

Crisis Systems Overview and Discussion
David Covington, LPC, MBA, CEO and President, RI International

One of the recommendations in the original 2017 ISMICC report was a set of national standards to guide crisis services and provide the opportunity to scale these approaches. The recent publication of the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit supports this goal.

There is a well-established emergency response system for medical health needs, with cost-efficient, standardized care. On the other hand, there is no nationwide set of standards for behavioral health crises; thus, the level of care can vary widely. Around 20,000 to 25,000 emergency department visits per day are for mental health, substance use, or suicidal crises. Care is fragmented and law enforcement is involved with many cases. The dependence on emergency departments to provide behavioral health evaluations is not appropriate, safe, or efficient.

The situation with behavioral health today is similar to how emergency medical care used to be. There were different telephone numbers for fire, police, and ambulance and these varied according to location. When the 911 system was introduced, it led the way to specialized responses for specific needs based on the level of intensity.

Full statewide systems to handle behavioral health crises began to be implemented starting in 2005. In 2016, the Action Alliance laid down a set of three fundamental components in the Crisis Now report and the National Association of State Mental Health Program Directors (NASMHPD) began the first of four years of Beyond Beds series on the importance of a crisis continuum. The recent National Guidelines provide the roadmap for scaling these approaches.

The SAMHSA guidelines lay out recommendations in three areas:

1. Immediate emergency response with enhanced service delivery
2. Specific national crisis billing codes to properly describe expectations

3. Adequate reimbursement for services delivered

The LOCUS (Level of Care Utilization System) model provides a framework for clinical staff to determine what specific level of service a person in crisis needs, including level of intensity and duration of services. Most communities are set-up that either a person needs the highest-level intensity of services, psychiatric inpatient or they do not and can get by with outpatient services, follow-up, or an appointment with their psychiatrist or clinician.

While around 82 percent of cases fall into the middle range of the spectrum, communities tend to be set up to treat individuals as if they were at the ends of the spectrum such that a person is considered to need either the highest level of intensity or the lowest. This means that people in the middle range, who could be treated at a lower level of intensity, are competing for limited psychiatric inpatient capability.

About 10 percent of police activity is related to mental health, substance use, and suicidal crisis, and these contacts for law enforcement take twice as long as the average. Law enforcement is looked to for transportation and attending in hospital EDs, which is challenging for law enforcement, hospitals, and individuals in crisis.

In addition, virtually everyone in crisis is shuttled through hospitals in the U.S., and individuals may spend up to 40 hours waiting time. The cost connected to all of these visits is more than $2,000 per person. Only a subset of those going to EDs will be able to receive specialized crisis services and many facilities end up screening out most of the individuals in need.

The new SAMHSA guidelines are about "anyone, anytime, anywhere." Crisis services should follow the law enforcement model where there is a core mission for law enforcement at every level of triage. Three elements are required by this process: 1) someone to talk to, 2) someone to come to you, 3) and someplace to go. Mr. Covington used the Crisis Call Hub, a community-based mobile crisis and 23-hour urgent crisis model, as an example of the fundamental building blocks of such a system. In this system (using Phoenix, AZ as the specific example), 90 percent of cases are resolved by the Call Hub and the individual turned back to natural supports in the community. Around 10 percent require a face-to-face evaluation, with about 25 percent of those cases needing to go to a facility. This system takes what seems to be an extraordinarily complex and overwhelming situation and makes it much easier. It is more cost efficient and effective and provides the level of service people need at the moment. A full implementation of this system should yield a 50 percent savings over the traditional model.

Currently, the National Suicide Prevention Lifeline receives about 3 million calls per year with about 13 million calls going to local and state crisis lines. Around 10 percent of the 240-250 million annual 911 calls are related to mental health, substance use, and suicide. It is hoped that the vast majority of these will go to the new 988-crisis line. Mr. Covington concluded by noting that the SAMHSA guidelines are achieving enormous momentum, including in places such as Los Angeles County, Virginia, and Arizona.

Discussion

Dr. McCance-Katz invited questions or comments on the presentation.

There was a comment on how many seriously mentally ill individuals do not believe they need psychiatric help. How would this system deal with people who do not wish to participate? The Arizona system, which informed much of the development of the new SAMHSA guidelines, still involves law enforcement that delivers people to programs, where individuals may stay involuntarily for a time.

A question was asked about availability of naloxone in ambulances in rural communities and whether this was included in any of the best practices toolkits. Dr. McCance-Katz explained that the Crisis Intervention Services have generally focused on the needs of people with serious mental disorders. SAMHSA has a large program that focuses on training and technical assistance to providers and communities on how to recognize opioid overdose and what to do should a person experience an overdose. There are also programs that provide funding to purchase naloxone. States are receiving funds to address the opioid crisis and these funds can be used for the purpose of addressing opioid overdose and administration of naloxone. Mr. Covington also noted that provider organizations delivering both mobile crisis services and crisis facilities are integrating across mental health and substance use including Medication-assisted Treatment and office-based opioid treatment and mobile crisis services. Georgia is the first state to have statewide mobile crisis services in all counties responding to children, adults, mental health, and substance use.

There was a comment about the differences in levels of care from state to state. It should be more consistent across the country. There is also an issue that accountability diversion through the court system means that people may only get help after committing a crime. Dr. McCance-Katz noted that SAMHSA depends on committee members to bring information to the meetings and also to push information and recommendations from SAMHSA out to their communities.

Lastly, a committee member asked whether there was training available regarding different types of mental health crises. It is a major focus of SAMHSA to make these kinds of training and technical assistance resources available to practitioners and peers and to members of the public. For this area of crisis services, NASMHPD has been key in reaching out across the nation to make training on best practices available. SAMHSA also provides no-cost training and technical assistance through an extensive network of providers. Programs are available on substance abuse prevention, addiction, and mental health.

ISMICC Members' Input on Evidence-based Practice Guidebook on Serious Mental Illness
Thomas Clarke, Ph.D., MPH, Director, Policy Laboratory, SAMHSA

Dr. Clarke provided an overview of the activities of SAMHSA's Policy Laboratory. The Policy Lab is focused on evidence-based practices. According to the Cures Act, the Policy Lab is to

provide leadership in identifying and coordinating policies and programs, including evidence-based programs related to mental and SUD. It also has a role in identifying, coordinating, and facilitating the implementation of policy changes likely to have a significant effect on mental health, mental illness, recovery supports, and the prevention and treatment of SUDs.

In 2018, the Policy Lab established the Evidence-Based Practices Resource Center, a repository of evidence-based practices (EBPs) focused on prevention, treatment, recovery, and mental health. The guidebooks in the repository are focused on practical implementation and cost effectiveness. It is the intention of the Policy Lab to release information that is feasible for communities to implement and has at least moderate but hopefully a significant body of evidence that supports it.

The resource center is populated in two ways. The first is by a committee of staff across SAMHSA that regularly meets with the Policy Lab to talk about existing EBPs that should be included. Other federal agencies are also consulted in this process. The second is the development of guidebooks, which follow a specific structure—first a statement of the problem, followed by the state of the science and epidemiology, recommended EBPs, guidance for selection and implement of EBPs, and finally how you would evaluate and monitor the implementation of the EBPs.

In 2019, SAMHSA released four guidebooks, marijuana prevention among pregnant women, co-occurring disorders, substance use prevention among emerging adults, and medication for opioid use disorders in criminal justice settings. For 2020, guidebooks on the following topics have been released or are planned to be released: stimulant use disorder, HIV (prevention, treatment, and mental health), vaping, serious emotional disturbance, and suicide. Guidebook topics proposed for 2021 include SMI, telehealth, poly-drug use, marijuana prevention among adolescents, and mental health promotion in school-based settings. SAMHSA would like input from the ISMICC on the SMI guidebook, specifically, what priorities should be covered in an EBP guidebook focused on SMI.

Several members provided input on what should be covered in the proposed guidebook. They include:

- Stigma and how it affects families, how to work with patients who have very serious mental disorders, psychotic disorders and how to talk to them about their diagnosis and ongoing care.
- Appropriate orientation for newly diagnosed patients, including addressing expectations and providing patient education.
- Ruling out SUD when diagnosing SMIs. There are instances when patients are diagnosed as having a psychotic disorder when they really have an SUD.
- Correctly diagnosing older individuals with SMI versus a drug interaction or other cause.
- EBPs with regard to HIPAA.

- The issue of suicide among individuals with SMI.
- Legal issues related to behavioral health, such as the question of self-directed treatment versus guardianship.
- Care coordination and integrated services.
- Modernization of civil commitment laws and criminal statutes related to SMI.
- Helping individuals retain a belief in their ability to recover.

Updates from Federal Members

Department of Justice
Tracy Trautman, M.P.A.

DOJ is wrapping up its grant year. One program of interest is the Justice and Mental Health Collaboration Program, which embeds clinicians into law enforcement agencies to assist with calls and provides technical assistance. The program also provides operating expenses for projects that assist individuals with severe mental health needs who are at risk of recidivism. The department continues to have well-funded programs in the Second Chance Act Reentry Programs as well as de-escalation training.

Department of Veterans Affairs
Sandra Resnick, Ph.D.

The Office of Mental Health and Suicide Prevention at VA took swift action to organize and streamline the flow of COVID-19 related communications to mental health providers. Within weeks, VA revised operations and policy to transition to telehealth. Activities included helping facilities and providers pivot from in-person, face-to-face care. Pre-COVID-19, about 85 percent of mental health services were provided face to face; post-COVID-19, about 80 percent are provided virtually. VA disseminated clear national guidance and training, including the Measurement-based Care in Mental Health Initiative, supporting clinicians in doing remote assessments and remote monitoring using brief, patient-reported outcome measures.

Department of Labor
Jennifer Sheehy, M.B.A.

DOL considers employment to be a recovery strategy. It worked to redirect funding during the pandemic after it became clear what a big impact COVID-19 would have on employment. DOL also has a demonstration grant program called the Retaining Employment and Talent After Injury/Illness Network (RETAIN). The purpose of the program is to provide early coordinated intervention strategies to people who experience illness or injuries while working. A large percentage of these individuals are experiencing mental health issues. The selected states will enroll thousands of workers who need early intervention services.

Centers for Medicare and Medicaid Services
Kimberly Brandt, MA, JD

Beginning in March, CMS began expanding access to telehealth services for Medicare beneficiaries. All Medicare beneficiaries can now access mental health preventative screening without having to go to a doctor's office or hospital. In addition, a mental health visit and a medical visit can now be reported on the same day for the duration of the public health emergency. Under Medicaid, states have the authority to implement telehealth reimbursement policies. CMS released a telehealth toolkit in April, including adoption of broader telehealth coverage policies in Medicaid and the Children's Health Insurance Program (CHIP). With regard to Medicaid and CHIP, CMS released guidance under Section 5022 of the SUPPORT Act (requiring that child health and pregnancy-related assistance include coverage of mental health services) to help provide enforcement oversight for Medicaid compliance. CMS has also approved more than 28 Medicaid Section 1115 demonstrations to improve access to SUD treatment, including new flexibility to cover inpatient residential treatment.

Department of Defense
Chad Bradford, CAPT, USN, MC

DoD has been working on mental health issues and COVID-19, including the increased risk of suicides. In addition, it has been updating some DoD instructions to target mental health stigma and examining changing its opioid safety training protocol.

Department of Education
Laurie VanderPloeg

ED has implemented an intra-agency workgroup around the opioid crisis and substance abuse, working across different departments within ED on developing and disseminating resources focusing on families, infants, and toddlers and also for school-aged children and support for staff and teachers. The department also issued a notice inviting applicants for the School-based Mental Health Services Grant Program. This program provides competitive grants to state educational agencies to increase the number of qualified mental health service providers providing school-based services. There is interest in developing additional resources around mental health-related issues in light of the COVID-19 public health emergency. Some of ED's technical assistance centers are emphasizing development of these resources.

Bureau of Prisons
Allison Leukefeld

As part of the First Step Act, the Bureau of Prisons is working to standardize its EBPs to ensure good fidelity and that the services are the best they can be for inmates across the U.S. In addition, it is frontloading assessments to determine the types of services needed by inmates. Also, the bureau has several new positions to treat inmates with SMI and trauma.

Public Comment
No public comments were received.

Adjournment
There being no further comments or questions, the meeting was adjourned at 4:22 p.m.

Appendix A: Meeting Agenda

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE (ISMICC)
FULL COMMITTEE MEETING

September 29, 2020
1:00 p.m. to 4:35 p.m. (Eastern Time)

Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Pavilions A and B
Rockville, Maryland 20857

Toll Free Number: 877-950-3592; Passcode: 4987834

AGENDA

OPEN SESSION

1:00 p.m. **Call to Order, Committee Roll Call, and Consideration of Minutes**

Pamela Foote, Designated Federal Official, ISMICC

1:10 p.m. **Welcome and Introductions**

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

1:30 p.m. **Current National Landscape**

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

2:30 p.m. **BREAK**

2:45 p.m. **Crisis Systems Overview and Discussion**

David Covington, LPC, MBA, CEO and President, RI International

3:15 p.m. **ISMICC Members Input on Evidence-based Practice Guidebook on Serious Mental Illness**

Thomas Clarke, Ph.D., Director, National Mental Health and Substance Use Policy Laboratory, SAMHSA

4:00 p.m. **Updates from Federal Members**

4:25 p.m. **Public Comment**

4:35 p.m. **Adjourn**

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

Appendix B: Official List of Meeting Participants

Trinidad de Jesus Arguello, Ph.D., LCSW, PMHRN-BC, Director, Compostela Community and Family Cultural Institute

Deepa Avula, M.P.H., Chief of Staff and Director, Office of Financial Resources, SAMHSA

Chad Bradford, CAPT, USN, MC, Department of Defense

Kimberly Brandt, JD, M.A., Centers for Medicare and Medicaid Services

Leola Brooks, Social Security Administration

Yasmine Brown, M.S., Chief Executive Officer, Hope Restored Suicide Prevention Project

Ron Bruno, Founding Board Member and 2nd Vice President, CIT International

Thomas Clarke, Ph.D., National Mental Health and Substance Use Policy Laboratory, SAMHSA

David Covington, CEO/President, RI International

Pete Earley, Author

Pamela Foote, ISMICC Designated Federal Official, SAMHSA

Dainery Fuentes, Ph.D., School Psychologist, Polk County School Board

Neeraj Gandotra, M.D., Chief Medical Officer, SAMHSA

Brian Hepburn, M.D., Executive Director, National Association of State Mental Health Program Directors

Jennifer Higgins, Ph.D., CCRP, Owner, CommonWealth GrantWorks

Johanna Kandel, B.A., Founder and Chief Executive Officer, Alliance for Eating Disorders Awareness

Steven Leifman, J.D., Associate Administrative Judge, Miami-Dade County Court, Eleventh Judicial Circuit of Florida

Allison Leukefeld, Bureau of Prisons

Adrienne Lightfoot, Peer Program Coordinator, DC Department of Behavioral Health

Amanda Lipp, B.S., Director and Filmmaker, Lipp Studios

Matt Litton, Department of Labor

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

Joyce Nicholas, Social Security Administration

Sandra Resnick, Ph.D., Department of Veterans Affairs

Jennifer Sheehy, M.B.A., Department of Labor

Winola Sprague, DNP, CNS-BC, Medical Director, Children's Advantage

Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court

Tracy Trautman, M.P.A., Department of Justice

Laurie VanderPloeg, Department of Education

Katherine Warburton, DO, Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals