

# **U.S. Department of Health and Human Services**

## ***Minutes of the Interdepartmental Serious Mental Illness Coordinating Committee Sixth Full Committee Meeting***

December 10, 2019 9:30 a.m. to 2:20 p.m. (Eastern Time Zone)  
Substance Abuse and Mental Health Services Administration  
5600 Fishers Lane, Pavilions A and B, Rockville, Maryland 20857

## Table of Contents

Call to Order/Committee Roll Call.....	1
Opening Remarks.....	2
Welcome/Consideration of Minutes .....	2
Report Outs by Focus Area.....	2
Focus Area 1: Data.....	2
Focus Area 2: Access and Engagement .....	4
Focus Area 3: Treatment and Recovery.....	7
Focus Area 4: Criminal and Juvenile Justice .....	9
Focus Area 5: Finance .....	11
Public Comments .....	13
President’s Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS).....	13
Pediatric Behavioral Health: Highlights of Cross-Federal Work .....	15
Department of Defense .....	15
Department of Labor.....	16
Department of Veterans Affairs.....	17
Substance Abuse and Mental Health Services Administration.....	17
Centers for Medicare and Medicaid Services .....	19
Final Comments .....	20
Appendix A: Meeting Agenda.....	22
Appendix B: Official List of Meeting Participants.....	24
Appendix C: Official List of Public Comments .....	26
Appendix D: Edits submitted by the VA on Meeting Minutes from July 2, 2019.....	30

## **Call to Order/Committee Roll Call**

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

The meeting of the Interdepartmental Serious Mental Illness Coordinating Committee was called to order at 9:30 a.m. and 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 Abuse 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 (VACO), Department of Veterans Affairs (VA)
- Chad Bradford, CAPT, USN, MC, Director, Mental Health Policy and Oversight, Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs, Department of Defense (DoD)
- Paul Dans, J.D., Senior Advisor, Office of Community Planning and Development, Department of Housing and Urban Development (HUD)
- Jennifer Tschantz, Early Learning Program Specialist, Secretary for the Department of Education (ED)
- Jennifer Sheehy, M.B.A., Deputy Assistant Secretary of the Office of Disability Employment Policy (ODEP) for the Secretary of the Department of Labor (DOL)
- Kim Brandt, J.D., M.A., Principal Deputy Administrator for Operations, Centers for Medicare and Medicaid Services (CMS)

## **Federal ISMICC Members Not Present**

- Commissioner of the Social Security Administration

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

- Linda Beeber, Ph.D., PMHCNS, FAAN, Distinguished Professor, University of North Carolina-Chapel Hill, School of Nursing
- Ron Bruno, Founding Board Member and Second Vice President, Crisis Intervention Team (CIT) International
- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Providence St. Joseph Health
- David Covington, LPC, M.B.A., CEO and President, Recovery Innovations (RI) International

- Maryann Davis, Ph.D., Director and Research Associate Professor, Department of Psychiatry, University of Massachusetts Medical School
- Pete Earley, Author
- Paul Emrich, Ph.D., Under Secretary, Family and Mental Health Services, Chickasaw Nation
- Mary Giliberti, J.D., Executive Vice President of Policy, Mental Health America
- Elena Kravitz, CPRP, Senior Staff Advocate, Disability Rights New Jersey
- Kenneth Minkoff, M.D., Senior Consultant, ZiaPartners
- Elyn Saks, J.D., Ph.D., Professor of Law, University of Southern California School of Law
- John Snook, J.D., Executive Director, Treatment Advocacy Center
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Misdemeanor Mental Health Court, DeKalb County Magistrate Court
- Conni Wells, Owner/Manager, Axis Group, LLC

### **Opening Remarks**

*Arlin Hatch, CAPT, USPHS, Ph.D., ISMICC Coordinator and Senior Psychologist/Clinical Advisor, Center for Substance Abuse Prevention (CSAP)*

Dr. Arlin Hatch greeted participants and shared his appreciation of the work being done by ISMICC. He announced that the focus area work groups would report on their work during the meeting.

### **Welcome/Consideration of Minutes**

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

Dr. Elinore McCance-Katz welcomed members and submitted the minutes from the July 2, 2019, ISMICC meeting for consideration. A motion to accept the minutes was made by Kim Brandt and seconded, and the minutes were accepted. Edits submitted by the VA will be incorporated into the official minutes as an amendment (see page 30).

### **Report Outs by Focus Area**

#### **Focus Area 1: Data**

*Brooklyn Lupari, M.S., Statistician, Center for Behavioral Health Statistics and Quality*

The Data Workgroup is continually working to improve data collections and use them in a meaningful way. One example is the 2018 National Survey on Drug Use and Health (NSDUH). The data indicate that there are large treatment gaps among those in the public with serious mental illness (SMI), those with co-occurring any mental illness (AMI) and substance use

disorder (SUD), and youth aged 12 to 17 with a major depressive episode. The National Center for Health Statistics collects vast amounts of data with the mission to guide actions and policies to improve Americans' health. Data sources related to mental health include the Hospital Care Survey, National Vital Statistics Survey, National Health and Nutrition Examination Survey, and National Death Index. The National Death Index is a database of death record information including ICD-10 codes. The 2018 early release file is available and the final file is anticipated to be released in January 2020. Although the Social Security Administration (SSA) does not specifically collect behavioral health data, it collects information on diagnoses through claims. The SSA workgroup member briefed the rest of the workgroup on how diagnoses are captured and provided caveats on the data. The briefing included information on data collection improvements being explored by SSA, such as technological advancements to look at images of medical data more efficiently.

The VA workgroup member is continuing to look at suicide data and briefed the workgroup on the PREVENTS executive order. The workgroup plans to reach out to the stewards of PREVENTS to explore common interests and possibly collaborate on initiatives.

The Agency for Health Research and Quality (AHRQ) collects data through its Healthcare Cost and Utilization Project (HCUP). HCUP captures hospital care data including discharge data from states and nearly 100 percent of short-term stays at psychiatric hospitals. AHRQ is currently working to receive information from emergency department and outpatient department visits.

Additionally, AHRQ has received approval from the Office of Management and Budget to add mental health content to the Medical Expenditures Panel Survey (MEPS); data collection will begin in 2020. In addition to the data already collected on prescription drug use, health care encounters, and several mental health status skills, data will now be collected on drug and alcohol use, use of different types of mental health treatment and support services, consumers' assessments of treatment, and barriers to treatment. AHRQ solicited the help of SAMHSA staff who work on the NSDUH when developing the additional mental health content for MEPS.

The SAMHSA Performance, Accountability, and Reporting System (SPARS) has been collecting ICD-10 codes since March 2019. In addition, SAMHSA recently funded the Mental Disorder and Substance Use Prevalence Study (MDPS), a three-year cooperative agreement. One of the study goals is to determine the prevalence of severe mental disorders such as schizophrenia, bipolar disorder, and psychotic disorders among U.S. adults. It includes non-household populations such as people who are incarcerated, in psychiatric institutions, and who are homeless.

Various interagency groups have helped improve cross-federal collaboration and coordination. The Health and Human Services (HHS) Data Council coordinates and disseminates information related to data policy and privacy issues. The council's Disclosure Risk Subcommittee has

begun an environmental scan of how agencies are assessing disclosure risk when determining whether to make data publicly available. The Confidentiality Data Access Committee is collaborating with Data Council members on matters related to disclosure to ensure they are not duplicating efforts. The Data Inventory Subcommittee recently completed an initial inventory of HHS data, which is the beginning of a comprehensive inventory of federal activities.

In addition to improved data sharing and collaboration, the workgroup also began discussion of youth-related data. Many current data sets include youth-related measures; however, there are still barriers to collecting it. The workgroup is brainstorming potential solutions and ideas for increased coordination.

### **Focus Area 2: Access and Engagement**

*Richard McKeon, Ph.D., M.P.H., Chief, Suicide Prevention Branch, Center for Mental Health Services (CMHS), and Steven Dettwyler, Ph.D., Public Health Advisor, CMHS*

The federal partners involved in the Access and Engagement Workgroup have made long-term commitments to the group and to the process of developing recommendations and products.

The Department of Education (ED) works with HHS to develop strategies to build capacity within schools to provide services to young people who may be experiencing trauma, mental illness, or other problems. They also promote healthy living among the student bodies. These efforts are immensely important and complement much of SAMHSA's work. ED also provides guidance and training on advanced degree practitioners in behavioral health and assesses workforce development throughout the United States.

ED frequently collaborates with other agencies through its funding, particularly with HRSA. In addition, ED funds evaluations to ensure that its work is actually achieving the associated goals. If programs are not achieving their goals, ED will make adjustments in funding and in the development of funding opportunity announcements.

HUD's requirement that each state have a continuum of care to establish and operate a central assessment system to improve access to housing and health care (including mental health) services coincides strongly with SAMHSA's work. SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) grants fund outreach to people who are homeless and potentially mentally ill to help them access services and the supports they need. HUD's Homeless Management Information Service (HMIS) collects data from all the continuums of care on the homeless population and resources they are provided. SAMHSA uses the same information system through its PATH grant and all grant recipients contribute data. The HMIS data system is essential to policy review and helps steer monitoring and evaluation of current and future funding.

The National Institute of Mental Health (NIMH) devotes enormous resources on research projects that have the goal of helping individuals with behavioral health needs. NIMH's RAISE

study, which examined First Episode Psychosis (FEP), helped influence SAMHSA's work. This study led to the development of community practices for people with FEP, generally known as coordinated specialty care teams. This model was promulgated through and supported by the research.

NIMH also collaborated with SAMHSA and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to conduct a three-year evaluation of the coordinated specialty care FEP that were funded by SAMHSA. There are currently more than 290 FEP programs that are very important to people who need access to services. The amount of time between the emergence of FEP and getting into care is gradually decreasing. Another NIMH-funded program, EPINET (Early Psychosis Intervention Network), collects data on programs providing services to people with FEP to determine their effectiveness and help make decisions on how to direct future funding and future research.

NIMH mandates that researchers collaborate with other federal agencies and the services that people access be improved.

SAMHSA has been engaged in several initiatives that involve significant federal collaboration, such as the movement to establish 988 as the nationwide three-digit National Suicide Prevention number. This initiative arose as part of the National Suicide Hotline Improvement Act, which mandated that SAMHSA, VA, and the Federal Communications Commission (FCC) collaborate. SAMHSA and VA made reports to the FCC that recommended implementing the 988 system, reasoning that a three-digit number would be easier to remember than the current number, 1-800-273-TALK, and would receive more calls.

SAMHSA and the VA concurred with this assessment but also indicated the importance of ensuring adequate capacity to handle the increased number of calls, noting that a three-digit number will only help if all of the calls are answered promptly. The FCC commissioners will be voting on the recommendation to do a Notice of Proposed Rulemaking on December 12, 2019. At that point, there will be an approximately 30-day period to submit comments. The FCC is recommending an 18-month timeline to implement the 988 system, meaning an 18-month period to increase call-center capacity with the National Suicide Prevention Lifeline. This change represents both a tremendous opportunity and challenge; namely, the telecommunications system must be made operational, there must be sufficient personnel to answer the calls, and people need to know that 988 is available.

SAMHSA and the VA are also collaborating on the Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families. In 2020, 28 states will be involved in implementation academies, which are efforts to use a comprehensive approach to preventing veteran suicide using multiple sectors. As part of this initiative, SAMHSA is helping localities using crisis mapping, identify the services they have available and the protocols for veterans' care when they access services in the community.

Regarding youth suicide prevention, data indicate that counties implementing Garrett Lee Smith Youth Suicide Prevention activities had lower youth suicide rates than matched counties that did not. SAMHSA works with several federal partners around youth suicide activities, including engaging with HRSA to help strengthen their youth fatality review system.

## **Discussion**

Dr. Hatch invited questions and discussion on the first two focus group presentations.

One item of discussion was the frequency of focus group meetings. Communications among the focus group members and collaborators are frequent and ongoing, and include conference calls, emails, and site visits. Focus group members work closely with colleagues within HHS and at other federal agencies.

The proposed 988 system was also discussed. Many federal partners will be involved in implementing an effective 988 system. In addition, one of the ISMICC recommendations relates to developing an ideal crisis response system. Now is a good opportunity to begin conceptualizing such a system, possibly building off the example of the HUD continuum of care. It was also noted that the language describing the 988 system frames it as a suicide prevention line but that it is also discussed as a behavioral health crisis line.

The full implementation of the 988 system will likely be a long-term process that may warrant a standing interdepartmental workgroup to look at conceptualizing and implementing the system. ISMICC could also spend time as a group on the issue. There was also concern that the FCC's recommendation that calls to 988 go to the Suicide Prevention Lifeline may not be the best choice because the lifelines are generally disconnected from local behavioral health crisis systems. During the discussion period, Dr. McKeon pointed out that, although the lifeline centers vary in their practices, many of them are closely connected to local mental health systems.

Regarding the comment about 988 system capacity, one of the Access Workgroup's tasks is to examine maximizing the mental health workforce. The workgroup can look at the system as it addresses this recommendation.

The difficulty of recognizing mental health needs in children and connecting those children to treatment was also raised for discussion. Schools are an important lynchpin in this process but cannot do it by themselves. ISMICC could help by thinking about and recommending ways that federal agencies can work together and with other partners to improve services for people with serious mental illness. Dr. Dettwyler agreed that identification of mental illness is incredibly important but that it is only effective if people are connected with the services they need. SAMHSA provides funding through targeted contracts for child mental health. It funds state systems of care with child mental health funds; these are often with states that are working with

school systems and trying to develop linkages. CMHS works with other SAMHSA centers on how the funding and direction are being used to promote child mental health.

There was comment about the Data Workgroup's presentation, noting that the Centers for Disease Control and Prevention's (CDC) Child Health Survey (particularly the Children With Special Health Care Needs Survey) contained a great deal of child mental health data. This data set has been discussed by the Data Workgroup, which is looking at ways to make data visualization more user friendly. One example is the NSDUH, which has excellent data visualization capability. The workgroup is also exploring some technological areas where the code could be made available for others to use the visualization tools with their own data.

One comment was a request for the Data Workgroup to develop a white paper addressing the interdepartmental exchange of data as it relates to HIPAA in 42 CFR Part 2. While there is an issue of time and staff resource availability, the workgroup will discuss the idea at its next meeting. As a rule, the workgroups and committee wish to make as much information available to partners as possible.

### **Focus Area 3: Treatment and Recovery**

*Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS, and Tracie Pogue, M.Div., M.S.W., L.C.S.W., Public Health Analyst, Office of the Chief Medical Officer*

The Treatment and Recovery Workgroup had a productive meeting on December 4 focusing on programs impacting children, adolescents, and youth. Some activities were to be discussed later during the ISMICC meeting so were not covered during this report. Many of the workgroup's activities focused on Recommendation 3.1, provide a comprehensive continuum of care for people with SMI and SED; Recommendation 3.4, make trauma-informed, whole-person health care the expectation in systems of care for people with SMI and SED; and Recommendation 3.5, implement effective systems of care for children, youth, and transition-age youth throughout the nation.

ED reported to the workgroup on the Positive Behavioral Intervention and Supports (PBIS) interconnected services framework to support social wellbeing in schools. The PBIS framework is built on the notion that all students need it and it should be integrated into other mental health support systems. There are PBIS contacts in every state who can provide coaching and support to school systems on the PBIS framework.

Also discussed was the National Center for Pyramid Model Innovations, which is intended to implement a sustainable system to support social and emotional competence in early education programs in children from birth to age five and to integrate early childhood mental health into education.

The Parent Hub, another ED activity, is funded by the Office of Special Education and provides parents and families with resources including mental health supports. The Project Prevent initiative has the goal of reducing the likelihood that students will commit violent acts. The National Technical Assistance Center on Transition helps state education agencies, rehabilitation agencies, and promising practices assist students to be gainfully employed after post-secondary education.

The Department of Labor reported on their activities in supported employment for youth with SED and SMI.

The Centers for Medicare and Medicaid Services (CMS) discussed the Institution for Mental Diseases (IMD) waiver. There is a strong focus on requiring states to describe their entire community continuum of care to achieve federal matching funds.

The VA reported on their collaborative program with DoD to support parents who have experienced trauma and other emotional challenges. The National Child Traumatic Stress Network has been a resource for this program.

Other collaborations include Federal Partners in Transition, a group led by DoL and including representatives from HHS, ED, and SSA to address supported employment and supported education needs of transition-age youth.

SAMHSA has many school mental health initiatives. From the Federal Commission on School Safety, there are a number of SAMHSA/HHS priorities to address school safety as it relates to mental health. Some examples include ongoing training on mental health conditions for school personnel; developing resources, such as the joint CMS-SAMHSA informational bulletin on financing mental health services in schools; increased funding to the TA/TTC centers specifically for school-based mental health; ongoing training in privacy regulations in educational settings through the Center of Excellence for Protected Health Information; and, ongoing support of grant programs such as Project AWARE, which has intended to expand state capacity to provide mental health services in schools. We are also collaborating on a DHS initiative, [schoolsafety.gov](http://schoolsafety.gov), which is federal clearinghouse for school safety. Further, SAMHSA is collaborating with AHRQ and HRSA on a project to provide a guide on screening for suicide risk in pediatric primary care settings.

The Treatment and Recovery Workgroup also discussed potential ideas for future interagency coordination. They include: 1) coordinating ED's efforts to promote the PBIS and Pyramid models with other federal technical assistance efforts; 2) collaborating to connect youth with 504 plans to supported employment opportunities; 3) using the Federal Partners in Transition group as a mechanism to promote supported employment opportunities for youth with SMI and SED; and 4) working across agencies to understand barriers to supported employment and whether supported employment could be more consistently bundled with coordinated specialty care in FEP programs.

Many young people with SED do not have individualized education plans through school. This changes the funding of their services. In addition, vocational rehabilitation systems often connect to special education programs to define students with disabilities as opposed to children who are not in special education programs; many children and youth with SED are not in special education.

With regard to strategies and potential next steps, one workgroup member presented information about ISMICC to the Federation of Families. It might be useful to have some visuals such as a matrix with recommendations and information about federal activities to present at this type of meeting.

#### **Focus Area 4: Criminal and Juvenile Justice**

*Larke Huang, Ph.D., Director, Office of Behavioral Equity and the Justice-Involved, Office of Intergovernmental and External Affairs*

The focus of the Criminal Justice Workgroup is practice change, program innovation, and policy change.

Among the workgroup members, ASPE is currently assembling the stakeholder group required by the SUPPORT Act (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT for Patients and Communities Act). This group will be responsible for gathering best practices to ease the health care-related transition of an individual who is an inmate of a public institution from the public institution to the community, including best practices for ensuring continuity of health insurance coverage or coverage under the state Medicaid plan under title XIX of the Social Security Act and relevant social services ideally within 30 days after release. The SUPPORT Act also stipulates that the list of best practices will form the basis of a report to Congress, which will in turn inform a Section 1115 demonstration developed by CMS. ASPE will be publishing an announcement in the Federal Register to give the public an opportunity to submit comments and nominations or recommendations for group members.

The stakeholder group and best practices report have important implications for people with all types of conditions transitioning out of incarceration. The stakeholder group and Federal Register responses will influence whether people with behavioral health issues are part of the 1115 demonstration. The legislation is written broadly so that there is a wide range of options for the demonstration, including health care coverage for up to 30 days prior to release from incarceration.

The Bureau of Justice Assistance (BJA) Justice and Mental Health Collaboration Program, recently reauthorized, has reached almost 500 jurisdictions in the United States including state, local, and tribal governments. In FY2019, BJA awarded funds to almost 50 grantees in three categories. Category 1 focuses on countywide collaborative efforts to improve a comprehensive response to people with mental illness in the justice system. Category 2 looks at the interaction

of law enforcement and people with mental illness, including how local law enforcement and mental health authorities collaborate. Awards made under Category 3 may fund projects from anywhere in the criminal justice system where that system interacts with people with mental illness.

BJA is also updating the Police Mental Health Collaboration Toolkit, an online toolkit that provides information and resources on operational police/mental health collaborations, data collection, and monitoring and evaluation. BJA wants to add the voice of consumers and people with lived experience to the toolkit.

In addition, BJA is receiving comments and questions on how it will implement Kevin and Avonte's Law, which will support families when a person with dementia or autism wanders from a safe environment. BJA is also establishing the National Training and Technical Assistance Center to guide jurisdictions in growing and enhancing cross-system responses between law enforcement and mental health authorities and also including a focus on intellectual and developmental disabilities (IDD) service delivery partners. The TTA Center will also address local response, needs, and outcomes for people with MI and IDD. BJA provides resources on how behavioral health information may be shared safely and responsibly between law enforcement, service providers, and other agencies and entities.

Upcoming resources include a guide for prosecutors to better understand and work with victims, witnesses, and defendants with mental health disorders and IDD and a training guide for law enforcement on responding to people with mental disorders and IDD.

The report on BJA activities concluded with discussion of the bureau's work assisting states on policies that increase the likelihood of success of collaborations between criminal justice partners and mental health authorities at the local level. BJA has hosted a series of convenings and will make new resources available in 2020.

The VA reported on two programs during the December workgroup meeting. Healthcare for Re-entry Veterans connects veterans with services prior to release from incarceration. The Veterans Justice Outreach program focuses on the front end of criminal justice systems. These programs work together to provide an "off-ramp" into treatment services.

Lastly, the Veteran Treatment Court Improvement Act program hired a national coordinator for Veterans Justice Outreach enabling long-term planning and an increased focus on veterans with mental health and substance use disorders. A policy change has served to increase veterans' access to legal services, particularly early prevention activity for civil legal services before becoming criminal violations. This enables partnerships with VA facilities hosting legal clinics.

The HUD report to the workgroup covered program linkages between homelessness and mental and substance use disorder. A current court case of concern, *City of Boise v. Martin*, has

potential ramifications for the ability to treat individuals with severe mental health and substance use disorder when there is forced removal from tent encampments.

SAMHSA recently released the document, *Screening and Assessment of Co-occurring Disorders in the Justice System*, which includes an annotated compendium of these tools. SAMHSA also released a document on principles of working with behavioral health treatment providers in criminal justice-involved people.

SAMHSA's goal is to divert from arrest, incarceration, and emergency department utilization and connect individuals to treatment and services, promoting successful community living. To that end, SAMHSA is conducting trainings on the Sequential Intercept Model and related topics. Trainings and webinars occur about once each month on topics generated by the field. Other training opportunities include the Virtual Learning Collaborative which has hosted trainings on early diversion and crisis response. In addition, SAMHSA has funded 11 awardees under the Law Enforcement and Behavioral Health Partnership for Early Diversion.

SAMHSA has also released action briefs on early diversion generated from an expert panel. These action briefs provide practical information and highlight successful early diversion programs. Communities of practice are another area of focus. States and county teams apply to participate and then have access to technical assistance with onsite and virtual facilitation with subject matter experts. SAMHSA found that this peer-to-peer interaction combined with intensive technical assistance has resulted in real progress among participants. SAMHSA also hosted policy academies in which six states and 12 counties participated.

Dr. Hatch opened the floor to questions. It was noted by one of the non-federal ISMICC members that the Bureau of Prisons, which recently joined ISMICC, did not attend the December 4 meeting. What are the implications for implementation of Recommendation 4.7 that calls for limiting or eliminating solitary confinement without their participation? The Bureau of Prisons reported on some activities at the July workgroup meeting but there has been no follow up since then.

Another comment focused on the proposed 988 system and how the collaborations and grant programs discussed are clearly connected to the issues surrounding development and implementation of the 988 and how grantees will interface with 911. In addition, it would be valuable to develop some interdepartmental state learning communities to help states determine how to develop the technical assistance and support to support counties and jurisdictions as they increase collaborative activities.

### **Focus Area 5: Finance**

*Christopher Carroll, M.Sc., Director, Health Care Financing and Systems Integration, Office of the Assistant Secretary (OAS), and Mitchell Berger, M.P.H., Public Health Advisor, OAS and Kirsten Beronio, JD, Senior Policy Advisor, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services*

The Finance Workgroup presentation began with a review of the workgroup members and the group's eight objectives described in the 2017 ISMICC report. In terms of the objective of implementing population health payment models, there have been developments in the health home benefit and the Medicaid program. The optional Medicaid health home benefit permits states to receive enhanced federal financial participation (FFP) for providing care coordination, comprehensive care managements and other services to beneficiaries with certain chronic conditions, including SMI and SUD. (See <https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html>). Although the enhanced FFP only is available for a limited time, this funding supports an incentive that some states have found useful in coordinating care for persons with SMI/SUD and other vulnerable populations. Twenty states and the District of Columbia currently offer this benefit and additional proposals are pending (see <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf>). Integrated Care for Kids is another population health model and is a demonstration project developed by the Center for Medicare and Medicaid Innovation (CMMI). CMMI worked closely with SAMHSA when developing the model.

Regarding the workgroup's second objective to fully fund the range of services needed for SMI/SUD populations, CMS has published guidance on Medicaid Section 1115 SMI/SED demonstrations entitled RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (Nov. 2018). CMS also has developed tools and templates for these demonstrations as well as a set of performance measures that participating states are to report on including access to appropriate care. Vermont and the District of Columbia are among the demonstration states.

The third objective is to enforce Mental Health Parity and Addiction Equity Act (MHPAEA) requirements to ensure that individuals with SMI and SED receive the mental health and substance use services they need and which are equivalent to services provided for physical health conditions. HHS and the Departments of Labor and Treasury recently issued a set of frequently asked questions that included guidance on improving disclosures relevant to parity implementation. A Compliance Policy Guide and Self-Compliance tool for health plan administrators have also been issued and additional guidance documents and training tools are forthcoming.

To address the fourth objective to eliminate financing policies that discriminate against behavioral health care, CMS demonstration programs are offering flexibility to states to pay for services in acute settings while the states take action to improve access to a continuum of care and improve quality. HHS is also implementing provisions in the SUPPORT Act that are focused on SUD treatment but offer flexibility around the IMD exclusion for pregnant women.

The fifth objective is related to payment for psychiatric services at rates equivalent to reimbursement for other health care services. CMS in collaboration with SAMHSA and AHRQ

has awarded planning grants to 15 states which will help states perform a comprehensive analysis of reimbursement rates to better understand how those rates are impacting state capacity to provide behavioral health services. Additionally, SAMHSA has developed billing tools and published guidance to help with integrated care. In its Medicare program, CMS has been working to support the availability of the collaborative care model whereby primary care providers can offer behavioral health services. CMS also has established billing codes to encourage Medicare providers to offer behavioral health care. Regarding workforce development, SAMHSA works with HRSA on the Behavioral Health Workforce Research Center based at the University of Michigan (<http://www.behavioralhealthworkforce.org/>).

In terms of the sixth objective, to pay for outreach and engagement services related to mental health, SAMHSA and CMS have developed a Roadmap to Behavioral Health and recently issued a grant announcement to support technical assistance for consumers and consumer-led organizations. This objective is also addressed in the CMS guidance of November 2018 and the SMI/SED Section 1115 opportunity; participating states are expected to implement strategies to identify and engage with people in need of behavioral health care.

Regarding the objective to fund home- and community-based services (HCBS), CMS is working closely with states to implement changes and improvements to their HCBS and is working on updating the Medicaid Preadmission Screening and Resident Review regulations.

To expand the Certified Community Behavioral Health Clinics (CBHCC) program, ASPE is conducting an evaluation of the program and HHS is working closely with the demonstration states on ways they can continue those models with existing Medicaid authorities.

Following the review of activities related to Focus Area 5 objectives, there was a summary of the December 4 focus group meeting, particularly related to Section 1115. There was concern about waiver budget neutrality requirements as a potential barrier to states implementing 1115 waivers for behavioral health. Other topics of discussion were the need for collaboration and coordination with respect to Medicare behavioral health services, the importance of CBHCCs, and the inclusion of behavioral health issues in current and future CMMI value-based reimbursement models. The group also discussed the function and organization of the group itself.

### **Public Comments**

Public comments were provided and may be found in Appendix C.

### **President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)**

*Barbara Van Dahlen, Ph.D., Executive Director, PREVENTS Executive Order Task Force, Office of the Secretary, Department of Veterans Affairs*

President Trump signed the executive order establishing PREVENTS on March 5, 2019. The PREVENTS taskforce is cabinet wide, so includes secretaries of every agency. Dr. Van Dahlen began her position as executive director in July 2019. A child clinical psychologist previously in private practice and in the nonprofit arena, Dr. Van Dahlen was new to government service.

PREVENTS represents an opportunity to put together the first ever national strategy to fight suicide among veterans that includes entities inside and outside government, including corporations and nonprofit organizations. From its inception, it was intended to be a public health focused effort. It focuses on three areas: 1) community integration; 2) research strategies; and 3) implementation strategies.

To be successful, the Roadmap cannot focus only on veterans but must also look at the families and service systems surrounding veterans. Additionally, veterans, service members, and military families should not be cast as people who are broken or damaged in society. They are at greater risk because of the work they do. This initiative can point the way to a broader effort to prevent suicide throughout the United States. In fact, many countries are dealing with this issue and are watching PREVENTS closely.

The pace of activities has been intense. More than 100 people are working on the task force and PREVENTS has hosted multiple events focused on topics such as health care delivery, research, suicide prevention best practices, and interagency faith-based efforts. Currently, the task force is engaging states and communities, beginning with Texas, Arizona, and Tennessee. It is also collecting the recommendations that will be set forth in the Roadmap and has developed five lines of inquiry as its research strategy. These lines of inquiry are: 1) risk identification; 2) prevention and intervention; 3) research translation; 4) data sharing; and 5) data integration. A White House Summit in September hosted 125 researchers to discuss the lines of inquiry.

State and local action has focused on identifying successful or promising models of suicide prevention in communities and creating some common themes that will be used to encourage new models of community-based care. PREVENTS is not just about identifying people who are most at risk, but also about empowering veterans, which can reduce their risk. This is another state and local focus. A total of 32 governmental and nongovernmental organizations have been engaged to serve on workgroups to look at state and local action.

Workforce and professional development is another aspect of the PREVENTS initiative. Efforts are focused on ensuring that the professional workforce is equipped and trained to conduct suicide risk assessment. The PREVENTS task force is working with the American Psychological Association, National Association of Social Workers, and American Medical Association to develop assessment tools.

The task force is also engaged in looking at lethal means safety and partnerships. Communications planning is focused on a large, national public health campaign in the tradition of massive, overarching campaigns such as CDC's Tips From Former Smokers, the American

Heart Association's Go Red for Women campaign, and Above the Influence from the Partnership for Drug-Free Kids. The campaign is scheduled to launch in March and will include national-level communications and marketing company engagement.

The presentation included the task force timeline extending through March 2022. The Roadmap report is due March 5, 2020 and will include the national research strategy, grantmaking structure, and the proposal for community collaboration and integration. Although the task force is scheduled to end in March 2022, it is building in a structure that will allow the activities to continue beyond that date.

ISMICC and PREVENTS clearly complement each other. Many of ISMICC's recommendations are echoed in PREVENTS. PREVENTS can help ISMICC by ensuring that the public health message is delivered to people with chronic mental illness and by amplifying relevant ISMICC recommendations.

## **Discussion**

Many active duty servicemen and women are experiencing anxiety and depression, including young recruits. Many turn to parents, grandparents, and other relatives because they do not want to let anyone in the military know they are experiencing these issues. Some of these relatives have discussed the issues among themselves and have determined that peer-to-peer outreach can help recruits in crisis. In addition, recruits may go to familiar places on base, such as restaurants, and these gathering spots offer additional opportunities for outreach. One of DoD's top priorities right now is suicide prevention and the task force is working with DoD on this issue, including transition planning and educating families.

There was agreement that the work of the PREVENTS Task Force and that of ISMICC were in alignment and that both could benefit from continuing to work together. In addition, the 988 system is an opportunity to think about how to implement a nationwide, crisis support system.

## **Pediatric Behavioral Health: Highlights of Cross-Federal Work**

### **Department of Defense**

*Chad Bradford, CAPT, USN, MC, Director, Mental Health Policy and Oversight, Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs*

DoD is committed to supporting the health and well-being of military children and provides a range of resources and support for parents and children who are at risk for developing or who have been diagnosed with a psychological health condition.

About 38 percent of DoD personnel have children. Around 33 percent of service members who have children are married and seven percent are single parents. About two-thirds of the 1.7 children of DoD personnel are 11 years of age or younger. Military children face unique stressors including parental deployment and frequent changes of location and schools which also

affect continuity of care. They also have access to unique benefits including DoD childcare programs and schools and access to health care throughout the military.

DoD-offered programs fall along a continuum between health promotion and treatment, with prevention and identification in the middle. Health promotion programs include the New Parent Support Program, which offers prenatal classes along with home visits, parenting classes, and playgroups. Sesame Street for Military Families is a website with information for parents and providers and interactive content for children. The Yellow Ribbon Reintegration Program, for National Guard and Reserve members, promotes their well-being by connecting them with resources throughout the deployment cycle including information on health care, education, financial, and legal benefits. It allows National Guard and Reserve members and families to connect with local resources before, during, and after deployments.

Prevention programs include Families OverComing Under Stress (FOCUS), which teaches practical skills to help families overcome common challenges related to military life. It is currently available at about 30 military sites. The National Military Families Association was begun by military wives who wanted to support their widowed friends. It offers several programs that support military families such as Operation Purple Camp, Operation Purple Family Retreats, and Operation Purple Healing Adventures. Military Kids Connect is an online community for children and youth ages 6 to 17 to help them deal with the unique psychological challenges of military life.

Identification and intervention programs include Military OneSource, a 24/7 call center and website that provides information, referrals, and support on every aspect of military life. Support includes relationship counseling as well as nonmedical and financial counseling. The Exceptional Family Member Program provides services for families with special health care or educational needs. DoD Education Activity oversees school-based programs for military children who require direct and indirect intervention and counseling services. The Family Advocacy Program focuses on addressing domestic abuse, child abuse and neglect, and problematic sexual behavior in children and youth. It is available at every military installation. The Military and Family Life Counseling Program supports service members and their families with nonmedical counseling.

Treatment programs include the Military Health System, which includes behavioral health specialty care and primary care behavioral health. TRICARE is the health insurance program for service members, their dependents, retirees, and some survivors and former spouses. It provides access to behavioral health care services in the civilian community and includes mental health and SUD treatment at every level of care. Also included are family therapy, psychological testing, psychotherapy, and psychiatric treatment. TRICARE's Extended Care Health Option is a supplemental benefit for families with a qualifying condition such as autism spectrum disorder.

**Department of Labor**

*Jennifer Sheehy, M.B.A., Deputy Assistant Secretary, Office of Disability Employment Policy*

The DoL presentation focused on several programs supporting children and families impacted by SED. The first program discussed is one that helps people with SMI and co-occurring SMI who are transitioning out of sheltered workshops into competitive, integrated employment. DoL recently launched another cohort of that project focused solely on those who have SMI and ISMICC's recommendations helped inform the thinking on what DoL is doing going forward with young people with SMI and SED.

Another program, Federal Partners in Transition, has been in operation for more than 15 years and coordinates services, programs, and policies of ED, SSA, and HHS related to transition-age youth with disabilities. This partnership has helped to move policies forward. For example, the partnership is about to start its 2025 plan; there are opportunities for ISMICC recommendations to feed into that process.

The Youth Transition Technical Assistance Center recently ended after more than 15 years. It produced several popular products including the Guideposts for Success, collections of strategies and policies that are necessary to support young people with disabilities as they transition out of school and into careers. DoL is looking at possibly updating a 2010 Guidepost for Success specific to children with mental health conditions.

DoL recently launched a Policy Development Center for young people with disabilities. One of its first initiatives is to develop a product looking specifically at how to support young people that experience their first mental health crisis and how they can take advantage of Pre-Early Transition Services. The agency is also about to announce a competition for researchers and policy experts to submit proposals for how best to serve young people with disabilities receiving Supplemental Security Income (SSI). Winning proposals will be funded so that the ideas can be tested.

**Department of Veterans Affairs**

*Shirley Glynn, Ph.D., Clinical Research Psychologist, VA Greater Los Angeles at Los Angeles*

The VA is mandated by federal law to serve eligible veterans, but it does not generally serve family members except in the service of the veteran's treatment plan. However, the Family Services Section, part of the Office of Mental Health and Suicide Prevention, receives many requests from veterans for support for their family members. There is now a federal law mandating that VA must offer family and couples counseling to eligible veterans.

In most cases, VA medical centers do not provide direct services to children. VA's overarching policy is to improve care for children by supporting veteran parenting. This approach allows VA to stay within its mandate while providing services many veterans need.

Support takes two forms: direct service provision to veterans and workforce training. VA has had several workforce training initiatives including Helping Veterans Be the Best Parents They Can Be, an on-demand asynchronous course for VA clinical providers, and Strategies for Dealing With Common Issues When Working With Veteran Parents, a live program that provides VA family clinicians with a comprehensive understanding of issues that arise when working with veteran parents struggling with mental health challenges. VA also offers two to three webinars each year on issues dealing with children and families.

Direct services to veterans are provided through programs such as Skills Training in Affective and Interpersonal Regulation (STAIR) for veterans who struggle with post-traumatic stress disorder and Parenting STAIR, which offers four to five sessions to veterans on emotion regulation and interpersonal functioning in the parenting domain. Notably, this program has attracted participation from a lot of women veterans as well as male veterans. VA also conducts a good deal of direct-to-veteran activities to promote parenting and distributes information from organizations such as Sesame Street and other agencies that are sensitive to the needs of military families.

Lastly, VA is part of an interagency collaboration through the National Child Traumatic Stress Network that supports veteran parenting. It is an attempt to galvanize federal and nonfederal partners to support veteran parenting to improve the lives of their children.

### **Substance Abuse and Mental Health Services Administration**

*Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS*

SAMHSA is doing a vast amount of work on behalf of children, adolescents, and youth. Programs supporting early childhood mental health include Project Launch and the Infant and Early Childhood Grant Programs. Project Launch focuses on building the early childhood mental health workforce and embedding mental health supports and expertise into early childhood systems. The Infant and Early Childhood Grant Programs also focus on workforce development.

For school-age children, the Children's Mental Health Initiative is one of the largest SAMHSA investments in services for youth from birth to age 21 with SED. Since 1993, more than 135,000 children and youth have been served. The Circles of Care Grant is awarded to tribes with the intent to provide tribal and urban Indian communities with tools and resources to design a community-based system of care for children, youth, and families. SAMHSA also has numerous initiatives addressing trauma, including the National Child Traumatic Stress Initiative and the Trauma-Informed Taskforce.

SAMHSA has many school mental health initiatives. From the Federal Commission on School Safety, there are a number of SAMHSA/HHS priorities to address school safety as it relates to mental health. Some examples include ongoing training on mental health conditions for school personnel; developing resources, such as the joint CMS-SAMHSA informational bulletin on

financing mental health services in schools; increased funding to the TA/TTC centers specifically for school-based mental health; ongoing training in privacy regulations in educational settings through the Center of Excellence for Protected Health Information; and, ongoing support of grant programs such as Project AWARE, which has intended to expand state capacity to provide mental health services in schools. We are also collaborating on a DHS initiative, schoolsafety.gov, which is a federal clearinghouse for school safety.

Programs intended to serve adolescents and transition-age youth include the Clinical High Risk for Psychosis Grant Program, which is designed to identify youth and young adults at clinical high risk for psychosis and provide evidence-based interventions to prevent the onset of psychosis and lessen its severity. Another initiative, the FEP Set Aside, uses block grant funds to develop comprehensive, team-based care for individuals with FEP, leading to a great increase in the number of programs for FEP. Now Is the Time (Healthy Transitions Program) provides developmentally appropriate services for youth ages 16 to 26.

For youth with co-occurring SUD, there are several programs that target this population including the Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transition Age Youth, and Their Families cooperative agreements. Drug-Free Communities grants focus on building community capacity to reduce substance use among youth.

In addition, SAMHSA has developed Treatment Improvement Protocols (TIPs), of which several are targeted toward youth. SAMHSA also provides guidance to states on statutory requirements through the Synar Amendment prohibiting the retail distribution of tobacco products to youth.

SAMHSA runs several public awareness campaigns dealing with youth, such as ones related to underage drinking and suicide prevention. It also supports initiatives related to drug courts and the idea of expanding substance abuse treatment capacity in families through those courts. Additional activities include residential and outpatient treatment for pregnant and postpartum women and an upcoming toolkit for families of suicidal loved ones.

SAMHSA provides extensive technical assistance programming. The Mental Health Technology Transfer Centers were created on August 15, 2018, under the direction of Dr. McCance-Katz. Other examples include the Technical Assistance Network for Children's Mental Health, the Center of Excellence for Protected Health Information, the Center for Excellence for Infant and Early Childhood Mental Health, and the Clinical Support System for Serious Mental Illness.

### **Centers for Medicare and Medicaid Services**

*Kirsten Beronio, J.D., Senior Policy Advisor for Behavioral Health Care, Centers for Medicare and Medicaid Services*

CMS works to improve care for children with behavioral health conditions in many ways. One is the new Medicaid Health Home benefit for medically complex conditions among child and

beneficiaries, including mental health conditions. Several types of services can be provided through this benefit including case management, care coordination, specialty and subspecialty medical services, transitional care from inpatient settings, patient and family support, referrals to communities and social support services, and use of information technology to better coordinate services. As an incentive, Congress allowed for a 15 percent increase in the federal Medicaid match for these services for the first two quarters. This benefit will go into effect in 2020.

A new Center for Medicare and Medicaid Innovation model on Integrated Care for Kids was announced in February 2019. CMS is currently reviewing funding applications and plans to announce awards very soon. This initiative is an opportunity to test a child-centered local service delivery model that also incorporates an alternative payment approach, aimed at helping communities identify children with complex conditions, including behavioral health conditions. The goal of these models is to reduce avoidable inpatient stays and out-of-home placements as well as to create a sustainable alternative payment model with shared accountability among the states and local providers for costs and outcomes.

Lastly, the Children's Health Insurance Program (CHIP) has been updated to make behavioral health coverage a required benefit as of October 2019. It specifically requires that child health and pregnancy-related assistance through the CHIP program include coverage of mental health services, including behavioral health necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders including substance use disorders. Services must be delivered in a culturally and linguistically appropriate manner. Coverage of behavioral services in CHIP was previously optional.

### **Discussion Related to Pediatric Behavioral Health Cross-Federal Work**

There is more activity around pediatric behavioral health care in the federal government than many may realize, and it could be helpful to have a visual with links to additional information or some other way to share the resources with the public.

In response to a comment regarding the concept of job sharing DoL briefly described an evidence-based program called customized employment that takes pieces of jobs and looks at the skills, talents, and interests of individuals to fit them into customized positions. Ms. Sheehy will share the information on job sharing with the DoL Policy Development Center.

There was a question about the status of IMD waivers related to inpatient and residential facilities treating SUD and how many states have applied for them. CMS has approved 27 states for the SUD initiative. These states have authority to receive federal matching funds for services provided in IMDs where the person is in the IMD primarily to receive SUD treatment. The initiative focused on SMI was more recently established and the District of Columbia and Vermont are the first to be approved to participate. Participating states will be expected to report on performance measures.

An attendee found the workgroup meeting the previous week to be extremely helpful, and suggested it could be valuable to spend some time at the next meeting thinking about linking data to outcomes.

It could be helpful to have a matrix or report on activities and the progress of the various recommendations. A great deal of interdepartmental coordination activity goes on outside of the focus area workgroups. It is a lot for the workgroups to be responsible for all of the recommendations. It might be better to think of the workgroups as being responsible for tracking the interdepartmental coordination activity.

Another comment focused on parity work and class action lawsuits that have been brought to improve access to care.

The University of Southern California and other schools are working on supported decision-making and psychiatric advanced directives. These initiatives help foster autonomy and restore people to being the architects of their own lives.

### **Final Comments**

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

Dr. McCance-Katz thanked the group for attending the ISMICC meeting, noting that one of the meeting goals was to show that there is a great deal of interagency collaboration. The meeting was structured to be responsive to members' requests about certain types of information.

Dr. McCance-Katz agreed that mental health issues among service members is extremely important. SAMHSA can move this issue forward through its interagency agreement with DoD. There is also a technical assistance center for service members, veterans, and their families that may be another avenue for addressing this issue.

Some of the ideas that attendees brought up at the meeting are already being implemented. For example, SAMHSA is interested in the ability to bring supports from communities into the recovery process for people living with SMI. It is allowing some of the grant programs to fund clubhouse types of activities. This demonstrates how the medical, psychiatric, and behavioral health professionals can work together with recovery services to bring together the continuum that is critical for people to recover from SMI and be able to live in their communities.

Dr. McCance-Katz thanked the attendees for their input. There being no further comments or questions, the ISMICC meeting was adjourned.

**Appendix A: Meeting Agenda**  
**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE**  
**FULL COMMITTEE MEETING**

December 10, 2019  
9:30 a.m. to 2:20 p.m. (Eastern Time Zone)  
Substance Abuse and Mental Health Services Administration (SAMHSA)  
5600 Fishers Lane, Pavilions A and B  
Rockville, Maryland 20857

Toll Free Number: 888-390-3417; Passcode: 2871942

WebEx Link: <https://protect2.fireeye.com/url?k=f0d6b13e-ac83b82d-f0d68001-0cc47adb5650-5a4df114f476795f&u=https://www.mymeetings.com/nc/join.php?i=PWXW9685761&p=2871942&t=c>

**AGENDA**

**OPEN SESSION**

- 9:30 a.m. Call to Order/Committee Roll Call**  
*Pamela Foote, Designated Federal Official, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)*
- 9:35 a.m. Opening Remarks**  
*Arlin Hatch, CAPT, USPHS, Ph.D., ISMICC Coordinator, Senior Psychologist, Center for Substance Abuse Prevention*
- 9:40 a.m. Welcome/Consideration of Minutes**  
*Elinore F. McCance-Katz, M.D., Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use*
- Report Outs by Focus Area – 20 Minute Sessions**
- 9:50 a.m. Focus Area 1: Data**  
*Brooklyn Lupari, M.S., Statistician, Center for Behavioral Health Statistics and Quality*
- 10:10 a.m. Focus Area 2: Access**  
*Richard McKeon, Ph.D., M.P.H., Chief, Suicide Prevention Branch, Center for Mental Health Services (CMHS), and Steven Dettwyler, Ph.D., Public Health Analyst, CMHS*
- 10:30 a.m. BREAK**
- 10:40 a.m. Focus Area 3: Treatment and Recovery**  
*Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS*
- 11:00 a.m. Focus Area 4: Justice**  
*Larke Huang, Ph.D., Director, Office of Behavioral Equity and the Justice-Involved, Office of Intergovernmental and External Affairs*

- 11:20 a.m. Focus Area 5: Finance**  
*Christopher Carroll, M.Sc., Director, Health Care Financing and Systems Integration, Office of the Assistant Secretary (OAS), and Mitchell Berger, M.P.H., Public Health Advisor, OAS*
- 11:40 a.m. Public Comments**  
*Pamela Foote, Designated Federal Official, ISMICC*
- 11:50 a.m. LUNCH (on your own)**
- 12:50 p.m. President’s Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)**  
*Barbara Van Dahlen, Ph.D., Executive Director, PREVENTS Executive Order Task Force  
Office of the Secretary, Department of Veterans Affairs*
- 1:10 p.m. Discussion Related to PREVENTS**
- Pediatric Behavioral Health: Highlights of Cross-Federal Work**
- 1:15 p.m. Department of Defense**  
*Chad Bradford, CAPT, USN, M.C., Director, Mental Health Policy and Oversight, Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs*
- 1:25 p.m. Department of Labor**  
*Jennifer Sheehy, M.B.A., Deputy Assistant Secretary, Office of Disability Employment Policy*
- 1:30 p.m. Department of Veterans Affairs (virtual)**  
*Shirley Glynn, Ph.D., Clinical Research Psychologist, VA Greater Los Angeles at Los Angeles*
- 1:40 p.m. Substance Abuse and Mental Health Services Administration**  
*Justine Larson, M.D., M.P.H., M.H.S., Senior Medical Advisor, CMHS*
- 1:50 p.m. BREAK**
- 2:00 p.m. Centers for Medicare and Medicaid Services (virtual)**  
*Kimberly Brandt, J.D., M.A., Principal Deputy Administrator for Operations*
- 2:10 p.m. Discussion Related to Pediatric Behavioral Health Cross-Federal Work**
- 2:20 p.m. Final Comments/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**

**Deepa Avula, MPH**, Chief of Staff and Director of Financial Resources, SAMHSA

**Linda Beeber, PhD, PMHCNS, FAAN**, Distinguished Professor, University of North Carolina-Chapel Hill School of Nursing

**Chad Bradford, CAPT, USN, MC**, Director, Mental Health Policy and Oversight, Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs, DoD

**Kimberly Brandt, JD, MA**, Principal Deputy Administrator for Operations, CMS

**Christopher Carroll, MSc**, Director, Health Care Financing and Systems Integration, Office of the Assistant Secretary for Mental Health and Substance Abuse, SAMHSA

**Clayton Chau, MD, PhD**, Regional Executive Medical Director, Providence St. Joseph Health

**David Covington, LPC, MBA**, CEO and President, Recovery Innovations (RI) International

**Paul Dans, JD**, Senior Advisor, Office of Community Planning and Development, HUD

**Maryann Davis, PhD**, Professor and Director, University of Massachusetts Medical School

**Steven Dettwyler, PhD**, Public Health Analyst, SAMHSA

**Pete Earley**, Author, Pete Earley, Inc.

**Paul Emrich, PhD**, Under Secretary, Chickasaw Nation

**Pamela Foote**, ISMICC Designated Federal Official, SAMHSA

**Mary Giliberti, JD**, Executive Vice President of Policy, Mental Health America

**Shirley Glynn, PhD**, Clinical Research Psychologist, Healthcare System at West Los Angeles, VA

**Arlin Hatch, CAPT, USPHS, PhD**, ISMICC Coordinator & Senior Psychologist, Office of the Chief Medical Office, SAMHSA

**Larke Huang, PhD**, Director, Office of Behavioral Equity and the Justice-Involved, SAMHSA

**Justine Larson, MD, MPH, MHS**, Senior Medical Advisor, SAMHSA

**Brooklyn Lupari, MS**, Statistician, Center for Behavioral Health Statistics and Quality, SAMHSA

**Elinore F. McCance-Katz, MD, PhD**, Assistant Secretary for Mental Health and Substance Use, SAMHSA

**Richard McKeon, PhD**, Chief, Suicide Prevention Branch, SAMHSA

**Kenneth Minkoff, MD**, Senior Consultant, ZiaPartners

**Tracie Pogue, MDIV, MSW, LCSW**, Public Health Analyst, OCMO, SAMHSA

**Sandy Resnick, PhD**, Deputy Director, NEPEC, Office of Mental Health and Suicide Prevention VACO

**Elyn Saks, PhD, JD**, Professor, University of Southern California

**Jennifer Sheehy, MBA**, Deputy Assistant Secretary, DoL

**John Snook**, Executive Director, Treatment Advocacy Center

**Rhathelia Stroud**, Judge, DeKalb County Misdemeanor Mental Health Court

**Tracey Trautman**, Deputy Director, Department of Labor

**Barbara Van Dahlen, PhD**, Executive Director, PREVENTS Executive Order Task Force, Office of the Secretary, VA

**Conni Wells**, Owner/Manager, Axis Group, LLC

## **Appendix C: Official List of Public Comments**

### **1. Sherri McGimsey**

Thank you all for being there. This is Sherri McGimsey. I still want to know why there are no long-term psyche hospitals for our veterans, only psyche floors. And with our state hospital, there is always a long wait – waiting list. No step down programs coming out of the hospitals, jails, or prisons. By not having these programs, you are setting your loved ones up for failure. The step down programs even a hospital or jail with a serious brain disease should be a requirement for entering back into the community.

In addition to case management, many, not all with a serious brain disease need onsite professional support with long positive – like club house models like the – house model, which I have visited in three different states and they work and that is what is needed almost to be in every community.

We have visited eight placement possibilities for our beautiful – our veterans' son and not one would support him for his illness. Housing models should range from transitional – intensive stabilization and supported housing to permanent supportive housing. The level of housing should be flexible so that people can be moved up or down if needed to keep them safe.

Thank you again. You are – working on that mother's prayer for me – glimmer of hope. Thank you very much.

### **2. Colleen Lord, Talbot Advocacy**

Thank you, Ms. Foote, and thanks to all of you for working together with SAMHSA helping to treat and save our loved ones.

My name is Colleen Lord of Talbot Advocacy, named for my son, Robby Talbot. I am speaking today in support of making crisis intervention training mandatory or better incentivized for police officers and corrections officers, but most importantly to implore all members of this esteemed ISMICC committee to do everything in their collective powers to decriminalize serious mental illness in the first place and help jail diversion programs be successful by prohibiting or de-incentivizing mental health providers from receiving treatment to the most seriously mentally ill with the only explanation being that they need a higher level of care, which is so often unavailable.

I am a parent of a peaceful, kind, and gentle young man with a serious mental illness diagnosed in childhood at age 8. My never violent son, Robby, a poetic genius on psychiatric disability, hilarious and loved by all was killed in a jail eight months ago at the age of 30 at the hands of corrections officers because he was laying down in the shower sick after not being given his medication by jail staff. He could not leave the shower when commanded. Videos showed he

never fought back, was never a threat when pepper sprayed three times, hit with a club and placed in five-point restraints in solitary cell as punishment for noncompliance until he was found dead hours later still in restraints with rigor mortis having already begun. Ruled a homicide. The case is currently with the state's attorney, waiting her decision whether to press criminal homicide charges. This is tragic for all involved.

Robby was in the jail for pulling the fire alarm in an emergency room in frustration when they refused to admit him. It rang for a few seconds and no one evacuated. He was rejected at this particular emergency room in New Haven, which has a huge adjoining psyche hospital. Forty times in a row in the years 2017 and 2018 even though he had been treated there six times inpatient from 2012 to 2016. Hospital staff said he was welcomed back any time he needed to come stabilize again, but then they declined to treat him 40 times in 20 months due to the severe lack of beds and Medicaid rules.

Our tragic story shows how the mental health and criminal justice system have failed us and many others over and over; yet, we still have hope for the hundreds of thousands of others who still need treatment.

Robby never hurt a soul in his entire 30 years, but he had SMI during an area that criminalized it. Now, with your help, there is much that can be done to help people like my son, which will save countless lives as outlined in the mental health plans of several senators recently and reflected in the work of scores of many SMI advocacy organizations. Please continue to do everything possible to decriminalize SMI, make crisis intervention training better incentivized for police and corrections officers and continue your excellent work with IMD exclusion labors. Our loved ones are patients, not prisoners.

I do want to say I agree with Mr. Earley that you all are rock stars. I appreciate your work so much. Thank you.

### **3. *Marti Rhoden Bessler, National Shattering Silence Coalition***

I am Marti Rhoden Bessler, calling in as a caregiver and as a member of the National Shattering Silence Coalition. We would be happy to speak with any of you at any time to share with you just how truly desperate our situations are. Just hearing the last caller calling, I almost cannot keep my composure. I was so grateful for the opportunity to attend the (indiscernible) Symposium about a month ago.

While I was away for just two days, I was praying that my 34-year-old son who suffers from schizoaffective disorder would not deteriorate in my absence. He was in the care of another family member. This is my life. This is my son's life. This is what our best days look like.

I am praying that we are all here today for the seriously mentally ill. At the symposium, I got to hear Dr. McCance-Katz and Dr. Clayton Chau and others speak, these talks with knowledge,

compassion, and conviction. I thank them. These talks were very reassuring to me. We all know that we are in desperate need of an IMD exclusion repeal, housing with medication administration, hospitalization instead of criminalization, AOT treatment - the list goes on and on. These things cannot just be standards on paper, but they actually must be implemented properly throughout our communities.

Thank you, Pete Earley, for being our voice and holding people accountable to things that are lapsing. And listening to the July ISMICC committee meeting in July, some comments were downright frightening to me. One of them was the psychiatric advanced directive, as soon as we are trying to reduce barriers to care with HIPAA, only to replace it possibly with more horrific consequences related to improperly completed psychiatric advances.

In 2017, only 37 percent of the general population has an advanced directive; yet, we are discussing a mandate for psychiatric advanced directives for our seriously mentally ill to complete while they are being pushed out of our hospitals, many times unstable.

Perhaps these things never occurred to some of you. We are making the assumption that the person has the capacity while in the hospital or is discharged to participate. How will we ensure this? Will we use the P&A attorneys who are walking the halls of our state psyche hospitals arguing that our loved ones have the right to be crazy to unethically and with bias determining competencies? What about those with Anosognosia? What do you think their advanced directives are going to look like?

I work as a hospice nurse in quality assurance performance improvements. I can assure you that no survey or a checked box on a discharge checklist to stay in compliance is the answer. There are so many other things that must be working well. There is a right time and a right place for psychiatric directives; however, certainly not in the hospital and certainly not mandated. For many of our loved ones, they might as well be signing their death certificates. Informed consent, HIPAA, and P&A attorneys in our hospitals have been deadly enough.

It is also frightening for me to hear suggestions about education and taking their meds as part of the discharge plan. Believe me, education is the least of our concerns in this failed mental health care system. Education works well with other illnesses where the brain is functioning well. There is a therapeutic environment that is inside of out of the hospital that works well and the patient is not wondering if they can ride home, where their next meal is going to be, or where they might sleep that night. What about loved ones who cannot even get a hospital bed or if they do or are unstable when discharged or the 50 percent who have Anosognosia and do not believe they are ill or even need medication?

Our focus must be stability in discharge. The correct prescriptions actually being received by the appropriate pharmacy so that the patient being discharged in the afternoon and a three-hour car ride home, can get to a pharmacy before it closes. If not, the hospital is willing to give the discharging patient a single set of meds so they might even have a chance to make it to the next

morning until the pharmacy reopens. These are the kinds of things that our loved ones really need at discharge.

And last but certainly not least, is the frightening comment by the VA senior consultant about the 25-year earlier mortality rate stating, "we know patients die sooner in America and in the rest of the world we do not know why and we do not know what to do about it." I am still in shock that I heard that for our veterans who have fought for our freedom. I am so sad and I cannot comment to that. I am sorry I am so down. We are struggling so bad out here. Thank you.

## **Appendix D: Edits submitted by the VA on Meeting Minutes from July 2, 2019**

Page 3 of the July 2, 2019 meeting minutes currently reads:

Sandy Resnick, Ph.D., Deputy Director, Northeast Program Evaluation Center (NEPEC), Office of Mental Health and Suicide Prevention, Virginia Central Office (VACO), for the Secretary of the Department of Veterans Affairs (VA)

Please change to: VA Central Office

Page 11 of the July 2, 2019 meeting minutes currently reads:

In 2004, a query program funded a study of the initial implementation and dissemination of supported employment across the VA. More recently, they have funded multi-site studies showing the efficacy of supported employment for veterans with PTSD and spinal cord injuries, as well as developmental work to determine adaptations to supported employment for veterans with poly-trauma and traumatic brain injury. Through a partnership with the Department of Labor, a customized employment program, called Therapeutic Supported Employment Service, is currently in place to provide training and ongoing national webinars to VHA vocational rehabilitation providers around customized employment.

Please change to:

In 2004, the Quality Enhancement Research Initiative (QUERI) program funded a study of the initial implementation and dissemination of supported employment across the VA. More recently, VA research has have funded multi-site studies showing the efficacy of supported employment for veterans with PTSD and spinal cord injuries, as well as developmental work to determine adaptations to supported employment for veterans with poly-trauma and traumatic brain injury. Through a partnership with the Department of Labor, training on Customized Employment has been integrated into VA's Therapeutic and Supported Employment Service. DOL is currently providing training and ongoing national webinars to VHA vocational rehabilitation providers around customized employment.