U.S. Department of Health and Human Services

Minutes of the Interdepartmental Serious Mental Illness Coordinating Committee

March 14, 2023
11:00 a.m. to 4:00 p.m. (Eastern Time), Virtual
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane
Rockville, Maryland 20857

SUBMITTED BY: Jami Hudson Craig, MA, PMP, CPC

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Call to Order, Committee Roll Call
Pamela Foote, Designated Federal Official, ISMICC

Ms. Pamela Foote, Designated Federal Official, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), called the meeting to order and conducted roll call. After establishing a quorum, Ms. Foote reminded participants the meeting is live streamed.

Federal Members

- CAPT Meena Vythilingam, Ph.D., and Joel Dubenitz, Ph.D., Designees, The Secretary of Health and Human Services
- Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration
- Mariel Lifshitz and Alison Leukefeld, Designee, The Attorney General
- Sandy Resnick, Ph.D., Designee, Department of Veterans Affairs (VA), Deputy Director, Northeast Program Evaluation Center (NEPEC), Office of Mental Health and Suicide Prevention, Veterans Affairs Central Office (VACO)
- Secretary of the Department of Defense*, Designee,* Richard Mooney, M.D., Acting Deputy Assistant Secretary of Defense, Health Services Policy, and Oversight
- Corey Minor Smith, Designee, Housing and Urban Development (HUD)
- Secretary of the Department of Education – Absent
- Rhonda Basha, Designee; Department of Labor
- Kirsten Beronio, J.D., Senior Policy Advisor on Behavioral Health Care, Senior Policy Advisor on Behavioral Health Care and Chris Carroll, M.Sc., Designee, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services
- Elliott Kennedy, Designee, Administrator of the Administration for Community Living
- Marion (Taffy) McCoy, Ph.D., Designee, Social Security Administration

Non-federal Members Present

- Trinidad de Jesus Arguello, Ph.D., LCSW, PMHRN-BC, Director, Compostela Community and Family Cultural Institute
- Ron Bruno, CEO, Criss Response Programs and Training (CRPT), Inc.
- David Covington, LPC, MBA, CEO and President, Recovery Innovations (RI) International
- Brian Hepburn, M.D., Exec. Director, National Association of State Mental Health Program Directors (NASMHPD)
- Jennifer Higgins, Ph.D., CCRP, Owner, CommonWealth GrantWroks
- Johanna Kandel, Founder and CEO, The Alliance for Eating Disorders
- Steven Leifman, J.D., Assoc. Administrative Judge, Miami-Dade County Court, Eleventh Judicial Circuit of Florida
- Amanda Lipp, Director and Filmmaker, Lipp Studios

- Winola Sprague, DNP, CNS-BC, Medical Director, Children's Advantage
- Rhathelia Stroud, JD, Presiding Judge, DeKalb County Misdemeanor Mental Health Court, DeKalb County Magistrate Court
- Katherine Warburton Williams, D.O., Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals

ISMICC Members Not Present

- Yasmine Brown, M.S., CEO, Hope Restored Suicide Prevention Project, LLC
- Adrienne Lightfoot, Peer Program Coordinator, DC Department of Behavioral Health

Welcome and Introductions

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

Dr. Miriam Delphin-Rittmon, ISMICC Chair and Assistant Secretary for Mental Health and Substance Use (SAMHSA), greeted ISMICC members and stated Congress voted to reauthorize the ISMICC. She also highlighted the newest member, Alison Barkoff, from the Administration of Community Living (ACL) who was represented by Elliot Kennedy. She then turned the meeting over to Ms. Foote.

Consideration of October 28, 2022, Minutes

Pamela Foote, Designated Federal Official, ISMICC

Ms. Foote opened the floor for comments or questions on the minutes from October 28, 2022, and entertained a motion to accept the minutes, which were unanimously approved.

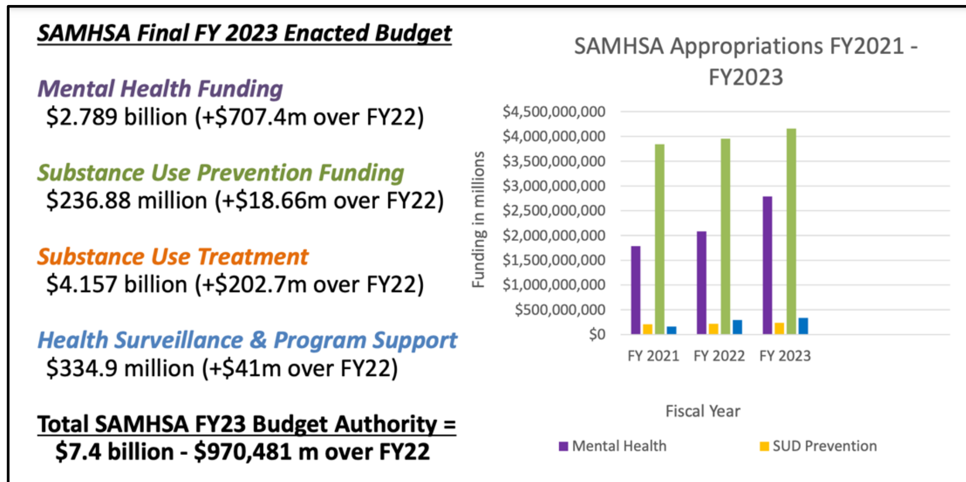
Opening Remarks

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

Dr. Delphin-Rittmon stated the National Survey on Drug Use and Health (NSDUH) released in December 2022 revealed troubling and challenging trends:

- More than one in ten young adults ages 18 to 25 report experiencing serious mental illness (SMI) in the past year.
- Two to three adults aged 18 or older with SMI received treatment.
- About 6.4 million adults had co-occurring SMI and substance use disorder (SUD) in the past year.
- More than one in ten young adults had serious thoughts of suicide in the past year.
- About one in five adolescents reported major depressive episodes within the past year.
- Individuals who have ever experienced SMI and SUD consider themselves to be in recovery.

Dr. Delphin-Rittmon shared resources to address these trends. For example, mental health funding has consistently increased over the last several years, resulting in an appropriation of almost $3 billion ($3B), an increase of over $700M in fiscal year (FY) 2022.



Dr. Delphin-Rittmon highlighted language from the FY 2023 Omnibus Appropriations Bill as follows:

> "Supporting Mental Health: Mental health care is health care. The COVID-19 pandemic revealed a crisis of mental health in our country that is affecting people of all walks of life but especially children and people from marginalized communities. Democrats secured resources to help us confront the mental health crisis and provide people with the resources that they need. This includes:
>
> - $1.01 billion for the Mental Health Block Grant to provide mental health treatment services and support community mental health services.
> - $501.6 million, a nearly $400 million increase, for the Suicide Prevention Lifeline to successfully transition to 988. The Lifeline and 988 is the new three- digit dialing code that will route callers to the National Suicide Prevention Lifeline and is now active across the United States.
> - $385 million for Certified Community Behavioral Health Clinics, a $70 million increase.
> - $140 million, a $20 million increase, for Project AWARE, which will expand efforts to identify and help children and youth in need of mental health care.
> - $130 million for Children's Mental Health Services, a $5 million increase."

Much of the budget will be implemented within the crosscutting principles and priority areas. An interim strategic plan has been released and will soon be available for public comment. Dr. Delphin-Rittmon explained programs and initiatives included in the plan include workforce, trauma-informed approaches, and a commitment to analyze data and evidence.

FY23 Omnibus implementation priorities include:

- Preventing Overdose - MAT/MATE, authorized/reauthorized State Opioid Response program, reauthorized and renamed the block grant, Part 8 rule language.
- Enhancing Access to Suicide Prevention & Crisis Care - Codified Behavioral Health Crisis Coordinating Office and Mental Health Crisis Response Partnership Pilot Program; crisis coordination with the Centers for Medicaid and Medicaid Services, Garrett Lee

Smith, and adult suicide program reauthorizations, Mental Health Block Grant reauthorization (codified crisis set-aside).

- Promoting Resilience and Emotional Health for Children, Youth & Families – Establishing a Maternal Mental Health Task Force, Pregnant and Postpartum Women Program (extended state pilot); reauthorized the Children's Mental Health Initiative, the Synthetics Trafficking and Overdose Prevention (STOP) Act, and Infant and Early Childhood Mental Health.
- Integrating Behavioral and Physical Health Care – reauthorized and requiring a 10 percent set-aside for psychiatric collaborative care model within the Primary and Behavioral Health Care Integration Grants.
- Strengthening the Behavioral Health Workforce – Codifies a Center of Excellence on Eating Disorders, authorized a mental health peer support program, and reauthorized the Minority Fellowship Program.

Dr. Delphin-Rittmon also highlighted reauthorizations of the Mental Health Block Grant, codification of a five percent set-aside to strengthen and build out the crisis care continuum. She explained in his FY24 budget released last week, President Biden proposed a $3.3B increase of SAMHSA's overall budget, bringing the budget to $10.8B. He also mentioned a continued focus on addressing mental health and substance use in his State of the Union address.

Policy areas affected by the president's budget include the Minority Fellowship Program, which requires fellows to work with underserved communities for up to two years. Work may include addiction medicine and serving sexual and gender minority populations. Other proposals within the budget include an accreditation process for Certified Community Behavioral Health Clinic (CCBHC) similar to the process for health facilities and that supports consistent implementation and adherence to the CCBHC model and certification criteria; an increase in the set-aside for crisis care from five percent to 10 percent within the MHBG; a new set-aside of 10 percent for at risk youth also within the MHBG; and a new 10 percent set aside for recovery within the Substance Abuse Prevention Treatment Recovery Services Block Grant.

In closing, Dr. Delphin-Rittmon recapped the budget priorities and expressed support of the president's proposed budget for FY24. She then turned the floor over to Dr. Anita Everett.

Opening Remarks
Anita Everett, M.D., DFAPA, Director, Center for Mental Health Services (CMHS)

Dr. Anita Everett acknowledged Women's History Month and highlighted the federal role in shaping and delivering mental health services across the nation.

- Dorothea Dix is known for her efforts to establish at least 30 different state psychiatric and hospitals and the Bill for the Benefit of Indigent Insane, a legislative set aside of over 12M acres, 10M of which to benefit the mentally ill. However, the bill was vetoed by President Franklin Pierce in 1853 because he believed the states should provide broad social support services.

- In 1962, President John F. Kennedy passed the Community Mental Health Services Act, which SAMHSA propagates through many of its different programs with the aim of providing high quality, and somewhat standardized, services across the nation.
- 2023 is the 50th year anniversary of the Minority Fellowship Program. With Dr. Delphin-Rittmon's championing, funding has increased over the last several years.
- In 1992, SAMHSA was created as its own entity 31 years ago and leads the charge of pulling together various factions with an interest in the care and treatment of SMI and serious emotional disturbance (SED).
- In 1999, the Olmstead Act established a very strong and clear role of the Federal Government in helping states develop integrated care and settings to treat SMI outside of psychiatric institutions.

Dr. Everett also reiterated the creation of the ISMICC, which was originally authorized in the 21st Century Cures Act and reauthorized in the Omnibus Act passed in December 2022. The committee is required to submit a report that summarizes advances in SMI and SED research, evaluates the effect and outcomes of related federal programs, and provide specific recommendations. As for its membership, the majority of ISMICC members will continue to serve on the committee and replacement members are under discussion.

SAMHSA has partnered with its newest member, the ACL, to create a report entitled, "Overview of the Impact of Long COVID on Behavioral Health", summarizing the literature thus far. The author, neuropsychologist Jacqueline Becker, Ph.D., is particularly interested in the cognitive effects of long COVID.

Lastly, Dr. Everett highlighted Black History Month and the opportunities to engage with scholars studying and researching black history with regards to mental health history. Specifically, Dr. Delphin-Rittmon, along with Drs. King Davis and Ronald Forbes, was featured at The Central State Hospital Archives: History, Methods, Clinical Findings, and Future Research presentation held at SAMHSA headquarters on February 28, 2023.

In segueing to the next session, Dr. Everett noted the incremental process the ISMICC has taken and the tremendous contributions of each focus group. She then turned the meeting over to Dr. Billina Shaw.

Future of the ISMICC
Anita Everett, M.D., DFAPA, Director, CMHS; Billina R. Shaw, M.D., MPH, FAPA, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA

Dr. Billina Shaw credited the Center for Behavioral Health Statistics and Quality, Office of Population Surveys for the data compilation and stated the NSDUH has been conducted since 1971. In 2021, almost 70,000 people participated in this comprehensive national household survey of civilian, non-institutionalized population, ages 12 and older, (excluding active military, long-term hospital residents, incarcerated, and those experiencing homelessness or who are not sheltered).

Current data is not comparable to past surveys due to changes in data collection methods, survey administration timing, and definition. Previously, in-person data was collected over two quarters while in 2021 collection occurred via web and hybrid methods over twelve months. Further, the definition of SUD changed as they began to use the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5) criteria, and therefore it could not be compared to 2019 or earlier.

For any mental illness as well as SMI, the highest rates occur among ages 18- to 25-year-olds, an age group that is also least likely to receive treatment. At least 50 percent of adults with SMI in any age group received services in the past year. And as for race and ethnicity, white or multiracial adults with any mental illness were more likely to receive mental health services in the past year than African Americans, Hispanic, Latino, or Asian adults. However, due to sample size, it is difficult to have a clearer understanding of disparities by ethnic group.

Regarding services, more than one in four adults with mental illness perceive their need for services has not been met while more than 50 percent of adults with SMI perceived an unmet need for mental health services. On the positive side, the data also reveals there are many who are getting services, living well, are in recovery, and believe services are needed.

As for co-occurring substance use and SMI, 6.4M adults ages 18 or older with SMI or any mental illness in the past year were more likely than those without SMI to be users of illicit drugs, marijuana, or misusers of opioids.

With respect to suicidality, in the past year, 12.7 percent of adolescents had suicidal thoughts, about six percent made a plan, and three percent attempted suicide. These statistics are also supported in the Surgeon General's report and the most recent Centers for Disease Control (CDC) release about the challenges with youth mental health. Notably, another 22.4 percent of youth did not want to answer questions about suicidality and 13.5 percent answered, "Not Sure/Don't Know". As with the other questions, adults ages 18 to 25 once again ranked highest in this area.

In 2021, one in five adolescents, aged 12 to 17 had a major depressive episode (MDE) in the past year and almost 75 percent with MDE had severe impairment. Further, among the 5.0 million adolescents affected, 40.6% received treatment for depression in the past year and were more likely to use substances compared with adolescents who did not have an MDE.

In preparing the way for group discussion, Dr. Shaw explained brainstorming by working group stewards resulted in the follow steps:

- Report to Congress
- Communications
    - Newsletter to be revived
    - Amplify public knowledge of ISMICC meetings
        - This meeting garnered four to five times the number of public comments than the previous meeting.
    - Enhance the website to be inviting and user friendly
- Consider the ISMICC appropriations request

    - Currently there is no appropriation for the work of the ISMICC which could be a point of discussion for future meetings
- Advance Recommendations
    - The goal is to link ISMICC work to applicable federal activities
    - Utilize a tracking mechanism for recommendations

Dr. Shaw introduced a SWOT analysis (Strengths, (internal) Weaknesses, Opportunities, (external) Threats) to the committee asking them to consider the function and structure of the working groups and the visibility and scalability of the recommendations. In opening the floor for discussion, the following comments were made:

STRENGTHS:

- Mr. Ron Bruno: Including non-federal members on the working groups results in a true partnership.
- Dr. Brian Hepburn: Though current representation is good, the ISMICC should include more people with lived experience. He affirmed the way SAMHSA priorities align with the movement of crisis prevention and resolution as well as recovery.
- Dr. Delphin-Rittmon: The meeting of subgroups between full ISMICC meetings spurs progress. She also noted the unprecedented SAMHSA funding.
- Dr. Sandra Resnick: The input of non-federal partners and the collaboration with other federal agencies has benefited the work of her agency and created synergy benefitting the ISMICC.
- Dr. Everett: The range of federal agencies and report outs benefit the work of the ISMICC.
- Ms. Amanda Lipp: The opportunity to review meeting minutes and reports, the partnership between federal and non-federal members, and the inclusion of people with lived experience is important. She also believes more people with lived experience should be included.
- Dr. Joel Dubenitz: Working across the developmental continuum is crucial and a great strength.

WEAKNESSES

- Dr. Hepburn: More time should be spent on prevention and early intervention, mirroring the efforts made to address substance use.
- Dr. Jennifer Higgins: A steady pace for the working groups would be more manageable and moving between working groups beneficial.
- Dr. Meena Vythilingam: Translating recommendations into action is challenging without funding and prioritization should be organized and data informed.
- Dr. Everett/Ms. Karen Gentile: SED is not as well addressed by the ISMICC; perhaps a subgroup focused on children is needed.
- Dr. Margaret O’Brien: Resources and support are needed; scheduling is a challenge.
- Ms. Mariel Lifshitz: Leveraging the work, time, and expertise of other agencies could decrease duplication of effort.

- Judge Steven Leifman: Finding "pockets of success" across the country and scaling best practices would educate the committee. Further, sustainable funding must be considered.

THREATS:

- Dr. Vythilingam/Mr. Doug Slothouber: Protecting the work of the ISMICC through administration changes is critical.
- Dr. Hepburn: Messaging that is polarizing rather than bipartisan creates a backlash and pushback. Further, investing in relationships with leadership is beneficial.
- Dr. Higgins: The ISMICC needs to be nimble and able to pivot; COVID-19 is a good example of the need to do so.

OPPORTUNITIES:

- Ms. Johanna Kandel: Diversifying the ISMICC membership would improve representation.
- Mr. David Covington: 1) Including the youth has been the most impactful in his experience; 2) Including a national commercial payer on the ISMICC is important for parity; and 3) Continuing to build out and on 988 reduces the burden on law enforcement.
- [Note: Dr. Delphin-Rittmon noted the synergy amongst members and their comments and concurred with the value of these approaches and opportunities.]
- Dr. Everett/Dr. Shaw: A newsletter could address the need for communication amongst working groups.
- Dr. Vythilingam: Use the information from the listening session with people with lived experience to inform the work of the ISMICC.
- Dr. Hepburn: Technology and provision of services should be explored.
- Judge Leifman: Technology may eliminate silos, such the predictive analytic case management system pilot project developed at the University of Vermont for people with SMI.

After summarizing the discussion, Dr. Shaw recessed the meeting and Dr. Delphin-Rittmon welcomed members back after the break. She then turned the meeting over to Dr. Shaw who framed the report outs, which would include triumphs, trials (challenges), a discussion on the group trials and progress, suggestions for the group and a vote on the recommendations presented. Dr. Delphin-Rittmon introduced the first group.

Focus Area 1 - Data and Evaluation Working Group Report, Discussion and Voting
Margaret O'Brien, Ph.D., JD, Social Science Analyst, Center for Behavioral Health Statistics and Quality, SAMHSA; Nima Sheth, MD., MPH, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA

- **Federal Members:** Kate Bistline (SAMHSA); Joel Dubenitz (ASPE); Jennifer Humensky (NIH); Christopher Jones (CDC); Ira Katz (VA); Edward Liebmann (VA); Kirstin Painter (NIDILRR/ACL); Michael Schoenbaum (NIH); Meena Vythilingam (OASH)

- **Non-Federal Members**: Yasmin Brown (Hope Restored Suicide Prevention Project, LLC); Jennifer Higgins (CommonWealth GrantWorks)
- **Meeting Frequency**: Every two months

Dr. Nima Sheth highlighted members from the Data and Evaluation Working Group and Measurement-Based Care (MBC) as the primary focus of the working group. The group prioritized Recommendation 1.6; however, 1.7 (quality measures) is related.

Dr. O'Brien stated the work on Recommendation 1.6 is a "triumph" for this group and they have continued to meet in smaller, federal workgroup meetings, which included Dr. Sandy Resnick and Jessica Barber from the Veterans Administration (VA).

The working definition adopted at the October 2022 meeting is as follows: "Measurement-based care in community-based settings is a clinical process that uses standardized, valid, repeated measurements to track a client's progress over time and to inform treatment, utilizing a shared patient provider, treatment planning, and treatment decision making process." With that understanding, the group created a brief report with the intent to explore the nuances of MBC and its implementation; the report is pending agency review. In addition to a brief summary of the literature, the report also includes:

- The clinical purpose for using MBC
- How implementation might vary by population and setting
- Factors to consider in selecting and using measures like patient reported outcomes
- Implementation strategies including the need for leadership, champions, teamwork, and partnerships
- Strategies for performance improvement
- Using MBC within a culture of safety and growth
- Interfacing with health information technology

Dr. O'Brien explained reporting on *Recommendation 1.8: Continue to follow and gather information on relevant data linkage activities* is a challenge and would be premature because data linkage efforts are underway or in the planning stages. However, they will continue to monitor these activities.

Dr. Delphin-Rittmon opened the floor for comments; seeing none, she called for a vote to accept the report, which was unanimous.

Focus Area 2 - Access and Engagement Working Group Report, Discussion and Voting
Michelle Cornette, Ph.D., Lead Public Health Advisor, Suicide Prevention Branch, Division of Service and Systems Improvement, CMHS, SAMHSA; CDR David Barry, Psy.D., Chief Community Support Programs Branch, Division of Service and Systems Improvement, CMHS, SAMHSA

- **Federal Members**: Christopher Bersani, Kate Elkins, Emily Hassey, Stephen O'Connor, Lauren Ramos, Elizabeth Sweet, Kareem Thomas, Megan Whittaker

- **Non-Federal Members**: David Covington, Brian Hepburn, Amanda Lipp, Winnie Sprague, Rhathelia Stroud
- **Meeting Frequency**: Varies, but most recently monthly

Dr. Michelle Cornette highlighted members of the Access and Engagement Working Group and explained their primary focus has been to increase access to behavioral health services (make it easier to get good care). They prioritized *Recommendation 2.8: Maximize the capacity of the behavioral health workforce. Through federal interdepartmental planning, find ways to increase the capacity of the behavioral health workforce to meet the needs of people with SMI and SED and their families.* This recommendation includes, but is not limited to:

- 2.8a. Include coverage of peer and family support specialists in federal health benefit programs.
- 2.8b. Remove exclusions that disallow payment to certain qualified mental health professionals, such as marriage and family therapists and licensed professional counselors within Medicare and other federal health benefit programs.
- 2.8e. Remove reimbursement and administrative burdens associated with psychiatric care within Medicare, Medicaid, and other federal health benefit program.
- 2.8g. Enable health care providers to practice to the full extent of their education and training. For example, remove barriers preventing advanced practice registered nurses from prescribing medication.

CDR. David Barry explained the group met with Dan Logsdon, Director of The National Center of Interstate Compacts at the Council of State Governments Center of Innovation to learn about the history and background of professional interjurisdictional pacts, and Ann Herron from SAMHSA's Office of Intergovernmental and External Affairs to discuss strategies for integrating peer support professionals. They also met with representatives from SAMHSA's Office of Recovery to discuss creative strategies for expanding the integration of peer support professionals into behavioral health care and were joined by a CMS representative, who offered insights into peer support reimbursement. However, states need to be educated and made aware of strategies for adopting the guidance.

CDR. Barry elaborated on the components of peer certification, which include eligibility, qualifications, rates of compensation, and the need for reciprocity between the states to allow peer specialists the ability to practice and fill workforce gaps if they move. The Commission on Accreditation of Rehabilitation Facilities (CARF) accredits peer service as well.

Regarding trials for this group, Dr. Cornette highlighted the following:

- Action on a prior recommendation of the working group's non-federal members to explore the possibility of a letter or statement from HHS leadership to states, professional associations, or both, encouraging the maintenance of the professional interjurisdictional pacts between states that are already participating and adoption of the pacts for states that are not.
- Explore opportunities with the Office of Recovery for further adoption and proliferation of peer support services, to include expansion of reimbursement

- Review, amplify, and further support the uptake/dissemination of SAMHSA's Office of Recovery's upcoming Peer Support Guidelines
- Engage Health Resources and Services Administration's (HRSA) Office of Telehealth to discuss ideas for the continuation and proliferation of telehealth in this post-COVID-19 emergency era, and explore strategies for sustainment of telehealth funding
- Continue connecting with the stewards of the Finance and Access and Engagement working groups
- Having lost their CMS representative, the group welcomes a replacement

Dr. Delphin-Rittmon opened the floor for discussion.

Discussion

Dr. Trinidad de Jesus Arguello expressed concern over and questioned if the group was asking for telehealth to be a primary form of contact in delivering services. CDR. Barry stated the group is not necessarily promoting it as the primary source, but rather wants to learn how telehealth can be preserved and where it would fit within a post-COVID-19 behavioral health environment.

Dr. Cornette explained the utilization of telehealth would be consumer and patient driven and concurred with the challenges while affirming the benefits. She also noted for the first time many licensed mental healthcare professionals are able to provide telehealth across state lines if their state participates and, in some cases, provide in-person services in another state for a very limited number of days without having to get licensed in that state. Ms. Rhonda Basha concurred, noting its benefits since people with disabilities often face major transportation barriers, and youth in transition tend to use technology.

Mr. Covington appreciated the working group's focus on the workforce and explained how certified peer coaches, who comprise at least one third of the staff, are deployed to the crisis centers. Leveraging all available resources is critical when the cost to provideservices is three to five times more expensive than pre-pandemic costs.

Dr. Delphin-Rittmon called for a vote to accept the report out, which was unanimous.

Focus Area 3 -Treatment and Recovery Working Group Report, Discussion and Voting
Doug Slothouber, MA, MSW, Chief, Eastern States, Division of State and Community Systems Development, CMHS, SAMHSA; Nancy Kelly, MS, Ed, Chief, Mental Health Promotions Branch, Division of Prevention, Traumatic Stress and Special Programs, CMHS, SAMHSA

- **Federal Members**: Meena Vythilingam (OASH), Richard Davis (DOL), Rhonda Basha (DOL), Sandy Resnick (VA), Susan Azrin (NIMH), Corey Minor Smith (HUD), Sarah Russo (DOJ), Yolanda Lusane (ED)
- **Non-Federal Members**: David Covington, Rhathelia Stroud, Amanda Lipp, Johanna Kandel
- **Meeting Frequency**: Approximately Monthly

Mr. Doug Slothouber stated the Treatment and Recovery Working Group has focused on promoting federal adoption and support for underused evidence-based practices, including

supported employment (SE), supported housing, and early SMI including first episode of psychosis (FEP) treatment.

As a triumph, Mr. Slothouber shared their work on *Recommendation 3.1: Provide a comprehensive continuum of care for people with SMI and SED*. Specifically, SE is underused, including the Individual Placement and Support (IPS) component, and would benefit from promotion and coordination through the ISMICC. This element was considered when it was included as part of psychiatric rehabilitation services in the revised criteria for Certified Community Behavioral Health Centers (CCBHCs). Mr. Slothouber pointed out the previous barrier of steady funding and hopes CCBHCs will meet that challenge.

Mr. Slothouber explained that with interdepartmental participation and collaboration, SAMHSA is developing a Policy Academy for selected states on SE for transitional aged youth. They have also provided a variety of guidance to states on using COVID supplemental funding and block grant funding, and made recommendations for SE. Notably, the Department of Labor's Office of Disability Employment Policy (ODEP), is also implementing SE by launching the Advancement of State Policy Integration Recovery and Employment (ASPIRE) initiative in seven states, allowing them to support and expand competitive integrated employment for people with mental health conditions. Mr. Slothouber called upon Ms. Rhonda Basha to elaborate.

Ms. Basha stated the second round of the ASPIRE initiative will include Florida, Indiana, Iowa, Virginia, which were also part of the first round, and three new states: Louisiana, Montana, and New York. Ms. Basha explained, "ASPIRE seeks to align state policy and funding to advance competitive integrative employment for individuals with mental health conditions that provide states with tailored and targeted technical assistance to expand these and evidence-based practices such as the IPS model of supported employment."

With support from subject matter experts and input from key mental health advocacy organizations, participating state organizations will create strategic plans to leverage mental health, behavioral health, Medicaid, vocational rehabilitation, and workforce and education systems. ASPIRE also provides a forum to explore policies and practices for implementing evidence-based models. Such technical assistance is provided by Westat Data Research Firm.

Additionally, the National Task Force on Workforce Mental Health Policy was announced in December 2022 and is co-chaired by Colorado Lieutenant Governor Dianne Primavera and Tennessee State Senator Becky Massey. The group is comprised of state policy makers, governors, representatives and mayors from the US Congress of Mayors Mental Health, and Unemployment Working Group. Created as part of the State Exchange on Employment and Disability (SEED) initiative, state and local governments are supported in adopting inclusive policies leading to competitive integrated employment. Through the use of intermediary organizations, including the National Conference of State Legislators, the National Governors' Association, the Council of State Governors, and the US Conference of Mayors, states can explore and identify policy options for addressing major workforce challenges and barriers to employment for people with mental health conditions.

The task force will meet once again in late April 2023 to address and review a series of policies and strategies related to non-discrimination, parity and benefits, care and supports, underserved communities, and behavioral health workforce shortages in state behavioral health resource systems. As Ms. Basha explained, "This work will inform the development of a series of workplace mental health resources, including a comprehensive policy framework for state and local policy makers."

Mr. Slothouber highlighted a comprehensive continuum of care for people with SMI or SED for people with early SMI, including first episode psychosis (FEP), as another priority. SAMHSA's new State Technical Assistance Contract includes developing an inventory of existing, emerging, and promising evidence-based practices (EBP) addressing the needs of individuals with the SMI, including FEP. A triage team will be convened to make recommendations on which EBPs should receive greater support and promotion. A variety of resources will be developed, including guidance manuals, issue briefs, distance education materials, and short documents.

In terms of trials, due to the broad focus of this workgroup, ensuring conversations are relevant to meeting participants is challenging and a goal of the workgroup stewards.

Dr. Delphin-Rittmon opened the floor for discussion.

Discussion

Ms. Basha stated she put out a paper on FEP exploring many models, its history, and leveraging the workforce system to fund it.

Mr. Kennedy stated ACL would be interested in partnering with the Treatment and Recovery working group. He asked if the working group had considered how competitive integrated employment has shifted through COVID-19 and the drug workforce crisis. Secondly, with ASPIRE funding, CMS could be part of the conversation.

Dr. Delphin-Rittmon asked for a motion to accept the report, which was accepted unanimously.

Focus Area 4 - Criminal Justice Working Group Report, Discussion and Voting
Karen Gentile, LCSW-C, JD, Director, Office of Policy Coordination and Innovation in Mental Health, CMHS, SAMHSA; Maia Banks, MS, Chief, Homeless Programs Branch, Division of Service and Systems Improvement, CMHS, SAMHSA

- **Federal Members**: Maria Fryer (BJA), Mariel Lifshitz (BJA), Cornelia Sigworth (BJA), Sarah Russo (DOJ/CRT), Dia Boutwell (BOP), Jhamirah Howard (ASPE), Nancy Kirshner (CMS), Marian "Taffy" McCoy (SSA), Michelle Keeney (DHS/USSS), Katharine Stewart (VA), Roxanne Castaneda (SAMHSA), Jon Berg (SAMHSA), Joseph Bullock (SAMHSA), Leah Compton (SAMHSA), Tiffany Russell (SAMHSA)
- **Non-Federal Members**: Judge Rhathelia Stroud (Dekalb County, GA), Judge Steve Leifman (Miami Dade, Florida), Ron Bruno (CIT International), Katherine Warburton (California Department of State Hospitals), Trinidad Arguello (Compostela Community and Family Cultural Institute)

- **Meeting Frequency**: Monthly

Ms. Maia Banks explained the Criminal Justice Working Group focuses on advancing the use of diversion at all points of the Sequential Intercept Model (SIM) and providing quality treatment and recovery supports for people with SMI and co-occurring disorders. The prioritized recommendations are:

- 4.3 Diversion
- 4.4 Competency to Stand Trial
- 4.5 Problem-Solving Courts
- 4.6 Universal Screening in Jails/Detention/Diversionary Community Services
- 4.7 Restrictive Housing, Seclusion and Restraint
- 4.8 Re-entry

Ms. Gentile highlighted the triumphs for this group, which include completing an inventory of activities for all intercepts to identify gaps and points of synergy between federal activities, foster collaboration, and inform discussion; aligning upcoming work and activities of the Bureau of Justice Assistance with the National Judicial Task Force recommendations from its October 2022 report pertaining to each intercept; and discussing Recommendation 4.4 regarding competency to stand trial.

Ms. Gentile noted the April 2023 meeting will include a discussion led by Tiffany Russell from SAMHSA's 988 and Behavioral Health Coordinating Office on Recommendation 4.3 regarding diversion in crisis services and how her office contributes to the field. They will also discuss the issue of racial disparities in diversion programs. As for trials, the group will need to focus more on youth in the adult criminal system and youth in criminal justice in their discussions and work, particularly since there is not a separate workgroup for this. They will do the same regarding issues of disparities.

Dr. Delphin-Rittmon opened the floor for comments; seeing none, she asked for a motion to accept the report, which was accepted unanimously.

Focus Area 5 - Finance Working Group Report, Discussion and Voting
David de Voursney, MPP, Director, Division of Service and Systems Improvement, CMHS, SAMHSA; Nikhil "Sunny" Patel, M.D., MPH, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA

- **Federal Members**: Jacob Ackerman (CMS), Beth Baum (DOL), Mitchell Berger (SAMHSA), Kirsten Beronio (CMS), Dr. Judith Dey (ASPE), Dr. Abdallah Ibrahim (SAMHSA), Noah Isserman (CMS), Jennifer Masoodi (DOJ), Jenny Nate Cornelia (SAMHSA), Amber Rivers (DOL)
- **Non-Federal Members**: Dr. Brian Hepburn, Hon. Rhathelia Stroud, Dr. Katherine Warburton
- **Meeting Frequency**: Monthly

Mr. David de Voursney stated the focus of the Finance Working Group is to develop finance strategies to increase the availability and affordability of care. Current priorities include finalizing an updated, revised version of the original working group recommendations and identifying activities and priorities within the approved recommendations to establish the financing agenda. Mr. de Voursney turned the meeting over Ms. Beth Baum (DOL).

Ms. Baum and fellow group member, Jacob Ackerman (CMS) work with representatives from the Department of the Treasury and the Internal Revenue Service in a tri-department process to implement the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA), which is a top priority.

Ms. Baum updated members on the group's rulemaking activity as well as the report to Congress. They continue to implement MHPAEA by continuing dialogue with the regulated community and interested parties, especially regarding requirements added to MHPAEA at the end of 2020 by the Consolidated Appropriations Act (CAA). Specifically, group health plans and health insurance issuers are required to perform and document comparative analyses of any non-quantitative treatment limitations applying to mental health or SUD benefits. Additionally, the tri-department working group is developing proposed rules under MHPAEA (publish date unknown). Once released and published in the Federal Register, public comments from interested parties are welcome.

Also as required under the CAA, the group is working on the report to Congress, which will detail the department's enforcement efforts on non-quantitative treatment limitations. Again, upon request, plans and issuers must prepare and provide analyses of how they are complying with mental health parity.

Regarding Recommendation 5.5, Dr. Nikhil "Sunny" Patel stated the group is exploring and hopes to conduct a study of the participation of the behavioral health workforce and public insurance programs, particularly providers accepting Medicaid and Medicare as insurance.

Mr. de Voursney noted the group's excitement over its progress regarding CCBHCs, which is of interest to a number of states. When CCBHCs were first established under the Medicaid demonstration, there were 67 CCBHCs in eight states. Through a combination of the CCBHC expansion grant program, there are now more than 500 CCBHCs across the country in 46 states and the District of Columbia, Guam, and Puerto Rico.

Due to the Bipartisan Safer Communities Act, which has provisions to expand the Medicaid demonstration for CCBHCs, SAMHSA launched one cohort of 15 planning grants this year and will launch another 15 in 2025. This effort will provide a sustainable pathway for CCBHCs as they will receive a cost-based reimbursement for their comprehensive service packages.

Other work on the initiative includes guidance allowing existing demonstration state programs to add additional clinics to their programs resulting in broader implementation. Further, a draft version of the updated criteria went out for public comment at the end of 2022. The new version will be released soon and includes more specifics around crisis services and an equity focus within CCBHCs as well as SE programs.

Mr. de Voursney explained the group is now able to advance the final set of recommendations and looks to the full ISMICC for approval. Recommendation 5.2 was agreed upon with an added focus on home and community-based services; focus on emergency department boarding; language related to inpatient care within a continuum of care, including crisis care and stepdown care; language on coordination of funding streams and engaging private health plans and states in Olmstead; early periodic screening, detection, and treatment; and the Emergency Medical Treatment and Labor Act (EMTALA).

Changes to Recommendation 5.4 include an important exception related to DOJ's stance on ending the Institutions for Mental Disease (IMD) exclusion, which is:

> "The U.S. Department of Justice enforces Title II of the ADA, and consistent with Olmstead v. L.C., 527 U.S. 581 (1999), seeks to ensure that people with disabilities receive services in the most integrated settings appropriate to their needs. Because of its enforcement experience, DOJ does not support the recommendation to end the IMD exclusion, or the recommendation to categorically exclude crisis stabilization beds from the definition of an IMD. Instead, DOJ recommends retaining current Medicaid limitations on reimbursements for IMDs because those limitations incentivize building robust community-based mental health services systems. DOJ also notes that there are already a number of waivers and other Medicaid authorities that permit states to fund IMDs using Medicaid dollars to a more limited extent."

The language also includes additional verbiage regarding crisis stabilization beds, Medicare provider types, and residential care.

Dr. Patel noted trials this group has faced include uncertainties related to the ending of the Public Health Emergency (May 2023) and ongoing conversations regarding the role of inpatient care and the IMD exclusion.

Dr. Delphin-Rittmon opened the floor for discussion.

Discussion

Ms. Kirsten Beronio explained the IMD exclusion is a statutory exclusion, and CMS tries to address concerns about how it creates barriers to access to care, particularly for people dealing with a crisis or a more serious mental health or SUD condition. Using its managed care authority, CMS has offered flexibility and highlighted crisis services as the part of the demonstrations to ensure provision of a more robust continuum of community-based and outpatient care, including crisis stabilization services.

Ms. Basha noted strong interest in primarily serving people in the least restrictive environment within the community.

Mr. Covington expressed appreciation for the focus on psychiatric boarding and the impact of the entire crisis continuum. Though most people associate psychiatric boarding with inpatient capacity, it is really associated with "choke holding everyone at higher intensity through that

hospital for medical clearance”. This drives law enforcement to a choice of incarcerating someone or waiting for a person in a hospital emergency department. Mr. Bruno concurred; the goal is to reduce law enforcement’s role and increase the role of behavioral healthcare services to handle crises.

Mr. de Voursney noted the IMD exclusion is a complex issue encompassing the need for people to have access to the appropriate level of care while there is also a legacy of people having improper placements and mistreatment within the system. The group is committed to serving people in the least restrictive setting possible and to improve community-based care.

Dr. Arguello, a clinician at the Taos County detention center, stated jail is not appropriate for people with mental illness; in fact, it exacerbates psychotic symptoms and creates more trauma. Further, when an incarcerated person needs to be hospitalized, she must contact the district judge to waive the charges and wait days before a facility is found.

Dr. Hepburn explained that though the IMD is in statute, its definition has changed over many years. The original intent for the IMD was to prevent states from having to pay for long-term care during a time when individuals were staying for over a year. Current proposals are being discussed as if the goal is for people to go back to state hospitals when in fact the goal is to provide community care that keeps people from being institutionalized and out of jail, (a crisis model recommended and supported by SAMHSA).

Judge Leifman stated IMD, which was written in 1965 when the field knew very little about neuroscience, is now “used as a sword instead of a shield to protect people”. Ironically, a person is only entitled to treatment if they commit a crime and are incompetent to stand trial. Further, because states do not have enough beds, they use most of the civil beds. Because crisis facilities generally do not get paid to keep people in the crisis beds if they meet criteria for long-term hospitalization, they discharge the person as quickly as possible, and the cycle repeats itself. He emphasized the limitation on 16 crisis beds is killing this population and urged laws that reflect current science and models.

Dr. Warburton explained there is a growing body of empirical evidence showing people without access to short-term stabilization in the community are arrested and housed in forensic state hospitals, jails, and prisons. Further, thousands of people across the nation are waiting to get into state hospitals. She spoke to the need of a nuanced approach to the IMD topic to ensure people who are in crisis with a neurobiological disease have the same access to care as people who are in crisis with other medical diseases.

Ms. Basha suggested adding language to the recommendation to explain it is meant for short-term stabilization, not as a gateway to institutionalization. Mr. de Voursney replied the group would support that; however, it would be up to the full ISMICC to decide.

Mr. Kennedy asked if data could be collected on states with 1115 IMD waivers to see if they are actually developing community behavioral health services and keeping people out of institutions. Mr. de Voursney replied the group is looking at many variables.

Dr. Delphin-Rittmon called for a motion to approve the report with the additions to Recommendation 5.2, which was accepted, and then a motion to amend Recommendation 5.4, which was also approved and will come back to the full ISMICC at the next meeting for review

and a formal vote. She then noted one of the strengths of the ISMICC is the many different perspectives and backgrounds members bring to the discussions and called for a break.

The One Mind Initiative: Social Innovation for Better Mental Health
Brandon Staglin, M.S., President, One Mind

Drs. Delphin-Rittmon and Everett introduced Brandon Staglin, President of One Mind. With his own lived experience, Mr. Staglin advocates for large-scale continuous improvement of services, prevention, and early intervention services for youth facing serious psychiatric illness. Mr. Staglin expressed his gratitude for the work of the ISMICC and the opportunity to speak.

When he was diagnosed with schizophrenia at age 18, Mr. Staglin's supportive family had the resources to access care within three days of his psychotic episode. Though many millions of people do not have the same access to care as he did, he is hopeful that will change with the work of the ISMICC and organizations like One Mind.

Based in Napa, California, One Mind has national, regional, and local influence and has been a change leader in mental health for 29 years through science, business, and media. One Mind is championing an accelerator program and a media division, two new frontiers working in tandem to improve care and access.

Because research shows YouTube is the most popular social media platform for searches related to mental health conditions, One Mind All Media is partnering with YouTube to produce content to destigmatize how young people feel about mental illness and promote health seeking. The goal is to reach about 12 million views per year and shift attitudes and behaviors by 10 percent by 2026.

The content is being developed based on their survey of 2,000 people aged 13 to 39 across the nation to understand how they experience mental illness and look for and use support and informational resources online. The research revealed:

- Mostly everyone has someone in their circle diagnosed with a mental health condition, most commonly, anxiety and depression; however, conditions such as bipolar disorder, major depressive disorder, and schizophrenia and psychosis were also reported.
- 81 percent have been diagnosed or recently sought support for their own mental health condition.
- 75 percent have felt stigmatized due to their mental health condition.
- 70 percent feel the term "mental health" still carries a stigma in our society.
- 64 percent of these people have felt discouraged from seeking help for their mental health condition. This is especially pronounced among historically marginalized communities, including people of color, LGBTQ+ individuals, teenagers, and men.

The survey also revealed the top three reasons people are not seeking help for their mental health condition are:

1. Cost or lack of financial resources
2. Embarrassment (self-stigma)
3. Unsure where to look for help or support

Outreach campaigns will be based on these three pain points as well as other survey data and focus on promoting self-acceptance and empowerment to individuals facing SMI; promoting help seeking for this population; and educating these individuals and their caregivers on how to engage with tools and services for their own healing.

To that end, One Mind All Media will produce two content streams. The first is expert content, such as understanding how and where to seek help, what mental illness means, different forms of mental health conditions, all presented in a very authoritative way. The second is lived experience, such as airing stories and having deep conversation with young people and influencers who experience mental illness themselves.

Launching mid-2023, *Healing with Tom Insel* will feature influencers with lived experience such as Chris Cullins and Jordan Sparks, who will share best practices and their lived experience with SMI. Hosted by Dr. Insel, a former director of the National Institute for Mental Health and One Mind partner, the webcast aims to reduce self-stigma, increase treatment seeking behavior, increase beliefs in recovery and empowerment, and address public stigma and the fear and distancing related to SMI. They will also produce pieces under one minute called "explainers" based on YouTube search inquiries with top subject matter experts. Further, 24 biweekly episodes, each five to 15 minutes long, will feature luminaries, such as webcast host for One Creative Mind, gold medalist Laurie Hernandez; X.ARI, a young LGBTQ musician; and comedienne Yamanieka Saunders.

Another content stream is PsyberGuide, an authoritative evidence-based review platform for mental health apps. Released monthly and under one minute long, these videos will also increase access to digital support and resources as well as amplify public awareness of One Mind initiatives.

The other frontier is the One Mind Accelerator. Though investment in mental health startups and apps, such as Calm and Headspace, has grown tremendously over the last six years, SMI has been largely ignored by the investment community. To turn this tide, One Mind Accelerator seeks to back visionary founders of early-stage startups with the network, education, and capital to correctly build category-defining companies and help them address the needs and improve the lives of people living with SMI. Investment focus areas are preventive services and deep science to improve actual treatment. The Guiding Council for the accelerator includes five national investment leaders: Garen Staglin, Christopher Lyle, Harvey Schwartz, Gwill York, and Aaron Gershenberg.

Launched two weeks prior to the meeting, the inaugural cohort includes Link, Zama, Sanarai, Flourish Labs, Options MD, Heading Health, Tetricus Labs, Flowly, Motif Neurotech, Flock Health, and Ceretype Medicine. Participants will receive eight weeks of virtual programming, one week of in-person training, and then participate in a demo day on May 3rd in Menlo Park, California.

The accelerator offers mentoring, community, brand development, capital, business development, and perks to rapidly grow the startup. The program will also include four other elements:

- Founder stories told by successful entrepreneurs with lived experience

- Expert sessions led by biomedical industry leaders Katya Malievskaia, Husseini Manji, Amit Etkin, Steve Paul, and Brett Wingeier
- Mentor matching to expand the startups network
- Pitch intensives led by top investor communication experts

In closing, Mr. Staglin noted the work of his colleagues Dalton Delan and Kelly Deckert of One Mind All Media, and Pushkar Joshi and Carmine DiMaro from One Mind Accelerator.

Dr. Delphin-Rittmon opened the floor for discussion.

Discussion

Dr. Everett noted the creative, innovative work to finance and facilitate the success of companies oriented to making life better for individuals with SMI.

Mr. Staglin explained for many years they have partnered with government agencies to provide follow-up funding to scale the innovations. He added because the academic process of getting new interventions out to the field is slow, they added this new program to leverage the investment community, its vast resources, and the speed with which they can operate.

Dr. Delphin-Rittmon turned the meeting over to Ms. Foote.

Public Comment
Pamela Foote, Designated Federal Official, ISMICC

Ms. Foote opened the meeting for public comment. She stated those who phoned in and requested to speak would be called upon in the order requests were submitted, and their public comments would become part of the meeting minutes. Unedited comments were as follows:

Ms. Anne Corcoran: Good afternoon. As a nurse, a mother of an adult son that lives with bipolar disorder, and an advocate for those that live with serious brain disorders, I first wanted to take the opportunity to thank this committee, along with the current administration, for the critical investment in addressing the mental health crisis that our country has so long faced.

I live in Massachusetts where we have seen some great things happen. We now have 29 CCBHCHs spread across the state. We passed the Mental Health ABC Act 2.0, addressing barriers to care, have made funding available to help mitigate the mental health boarding crisis, continue to increase the number of inpatient beds, and have developed some great diversion programs within the criminal justice system, such as the Boston Outpatient Assisted Treatment and the Services Over Sentences Programs.

Despite these wonderful accomplishments, living with a serious mental illness in Massachusetts has become synonymous with either a death sentence or a life sentence. As I have mentioned during past meetings, we are one of three states in the entire country without an assisted outpatient treatment (AOT) model.

This past December, 48-year-old Latasha Sanders was convicted on two counts of first-degree murder for stabbing her five- and eight-year-old sons. She was mentally ill, refused treatment, and had become obsessed with voodoo rituals starting two years prior.

In February, 56-year-old Marian Griffiths was shot dead by police after her son called for a wellness check. Marianne had known mental health issues and suicidal ideation. She was well known to police as they had been called to her house on many occasions for threats of harming herself. Police shot Marianne after she appeared in her doorway with what appeared to be a rifle aimed at police officers. Upon further examination it was noted to be a BB gun. Unfortunately, tragedies like this related to untreated serious mental illness are becoming the norm in Massachusetts.

Assisted outpatient treatment is a missing link in our state. It is supported by SAMHSA and recognized as evidence-based treatment. The unfortunate reality is that many still struggle in getting their loved ones with serious mental illness needed treatment despite having AOT laws. Without standards in place these laws often don't help the way they were intended to.

I urge this committee to focus on developing standards and best practices for AOT programs, and to increase funding for this evidence-based practice. I encourage all states to adopt AOT laws and offer funding similar to what has been done for CCBHCHs. Doing so will help transform treatment for those specifically with serious mental illness who without AOT would continue to cycle in and out of the hospital, become homeless, incarcerated, or dead. Our loved ones deserve more, families like mine deserve more.

As an addendum to my original comment, last night my son was threatening to take his life. As a parent I beg this committee to focus on solutions to help those living with severe mental illness. It is my understanding that ISMICC was developed to focus on those like my son who live with a no-fault brain disorder, yet every day my biggest fear is whether or not he will live another day. Families like mine have few if any viable options. As a civilized society we simply have to do more. Thank you for giving me the opportunity to have my comments heard.

Sherry Makenzie: This is Sherry Makenzie, I am part of NAMI South Mountain, I'm on the NAMI North Carolina Policy Board and on the Board of National Shattering Silence. These are my asks. End the lifetime Medicaid and Medicare cap, reclassify schizophrenia neurological disorders, increase reimbursement rates, modify HIPAA, educate providers about the current HIPAA laws, federalize improved commitment laws, do not wait until dangerousness. Fund assisted outpatient programs in civil and criminal mental health courts.

Allow HUD to subsidize supported community living along the continuum of care. Fund psychiatric assisted living campuses, loan forgiveness for the mental health professionals, expand medical and mental health profession programs, fund certified Community Behavioral Health Centers.

The Federal 988 number will only be as good as where families, police, sheriffs, and EMS can divert them to. I've been so thankful for them being there by my side, they can't say no either.

While politics are important to me it's getting healthcare that is needed. Serious mental illness is a no-fault brain disease, not a crime. Not getting the supported care is.

For the last 16 years and 32 hospital stays we have [kept his] beautiful minds alive. A veteran marine, getting guardianship was heartbreaking but it has allowed communication with his healthcare providers outside of HIPAA, participation in his treatment plans and medication, while protecting his rights as a human being to be treated with respect and dignity. He has that one percent of the most serious no fault brain illness that strikes a young man. He has survived through the manic, the paranoia, the delusion, the manic depressive, and the PTSD of this disease. After he became a harm to himself and others, we finally got him the long-term care in one of our state hospitals. He is stable enough to live alone now, yet he is isolated.

The one thing you learn with this illness is it is very isolated for our loved ones living with SMI. So here we are trying to start a brighter House clubhouse in our rural town. We have put it on hold for two years because of the pandemic. I watched our government move mountains during the pandemic, and we thank you.

Yes, it was difficult to watch because families like ours have lived in crisis mode for the last 50 years. We know what it's like to wait on a bed and a vaccine and a cure. So please if you don't have the power to end the IMD exclusion or to reclassify schizophrenia so this illness can receive the treatment and care that is needed, a 24- hour hold or a 72-hour hold is not enough time when your loved one is in psychosis.

When our son has experienced anosognosia, he became the archangel Michael, and we have seen his adrenaline so high he could stroke out. And if it's this difficult as a mom of a veteran marine to get the mental healthcare that's needed, I really can't imagine what a single mom is going through. Thank you for your time and your help for families like ours.

[Ms. Foote called on the following people who did not respond: Danny Landrove, Shanita Malaki, Kimber Rotchford, and Sharma Weeks.]

Katie Dale: Thank you for fielding my comment today. To members of ISMICC, we, the members of the National Shattering Silence Coalition are comprised of people with lived experience like myself, families, caregivers, and professionals, continuing to follow your policy efforts. And in response to your October meeting minutes we wanted to share the following thoughts. Again, we would like to emphasize the imperative need there is to eliminate the barriers to accessing treatment.

There is now one hopeful bill standing by, HR 7803, the Michelle Alyssa Go Act that would strike the most obvious and broadest barrier to care down, as we repeatedly stress repealing the IMD exclusion would allow for increased reimbursement for inpatient care in all facilities at various levels of care, including access centers and longer-term housing like (inaudible).

In past meetings members of the ISMICC working group for IMD has discussed and disagreed over this point. The NSSC would like to make the case for why we need to end IMD laws, and

why as the civil rights division quotes $40 to $60 million in Federal Government costs are not as costly as the price paid by continuing to keep this archaic and discriminatory law in place.

Firstly, the IMD exclusion is costing the public more than appropriate treatment. In 2021 the Schizophrenia and Psychosis Action Alliance published an extensive review of peer reviewed published studies, the societal costs of schizophrenia and related disorders. Their findings show that direct and indirect costs of having a serious brain illness are over $281 billion from our annually in the cost of persons not affected, in that many cases go untreated. The SMPAA report estimates that the caregiver burden and unpaid labor to be about $104 billion, and the SMPAA report estimates the societal cost to be approximately $5.1 billion.

Secondly, the IMD exclusion proposes societal costs, public and family tragedies, repealing the IMD exclusion allowing for early intervention and appropriate treatment would decrease the likelihood of law enforcement interaction.

Thirdly, eliminating the IMD exclusion and allowing appropriate treatment in the most appropriate setting eliminates the cost of providing a jail for nearly 400,000 people with serious brain disorders or serious mental illness currently in the prison population, and takes many of the estimated up to 325,000 people with serious brain disorders off the streets, greatly reducing the emotional and financial burdens to local, county, and state governments caring for our homeless population.

We are the voices of those who know, we are speaking from firsthand experience, and we are watching for you to act. Signed, the NSSC Policy Action Committee on behalf of the members of the National Shattering Silence Coalition. Thank you.

Ms. Foote called on Carolyn Grey and Janet Hayes who did not respond. She then thanked each caller, adding that all submitted written comments, including those unread, would be available in full, for the written record of this meeting. She then turned the meeting over to Dr. Delphin-Rittmon for closing comments.

Final Comments and Adjourn
Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use (SAMHSA)

Dr. Delphin-Rittmon thanked all meeting participants and adjourned the meeting at 3:45 p.m.

Full Public Comments Submitted for Meeting Record, March 14, 2023

Ann Corcoran RN, MSN
Co-Chair, Policy Action Committee
National Shattering Silence Coalition

Dear Members of ISMICC,

As a nurse, a mother of an adult son that lives with bipolar disorder, and an advocate for those that live with serious brain disorders I first wanted to take the opportunity to thank this committee along with the current administration for their critical investment in addressing the mental health crisis that our country has so longed faced.

I live in Massachusetts where we have seen some great things happen. We now have 25 CCBHC's spread across the state, we passed the Mental Health ABC Act 2.0 :Addressing Barriers to Care, have made funding available to help mitigate the mental health boarding crisis, continue to increase the number of inpatient beds, and have developed some great diversion programs within the criminal justice system such as the Boston Outpatient Assistant Treatment and the Services Over Sentences Programs.

Despite these wonderful accomplishments, living with a serious mental illness in Massachusetts has become synonymous with either a death sentence or a life sentence. As I have mentioned during past meetings, we are 1 of 3 states in the entire country without an Assistant Outpatient Treatment law.

This past December, 48-year-old Latarsha Sanders was convicted on two counts of first degree murder for stabbing her 5 and 8 year old sons. She was mentally ill, refused treatment and had become obsessed with voodoo rituals starting two years prior.

In February, 56-year-old Marianne Griffiths was shot dead by police after her son called for a wellness check. Marianne had known mental health issues and suicidal ideation, she was well known to police as they had been called to her house on many occasions for threats of harming herself. Police shot Marianne after she appeared in her doorway with what looked to be a rifle aimed at police officers. Upon further examination it was noted to be a BB gun. Unfortunately tragedies like this related to untreated serious mental illness are becoming the norm in Massachusetts.

Assisted Outpatient Treatment is the missing link in our state. It is supported by SAMHSA and recognized as evidenced based treatment. The unfortunate reality is that many still struggle in getting their loved ones with serious mental illness needed treatment despite having AOT laws. Without standards in place, these laws often don't help the way they were intended to.

I urge this committee to focus on developing standards and best practices for AOT Programs and to increase funding for this evidenced based practice. Encourage all states to adopt AOT laws in offering funding similar to what has been done for CCBHC's. Doing so would help transform treatment for those specifically with serious mental illness who without AOT would continue to

cycle in and out of the hospital, become homeless, incarcerated or dead. Our loved ones deserve more, families like mine deserve more.

Sincerely,
Ann Corcoran RN, MSN

Sherri McGimsey

End lifetime Medicaid and Medicare Caps

• Reclassify as Neurological Disorders

• Increase Reimbursement Rates

• Modify HIPAA / Educate providers about current HIPAA laws

• Federalize Improved Commitment Laws (don't wait til dangerous)

• Fund AOT (Assisted Outpatient Treatment Programs) & Civil & Criminal MH Courts

• Allow HUD to Subsidize Supportive Community Living all along Continuum of Care

• Fund Psychiatric Assisted Living Campuses

• Loan Forgiveness for MH Professionals

• Expand Medical & MH Professional Programs

• Fund CCBHC's (Certified Community Behavioral Health Centers)

Anosognosia is a Brain illness causing a Lack of Insite. Lort the medication they need will take 23 years off their life, also makes them impotent.
Suicide when they are so manic they want to die when manic depressed they can be a danger to self and others. The federal 988# will only Be as good as where Family's, Police, Sherriff and EMS can divert them to. I'm So thankful for them being there by my side. They can't say no either.

Why politics are important to me is getting the health care that is needed. Serious Mental illness is a no-fault brain disease. It is Not a crime. Not getting this supportive care is.

For the last 16 years and 32 hospital stays we have loved and fought to keep our beautiful mind alive, a Veteran Marine. Getting Guardianship was heartbreaking, but it has allowed communication with his health care providers outside of HIPPA, participation in his treatment plans and medications while protecting his rights as a human being to be treated with respect and dignity.

He has that 1% of the most serious no fault brain illness that strikes the young schizoaffective. He has survived through the manic the paranoia the delusions the manic depressive and the PTSD of this disease. After he became a harm to self and others, we

finally got him the long-term care in one of our state hospitals he is stable enough to live alone now yet he is isolated.

The one thing you learn with this illness is that it is very isolating for our loved ones living with SMI and living alone.

So here we are trying to start a Brighter House Clubhouse in our rural town. We had put it on hold for two years because of the pandemic.

I watched our government move mountains during the pandemic, and we thank you. Yet it was difficult to watch because families like ours have lived in crisis mode for the last 50 years. We know what it's like to wait on a bed, and a vaccine, and a cure. So please if you don't have the power to end the IMD Exclusion or to reclassify schizophrenia so this illness can receive the treatment and care that's needed. A 24 hour hold or a 72 hour hold is not enough time when your loved one is in psychosis when our son experienced Anosognosia, he became the Archangel Michael and we have seen his adrenaline so high that he could stroke out.

If it is this difficult, as a Mom of a Veteran Marine to get the Mental healthcare that's needed, I Really can't imagine what a single Mom is going through.

Thank you for your service, support and time.

Sincerely

Sherri McGimsey

Ann Marie Smith
Volunteer at NAMI

With the lack of access, therapy, counseling for mental illness, are there incentives/funding for more training (certification), employment/social training and housing so that more trained counselors will be available?

We have a hard time finding adequate therapy for our adult son.

Thank you.
Ann Marie Smith

Jacqueline Fowler

These are 5 specific recommendations for using Massage therapy and other Holistic modalities to better coordinate the administration of mental health services for adults with Serious Mental Illness (SMI).

Stressbusters Inc has for over 20 years working with persons living with SMI. We suggest adding this Alternative Holistic Care field to the Granting list.

1. Collaborate with mental health professionals: Massage therapists can work collaboratively with mental health professionals to develop treatment plans for individuals with Serious Mental Illness (SMI). They can share information on the client's progress, goals, and other relevant information to help improve their mental health outcomes.

2. Tailor massage therapy to the client's needs: Massage therapists should tailor their approach to the client's needs, taking into consideration any physical or emotional issues that may impact their ability to receive treatment. For example, individuals with SMI may have sensory issues, so therapists can adjust their touch to be more gentle and avoid overstimulation.

3. Incorporate relaxation techniques: Massage therapy can be an effective tool for promoting relaxation and reducing stress, which is important for individuals with SMI. Massage therapists can incorporate relaxation techniques such as deep breathing exercises or progressive muscle relaxation to enhance the therapeutic benefits of the massage.

4. Educate clients on self-care practices: Massage therapists can educate clients on self-care practices that can complement massage therapy and help them better manage their mental health. This can include techniques such as mindfulness meditation, journaling, or regular exercise.

5. Monitor progress and adjust treatment plans as needed: Massage therapists should regularly monitor their clients' progress and adjust their treatment plans as needed. They can collaborate with mental health professionals to determine the effectiveness of massage therapy in improving mental health outcomes and make any necessary changes to the treatment plan.

Dani Lindroth

I am a person in long-term Recovery from substance mis-use; and a CPRC providing support to my Peers. I work & live in Shiawassee County. I have been searching for services for one of my Peers that is struggling with Mental Health, Substance Use Disorder, and a tumor on her brain that is being monitored for Cancer. My Peer underwent a brain surgery 1.5 years ago and had a tumor removed that came back as cancerous. Since then, she has faced short term memory issues and it was then discovered that she had developed an additional tumor. She has taken every effort to maintain her Mental Health & Substance Use Disorder for over a year now, by attending weekly &/or bi-weekly MH Therapy, SUD – MAR therapy, attending Groups for Recovery support, and regularly meeting with her Psychiatrist. In addition, she was found to be eligible to start receiving SSI last December 2022.

My Peer is 35years old, unable to drive and has additional appointments above her MH & SUD appointments, with specialists to monitor her brain tumor and therapy for her Speech. We recently met with a Social Worker from DHS for her assessment, to see if she qualifies for assistance in her day to day functions. I have tried for months to find a resource to help her keep track of her many appointments, help with her medications, transport her to her appointments

and attend those that require notes be taken, and keep her many Doctors on the same page for her treatment and care she is receiving. All of this goes above and beyond what I would typically do as a Recovery Coach; but my employer believes in supporting our Peers where we are needed and especially when they cannot find the services they need. I was floored to find out that the services I have been searching for do not even exist at a State Level!

The places we have contacted were: SSI, MDHHS, Social Worker at Memorial Healthcare, Shiawassee Health & Wellness.

I was informed by the MDHHS Social Worker that the services I was looking for did not exist. Most of the places we contacted could only fill in a portion of the services my Peer needs and not enough to make it worth adding an additional person to her small group of support. Currently that group consists of myself, a family friend, and her Fiancé'. Her Fiancé works full-time to provide for the family; he is also her Trustee for her SSI. It is too much on my Peer to have multiple appointments in one day for her Fiancé' to set up a few things 1 day a week and miss work to take her.

I am sending this example of Unavailable Services that are Greatly Needed to help people in our communities that struggle with Mental Health & need assistance but not to the extent of parttime or fulltime nursing, etc. Transportation is also a HUGE gap in services that are offered and desperately needed.

If there is some type of service provider out there that I have not yet found or been made aware of that could fill the gaps my Peer needs, please let me know. I am more than happy to make calls, do more research, to help my Peer in finding a good fit of services for her.

I am not certain if this fits in line with what you will be addressing, or if it fits at all, but I felt strongly enough to send along 1 example of a Real Persons struggle in getting the help they need, to navigate their life to live healthier and happier with less stress and reduce the risk of falling into active illness or a mental health crisis.

Thank you for taking the time to review my lived experience of the real struggles people are facing due to the lack of services available in our State.

Dani Lindroth

Celia Wilson

Below please find my comment regarding providing better services to youth with SED.

Suggesting that certified prevention consultants/specialists are located in schools to provide intervention education services to help children with SED manage their emotions and behaviors is within their scope of practice, as intervention is a function of the Prevention Framework, which would improve service provision. Contrary to the oft-touted statement that certified prevention consultants provide only prevention services, which are needed before interventions, this group of licensed professionals could fill the gaps in violence prevention and stress reduction in schools.

Thank you.

Dr. Shenetta Malkia

Greetings Ms. Foote

I do hope this email finds you well. I would like to add a comment please. I would first recommend that we have more grassroots organizations supported in efforts of training to prevent suicides. We offer community trainings called safeTALK (suicide alertness for everyone). We would recommend that all HR officers, teachers, schools officials, foster care providers, law enforcement providers and health care providers.

This trainings is for everyone.

2. We would recommend that there be a longer amount of time be in which insurance companies will pay and cover cost for counseling.

3. We would recommend recovery homes for those who have recently experienced an attempt to heal and gain support with around the watch care.

4. School programs where students can study phycology for free with the lack of therapist and medical providers across the country.

5. Require all employers to provide a mental health coordinator for their companies which relation to layoffs and firing.

These are my main talking points.

Thank you for the opportunity to share.

Dr, Shenetta Malkia-Sapp h.c.

Larry Morrison

The anticipated meeting if feasible, one will like to briefly comment on epigenomic modulations and mental illness and request the federal govt assistance to racial and ethnic minorities in addressing disproportionate burden of emotional and mental illness among racial/ethnic minorities .

Kimber Rotchford

Funding to promote cost-effective care for those with serious mental illness (SMI) and substance use disorders (SUDs) warrant similar or identical criteria. SUDs often represent serious mental illness and both should be approached with similar professional oversight and accountability as with general medical care. Managing SMI and SUDs through our criminal justice system is not cost-effective and should be limited to the most severe cases when community safety concerns are pertinent. Punitive measures for offenses related to SMIs and SUDs are counterproductive and need to be minimized.

Our funding of services, let alone who is responsible for providing the service speaks to longstanding implicit and explicit biases that exacerbate our expensive and poor outcomes. Further initiatives to break down the “silos" within healthcare and to promote comprehensive and collaborative care are indicated.

Lastly, I suggest funding to further explore how to better mitigate the consequences of outdated beliefs regarding free will and individual rights as they relate to dangerous and/or criminal behaviors associated with untreated brain pathology, SMI, and SUDs.

Sharma Weeks

Too many folks with psychiatric disabilities are homeless or in jail

Police are still killing folks with mental health problems over trivial things. Shouting in public. Acting mentally ill. Waving a knife around. Police shout out commands rather than deescalate. Peer groups outside the system are poorly funded. Mental health system tries to make peer providers act like them get with recovery or move along. Jails are very poor places for substance abusers to detox. In some cases are treated brutally.

Elsa Merlino

Hi Pamela-I received an email asking to email in questions or comments regarding mental health/serious mental illness in youth questions.

My 15-year-old son Julian died by suicide. I don’t want anyone to ever go through what my family has.

I’m just confused what type of question or comment to make. However I do want to help break the stigma, and save any child, teen or adult from taking their own life.

Please help me understand how I can help! I want to help.

Katie Dale

To Members of ISMICC:

We, the members of the National Shattering Silence Coalition, comprised of people with lived experience, families, caregivers, and professionals, continue to follow your policy efforts. In response to your October meeting minutes, we wanted to share the following thoughts:
Again, we would like to emphasize the imperative need there is to eliminate the barriers to accessing treatment. There is now one hopeful bill standing by (H.R. 7803 - the Michelle Alyssa Go Act) that would strike the most obvious and broadest barrier to care down. As we repeatedly stress, repealing the IMD Exclusion would allow for increased reimbursement for inpatient care and all facilities at various levels of care, including access centers and longer-term #HousingThatHeals.

In past meetings, members of the ISMICC working group for IMD have discussed and disagreed

over this point. The NSSC would like to make the case for why we need to end IMD laws, and why, as the Civil Rights Division quotes "40-$60B Billion" in federal government costs, are not as costly as the price paid by continuing to keep this archaic and discriminatory law in place:

1. The IMD exclusion is costing the public more than appropriate treatment. In 2021, the Schizophrenia and Psychosis Action Alliance (S&PAA) published an extensive review of peer-reviewed published studies, Societal Costs of Schizophrenia & Related Disorders,. Their findings showed the direct and indirect costs of having a serious brain illness are over $281 billion more annually than the costs of persons not affected and that many cases go untreated. The S&PAA report estimates the caregiver burden and unpaid labor to be $104.5 billion. The S&PAA report estimates this societal cost to be $5.1 billion.
2. The IMD exclusion imposes social costs: public and family tragedies. Repealing the IMD Exclusion, allowing for early intervention and appropriate treatment would decrease the likelihood of law enforcement interaction.
3. Eliminating the IMD exclusion and allowing appropriate treatment in the most appropriate setting eliminates the cost of providing a jail for nearly 400,000 people with SBD currently in the prison population, and takes many of the estimated up to 325,000 people
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with SBD off the streets, greatly reducing the emotional and financial burdens to local, county, and state governments of caring for our homeless population.
We are the voice of those who know. We are speaking from first-hand experience. We are watching for you to act.

Signed,

NSSC Policy Action Committee on behalf of members of the National Shattering Silence Coalition

Carolyn Gray

"My son Nathaniel has been in the metro jail in Nashville, TN for 2 months. He is being held there on a federal grant they have to hold federal prisoners because he has a federal charge dealing with an "interstate threat" because he said something really bad to one of his friends over facetime while he happened to be very drunk on hard liquor. He is 21 and had only been drinking for a month and seldom hard liquor. This was on Nov. 11th. His friend was very concerned about what he said so he called the police which landed my son in a psych hospital for about 2 weeks then I sent him to what was supposed to be a rehab that was also for mental illness in CA which actually was not for mental illness because when he told the therapist there what he said she freaked out and sent him to a psych hosp in CA. He was released from there after a couple of weeks on the condition I had him outpatient care set up at home. So I flew him back to TN and he began his online outpatient care and he went back to work and was doing great and not drinking at all and we even got to celebrate Christmas thankful all this was behind us. 3 days after Christmas while I was at work the FBI came to my house and put him jail and that is where he has been ever since. He had a bond hearing on Feb. 3rd and even though the judge was very sympathetic and thought jail was not the right place for him because of his mental issues there

was no place else to send him. He had been accepted at an outpatient place that he could have went to if he had been released. The district attorney did suggest he be sent to a place where they go to be made competent to stand trial but his lawyer fought against it because she believes he is competent and that someone could come to the jail and evaluate him for that easily...plus the place they suggested he be sent had a waiting list and would just prolong his time to his trial. So we have been trying to find an inpatient place that he could go to until the trial but since we were looking for something for about 9 months it is hard to find such a place that my insurance will cover. I have spoke to a place that says they can work with the insurance and the courts and offer at least 6 months and probably more if needed but that is on the back burner for now since his lawyer wants him to be proven competent 1st before we consider anything else. Plus I found out if he does go to these places that it will not count as time served if he goes to court and is found guilty like it would be if he stays within the prison system. I tell you this long story because my comment/question is why doesn't the federal government have anywhere else someone like my son can be housed then a jail where he is locked in his cell 22hrs a day? Until he went to jail he had been under mental health care for 6 weeks. Ever since the incident happened and had been oked to come home by a Dr. in CA with outpatient care set up. When put in jail it took weeks to get him on about a third of the dose of Lithium he was when he went in and now he is on anti-depressants understandably because he had done everything required of him since this incident and had never done anything wrong, but had just said something bad while drunk which he had no idea was against the law. Since the incident he has only repeated what he said to health professionals and law enforcement. Since that night he has said that he no longer thought the thoughts were cool and he completely quit having them when he went to CA. He is a mental patient not a criminal. He is probably autistic as well although he has not been officially diagnosed yet. The federal government needs to do better then they have for him and others like him. For him to have to stay in jail with all the restrictions it has with very little done for his mental health while he is sinking into depression and has given up hope is unthinkable and I believe criminal. Sorry so long but if I don't speak up for my son and those like him I don't know who will. He has done nothing wrong and has reached out for mental health help and complied with everything ask of him. He is just 21 and has never been in trouble before and swears knowing what he knows now he will never say anything so stupid again. He does understand the seriousness of his charges but doesn't understand the punishment he is experiencing now when he may not even be found guilty, but the price he will have paid because of months without the correct mental health and being treated like an animal may affect him the rest of his life. It is criminal that the federal government does not have facilities for behaviol health that these non-violent inmates can stay at til trial and be able to receive mental health care..not just related to whether they are competent to stand trial but to treat them with the dignity they deserve as anyone with a physical ailment would be treated. Putting the mentally ill with the hardened criminals is not in the best interest of anyone because after months being locked up with criminals he will have been exposed to things he never would have been and that his mind can't process correctly but will definitely not help him be a functioning member of society which he was on his way to being before he was locked up." Thanks for your time. Carolyn

Eating Disorder Coalition - Allison Ivie and Christine M. Peat

Dear ISMICC Committee Members,

On behalf of the Eating Disorders Coalition for Research, Policy, & Action (EDC), we thank you for the opportunity to provide public comment in advance of the March 14, 2023 Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).
The EDC is a nonprofit organization comprised of patient and caregiver advocates, treatment providers, advocacy organizations, and academics, focused on advancing the recognition of eating disorders as a public health priority throughout the U.S. By promoting federal support for improved access to care, the EDC seeks to increase the resources available for education, prevention, and improved training, as well as for scientific research on the etiology, prevention, and treatment of eating disorders.1
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Eating disorders are complex, biologically-based serious mental illnesses that have the second highest mortality rate of any psychiatric illness—with one person losing their life every 52 minutes as a direct result of an eating disorder.2 Approximately 28.8 million Americans experience a clinically significant eating disorder during their lifetime,3 affecting individuals of all ages, races, genders, ethnicities, socioeconomic backgrounds, body sizes, and sexual orientations.4 Eating disorders are not only deadly, but they are also expensive. Eating disorders are estimated to cost the U.S. economy $64.7 billion annually with families and individuals shouldering $23.5 billion of that cost.5

Recommendation: Classify Eating Disorders as a Serious Mental Illness

Serious mental illnesses (SMI) are defined as "someone over the age of 18 who has a diagnosable mental, behavioral, or emotional disorder that interferes with or limits one or more major life activities."6 New research shows individuals under age 65 comprise 16% of all Medicare enrollees, however; they represent approximately 42% of enrollees with an eating disorder diagnosis.7 Thus, eating disorders are a highly debilitating psychiatric illness with a significant proportion of individuals qualifying for Medicare due to disability status. Among Medicare enrollees, individuals with eating disorders are medically complex with more than half having greater than six comorbid conditions.8 Enrollees with eating disorders are 2.4 times more likely to be dual eligible for Medicare and Medicaid.9 Data from 2016 shows Medicare enrollees with an eating disorder diagnosis had more than $20,000 higher average healthcare expenditure than their counterparts without an eating disorder.10
In addition to the immense financial expense, individuals with eating disorders that are dual eligible are met with significant limitations in treatment coverage. For example, SSDI does not cover inpatient treatment in a psychiatric hospital, residential treatment, a consultation with an eating disorder specialist, or critical medical nutrition therapy services (MNT) for individuals with an eating disorder. We have heard countless stories from our community of people taking a second mortgage out on their homes or selling their home in order to pay for comprehensive eating disorders treatment. Without the appropriate coverage for eating disorders treatment within the SSDI program, we are placing an impossible financial burden on the patients and their families and loved ones.
The COVID-19 pandemic has exacerbated eating disorders across the nation as eating disorder treatment providers have seen a 30-100% increase in demand for care, with call volumes and inquiries for care doubling, significantly increased acuity in nature of illness presented and wait

times expanding from one week to six to eight months in some areas of the country.11 Individuals with eating disorders should not have to endure additional barriers to care or be barred from services because the condition is not classified as a SMI. In turn, we strongly urge ISMICC to work with SAMHSA to designate eating disorders as a SMI to allow individuals to access benefits that will help support them as they work to receive treatment and recover from their eating disorder.

Thank you for your consideration.

Sincerely,

Christine M. Peat, PhD, President, Board of Directors
Eating Disorders Coalition for Research, Policy, & Action

Janet Hayes

Dear Committee members,

My name is Janet Hays and, for those new to this committee who may not be familiar with my work, I am founder and director of Healing Minds NOLA, a nonprofit charitable and educational 501©(3). We advocate for the implementation of a full continuum of coordinated psychiatric treatment and care for people who live with serious mental illnesses within all demographics. We do not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin, disability, marital status, sexual orientation, or military status.

The ISMICC was created in December 2016 and established on March 15, 2017, in accordance with the 21st Century Cures Act ascribable to outrage in the community that there was no federal body representing adults with serious mental illnesses (SMIs) and children and youth with serious emotional disturbances (SEDs) and their families. Six years later, many of the same groups who pushed for the ISMICC remain frustrated that, despite federal investments, we continue to see increases in incarceration, homelessness death and repeat psychiatric hospitalizations for this population because they are unable to care for themselves or others, their safety, their property and who may be threatening to family or community when symptomatic.
Having worked to implement the Assisted Outpatient Treatment (AOT) Court in New Orleans with Judge Kern A. Reese, I have been privy to the internal workings of the psychiatric system in my city and state. My comments are based on my experience in that context.

Unfortunately, people living with untreated and under-treated serious mental illnesses who need long-term inpatient and outpatient care are not getting it. The AOT program has done wonders for some of our participants - especially those who are able to live with caregivers who supervise and monitor adherence, but some individuals are too sick to live with families even when treatment adherent, and definitely too sick for permanent supportive housing with driveby case management.

New Orleans is the canary in the coal mine as we are far ahead of many cities in development of psychiatric infrastructure. Louisiana's civil commitment laws are less restrictive than other states and New Orleans is fortunate to have adequate psychiatric bed capacity in our region. So why do psychiatrists and first responders complain there are not enough beds? The answer is lack of adequate and appropriate discharge destinations.

We need more ACT/ FACT and PSH but given I only have 3 minutes; I want to focus on asking this committee what it is doing to address the elephant in the room - ie. the severe lack of intermediate levels of care to put more rungs on the ladder for those who need gradual reentry into the community - not kicked out the door of an intensive inpatient hospital stay to the bottom of the cliff from whence they came. The dearth of supervised 24/7 residential treatment facilities with on-site clinical, psychosocial and social support has created a system of short-term revolving door hospitalization that backflows to police and is exacerbated by boarding in acute hospital beds for those under long term judicial commitments (judges orders) that take acute beds offline. This is madness. It's time for an innovative approach to create throughput in the system where all components are weighed to prevent the horrendous conditions and human logjams we are experiencing in our State. I would very much like to discuss what that approach could look like with ISMICC Committee members.

Thank you for taking my comment.

Certification

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

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Date

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

Minutes will be formally considered by the ISMICC at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.