

U.S. Department of Health and Human Services

Minutes of the Interdepartmental Serious Mental Illness Coordinating Committee

April 13, 2022, 1:00 p.m. to 5:00 p.m. (Eastern Time)
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Rockville, Maryland 20857
[https://www.zoomgov.com/j/1609923541?pwd=MkhidVpJbHJweGt4TTljeDIraFd
Mdz09](https://www.zoomgov.com/j/1609923541?pwd=MkhidVpJbHJweGt4TTljeDIraFdMdz09)

/Miriam Delphin-Rittmon/

Signed 06/28/22

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Call to Order, Committee Roll Call

Pamela Foote, Designated Federal Official, ISMICC 1:05

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 that the meeting is live streamed.

Federal ISMICC Members or Designees Present

- Joel Dubenitz, Designee, Secretary of the Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE); Social Science Analyst, Division of Behavioral Health and Intellectual Disabilities Policy
- CAPT. Meena Vythilingam, M.D., Designee, Secretary of the Department of Health and Human Services; Director, HHS Center for Health Innovation
- Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration
- Maria Fryer, Designee, The Attorney General; Designee, Department of Justice
- 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)
- Richard Mooney, M.D., Designee, Secretary of the Department of Defense; Acting Deputy Assistant Secretary of Defense, Health Services Policy and Oversight and CAPT. Ken Richter, Designee, Secretary of the Department of Defense
- Corey Minor Smith, Designee, Housing and Urban Development (HUD)
- Christy Kavulic, Designee, Department of Education, Office of Special Education Programs
- Taryn Williams, Secretary, Department of Labor
- Judith Cash, Acting Deputy Director, Designee, Centers for Medicare, and Medicaid Services (CMS), Acting Deputy Director, Center for Medicaid, and CHIP Services
- Marion (Taffy) McCoy, Ph.D., Designee, Social Security Administration

Non-Federal ISMICC Members Present

- Trinidad de Jesus Arguello, Ph.D., LCSW, PMHRN-BC, Director, Compostela Community and Family Cultural Institute
- Yasmine Brown, M.S., CEO, Hope Restored Suicide Prevention Project, LLC
- Ron Bruno, Founding Board Member and Second Vice President, Crisis Intervention Team (CIT) International
- David Covington, LPC, MBA, CEO and President, Recovery Innovations (RI) International
- Pete Earley, Author
- 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, Decatur, Georgia
- Katherine Warburton Williams, D.O., Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals

Non-Federal ISMICC Members Not Present

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

Welcome

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

Dr. Delphin-Rittmon welcomed participants and highlighted President Biden’s national strategy to address mental health and substance use disorders with a set of priorities garnering broad bipartisan support. Both the ISMICC and the Department of Health and Human Services’ (HHS) Behavioral Health Coordinating Council (BHCC) will play key roles in implementing the President's vision. Specifically, one ambitious goal calls for the integration of behavioral health into health care. Ensuring equitable access to evidence-based, culturally appropriate, and person-centered care for all, this goal emphasizes the cross-cutting principles of integration and equity and encompasses the three fundamental components of the President's vision that fall squarely on the ISMICC: strengthening system capacity, which addresses severe workforce shortages; connecting more Americans to care (access); and supporting Americans by creating healthy environments, which addresses the social determinants of behavioral health.

Dr. Delphin-Rittmon thanked participants for their feedback on the recently submitted 2021 ISMICC Report to Congress. The letter accompanying the report asked Congress to reauthorize the ISMICC for another six years. She then turned the meeting over to Ms. Foote.

Consideration of December 16, 2021, Minutes

Pamela Foote, Designated Federal Official, ISMICC

Ms. Foote allowed for a time of questions and comments before entertaining a motion to accept the December 2021 meeting minutes, which were accepted.

Presentation: National Judicial Task Force to Examine State Courts’ Response to Mental Illness (NJTF)

Hon. Paul L. Reiber, Chief Justice, Vermont Supreme Court, Co-Chair, NJTF; Hon. Loretta H. Rush, Chief Justice, Indiana Supreme Court, Chair, Education Partnership Implementation

Work Group NJTF, former Co-Chair, National Judicial Opioid Task Force, and incoming President, Conference of Chief Justices

Chief Justice Paul L. Reiber, co-chair of the National Judicial Task Force to Examine State Courts' Response to Mental Illness (NJTF), explained that the NJTF was created by the Joint Conferences of the Chief Justices and the Conferences of Court Administrators, which are in every state and territory.

As appellate judges, chief justices decide cases on appeal and are also responsible for the overall administration of their state court systems, including every docket and all aspects of management. The conferences allow for collaboration on solutions to difficult problems and provides an opportunity for the ISMICC to impact policy choices, including the practice and operation of all state courts and territories. The issue of mental illness is critically important to the conferences as evident in the creation of the NJTF.

According to Chief Justice Loretta H. Rush, state courts have become the "government emergency rooms" for vulnerable populations and the number one referral to mental health and substance use services. To assess how state courts are handling these populations, the National Center for State Courts and the State Justice Institute designed a rubric and set about disseminating best practices and products to the judges on how to divert people with serious mental illness (SMI) and co-occurring substance use disorder (SUD) from the system. Currently, 30,000 trial court judges across the system are being taught to understand that SUD is a treatable disease and not a moral failure. Regional summits provide a setting for teams across all three branches of government or judicial leadership to learn best practices. The NJTF will also produce products to help judges learn how to better handle competency hearings, which is crucial since there are reports of people languishing in jail for six months as they wait for a hearing. Differentiating misdemeanors would be a start.

Chief Justice Rush noted that convenings are another way NJTF brings together community and those on the front lines to effect change. She stated several task force members traveled to Miami Dade, Florida to see how the county handles these challenges and hopes that their methods become the national standard. Lastly, she looks forward to collaborating with the ISMICC and hearing from its members.

Discussion

Judge Steven Leifman thanked the presenters, noting that there are many products to be shared with NJTF. States are now holding their own conferences citing Topeka, Kansas as an example with over 700 participants including all three branches of state government.

Peter Earley asked the presenters about the abysmal wait time for competency hearings. Chief Justice Reiber stated one of the challenges is state differences in process and definition and that changing the process is a key focus of the NJTF. Chief Rush stated there is a blueprint for change that addresses best practices and, if followed, should significantly reduce the wait time. However, capacity is also an issue, and they are considering telemedicine especially for rural communities. She added that diverting people from the criminal justice system and making use of community health facilities for those awaiting evaluation may be an alternative.

Judge Leifman countered that the better solution is to limit restoration for those who need to go to prison and thereby, significantly reduced the waitlist. He explained the Miami programs divert misdemeanors to treatment with court monitoring. If they do well, the courts drop the charges. They also have a felony diversion program wherein those who would have gone to competency restoration are put in an alternative program focused on community restoration. Once stable, they are put in the felony diversion program with one year of court monitoring. Notably, this program is about 30 to 50% cheaper and quicker with 100% better outcomes than restoration. He suggested the creation of a federal pilot program focused on the alternatives, particularly considering the onslaught of litigation against federal and state governments. Lastly, he stated building community capacity for treatment would be more beneficial.

Overview: ISMICC Working Group Presentations

Cynthia Kemp, MA, LPC, Deputy Director, Center for Mental Health Services (CMHS), SAMHSA

Cynthia Kemp greeted participants and explained the characteristics and function of the five ISMICC working groups, which would be presenting their recommendations for retaining, revising, or retiring the activities of their focus area. Though the groups were given the same parameter and structure, they had the flexibility to accomplish the task as they saw fit. She also explained that the full ISMICC is required to review, discuss, and deliberate on the recommendations, then accept or reject the recommendations or accept the recommendations with changes from the working groups. Once decided, the working groups will follow up on the recommendation and outline a plan for addressing them over the next six months. Lastly, Ms. Kemp noted that feedback about the presentation format and acceptance process is welcomed.

Focus Area 1 - Data Working Group Report Out

Nima Sheth, M.D., MPH, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA; Thomas Clarke, PhD, MPH, Acting Deputy Director, Center for Behavioral Health Statistics and Quality, SAMHSA

Dr. Thomas Clarke, co-lead with Dr. Nima Sheth of data working group, first acknowledged the new members of the working group and overviewed the meetings held March 23, 2022, and April 7, 2022.

The Data and Evaluation Recommendations are:

- 1.1 Improve ongoing interdepartmental coordination under the guidance of the Assistant Secretary for Mental Health and Substance Use
- 1.2 Develop and implement an interdepartmental strategic plan to improve the lives of people with SMI and serious emotional disturbance (SED) and their families
- 1.3 Create a comprehensive inventory of federal activities that affect the provision of services for people with SMI and SED
- 1.4 Harmonize and improve policies to support federal coordination

- 1.5 Evaluate the federal approach to serving people with SMI and SED
- 1.6 Use data to improve quality of care and outcomes
- 1.7 Ensure that quality measurement efforts include mental health
- 1.8 Improve national linkage of data to improve services

Guiding questions included:

- What recommendations are short term (achievable by late 2022) vs. long term (beyond March 2023)?
- Are there existing activities or initiatives that can support any of the recommendations (quality measurement work, mental health data collections, etc.)?
- What activities have been done in the past that could be updated or seen as complete?

The group chose to retain the following recommendations 1.1, 1.6, 1.7, and 1.8. For Recommendations 1.6 – 1.8, Dr. Sheth reviewed the breakdown of efforts in year one, long-term, and implementations steps. Specifically:

1.1 Improving ongoing interdepartmental coordination under the guidance of the Assistant Secretary for Mental health and Substance Use

Year 1: Working on the this through coordination required from recommendations 6-8

Long-term: N/A

Implementation Steps: Data Workgroup will focus on recommendations 6-8 in Year 1

1.6 Use data to improve quality of care and outcomes

Year 1: Explore a collaborative partnership between VA, HHS, and other potential stakeholders to make recommendations for the implementation of measurement-based care in community-based settings.

Long-term: Support the integration of measurement-based care into clinical practice, and the use of aggregated data from measurement-based care as behavioral health outcome-focused quality measures.

Implementation: Explore option to coordinate with the Treatment Workgroup to convene a measurement-based care task force. Support the integration of measurement-based care implementation such as IT infrastructure, patient reported outcome measure selection recommendations etc. Utilize strategies for developing and validating methods for use of aggregated data from measurement-based care as behavioral health outcome-focused quality measures.

1.7 Ensure that quality measurement efforts include mental health

Year 1: To evaluate the feasibility of using aggregated data from measurement-based care to calculate behavioral health outcome-focused

quality measures for healthcare quality reporting and value-based payment systems. Additionally, a goal is to identify existing data from various federal agencies for secondary analyses to guide implementation of measure-based care and behavioral health quality measures. Examples of this include the Administration for Community Living's National Institute on Disability Independent Living and Rehabilitation Research (NIDILRR) and SAMHSA's Certified Community Behavioral Health Clinics.

Long- Term: To develop and validate an expanded set of outcome-focused quality measures and promote their use as a common practice in quality improvement. Additionally, they suggest translating research findings into evidence-based strategies for providing measurement- based care, and into methods for using aggregated data to measure quality and performance.

Implementation Steps: The group will incorporate the work around mental health quality measures into the workgroup formed for #s 6 and 7.

1.8 Improve national linkage of data to improve services

Year 1: The Food and Drug Administration and the Centers for Disease Control will link Sentinel to the National Death Index.

Long- Term: Enable broader linking of various data sets, including mortality data to help improve quality of care and outcomes. These efforts would be incorporated into Workgroups for #s 6 and 7.

Implementation Steps: put the workgroup in place to start linking the data.

Recommendations 1.2 – 1.5 were retained with justification even though they are not key priorities at this time.

Justification for not prioritizing these recommendations as key are:

- 1.2 ISMICC overall processes largely addresses this recommendation.
- 1.3 Cannot be achieved within the next year
- 1.4 Broad in scope and not necessarily achievable with the next year
- 1.5 Individual agencies serving populations within SMI/SED are already creating internal evaluation strategies that align with the specific populations they serve.

The proposed action step for high priority recommendations is to explore ways of creating an interagency workgroup focused on measurement-based care and inclusion of relevant quality measures to support the above recommendations.

ISMICC Discussion, Deliberation, and Acceptance of Focus Area 1 Recommendations ISMICC Members

Dr. Sandy Resnick wholly endorsed the recommendations and appreciated the linkage to Focus Area 3: Recovery. As there were no further comments, Dr. Delphin-Rittmon asked for a motion to accept the recommendations, which were then accepted.

Focus Area 2 - Access Working Group Report Out

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

Dr. Michelle Cornette acknowledged the members of the workgroup and provided a summary of the first meeting in March 2022 noting that recommendations 2.3, 2.9, 2.10 were retained and the rest revised; none were retired. The second meeting will be held in May 2022.

The Access Recommendations are:

- 2.1 Define and implement a national standard for crisis care.
- 2.2 Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization.
- 2.3 Educate providers, service agencies, people with SMI and SED and their families, and caregivers about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, including 42 CFR Part 2, in the context of psychiatric care.
- 2.4 Reassess civil commitment standards and processes.
- 2.5 Establish standardized assessments for level of care and monitoring of consumer progress.
- 2.6 Prioritize early identification and intervention for children, youth, and young adults.
- 2.7 Use telehealth and other technologies to increase access to care.
- 2.8 Maximize the capacity of the behavioral health workforce.
- 2.9 Support family members and caregivers.
- 2.10 Expect SMI and SED screening to occur in all primary care settings.

The priority recommendations presented by Dr. Cornette are:

- 2.1 Continue to build upon the significant investments made in bolstering the operations, capacity, and quality of behavioral health crisis service provision throughout the U.S.
- 2.2 Building upon recent investments and momentum, continue to take steps to grow and transform the behavioral health crisis services continuum through partnerships at the Federal, state, and local levels.
- 2.8 Maximize the capacity of the behavioral health workforce.

Dr. Cornette presented the revised as high priority

Recommendation 2:1 Continue to build upon the significant investments made in bolstering the operations, capacity, and quality of behavioral health crisis service provision throughout the U.S. Continue to make financial investments in behavioral health crisis services and structure. Continue to work toward 988 implementation and transformation of the behavioral health crisis

service continuum with particular attention to development and implementation of clinical standards and standardized training; growing and training a robust, competent workforce; and coordination with 911 PSAPs. Continue to incentivize states and communities to support and sustain adequate crisis care systems.

The revision to this high priority recommendation is due to the efforts in this area since 2017, including:

- SAMHSA published the *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit* (Feb. 2020).
- Congress passed the National Suicide Hotline Designation Act of 2020; solidifying a path to have 988 operational as a three-digit national crisis line by July 2022 (July 2020).
- The National Association of State Mental Health Program Directors (NASMHPD) published *Crisis Services: Meeting Needs, Saving Lives* (Dec 2020)
- In 2021, a five percent SAMHSA Mental Health Block Grant Crisis Set-Aside was established to advance crisis care and deliver immediate access to care for individuals in need.
- An enhanced 85% Medicaid Federal Medical Assistance Percentage for mobile crisis services was put in place (2021/ 2022).
- SAMHSA launched the 988 & Behavioral Health Crisis Coordination Office within the Office of the Assistant Secretary (Sept 2021).
- The announcement in December 2021 of \$282M in total National Lifeline funding.

Dr. Cornette presented retain as a high priority

Recommendation 2:2 Building upon recent investments and momentum, continue to take steps to grow and transform the behavioral health crisis services continuum through partnerships at the Federal, state, and local levels. Prioritize the growth of mobile crisis services and crisis stabilization units. Continue to prioritize principles of least restrictive intervention at each step in the crisis continuum.

Efforts in this area include:

- *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit* (Feb 2020)
- CMS awards \$15M for state planning grants to bolster mobile crisis intervention services (July 2021).
- In 2021, a five percent SAMHSA Mental Health Block Grant Crisis Set-Aside was established.
- The H.R.7232 - 9–8–8 and Parity Assistance Act of 2022 was introduced in the House of Representatives (March 2022).
- NASMHPD published *Sustainable Funding for Mental Health Crisis Services - Healthcare Crisis Service Coding Guidelines to Support Standardized Billing and Access to Coverage from All Insurers* (March 2022)
- While progress has been made, advancement of crisis receiving centers that evaluate and treat all incoming patients and connect to the appropriate next level of care is limited.

CDR. David Barry presented retained but not high priority

Recommendation 2:3 Educate providers, service agencies, people with SMI and SED and their families, and caregivers about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, including 42 CFR Part 2, in the context of psychiatric care.

This is lower priority because it can be accomplished outside the ISMICC and promoted across federal offices and platforms. Relevant work in this area includes the establishment of SAMHSA's Center of Excellence for Protected Health Information – Technical Assistance, the *HIPAA Basics for EMS Practitioners* poster, and the SAMHSA *42 CFR Part 2 Revised Rule Fact Sheet* (July 2020) addressing psychiatric care.

CDR. David Barry presented revise low priority

Recommendation 2:4 Reassess civil commitment standards and processes

A secondary priority because many states have civil commitment laws (Assisted Outpatient Treatment – AOT) and those efforts fit with other focus areas. There are also revision opportunities of the recommendation synergize with 2.1 and 2.2 to identify where civil commitment can be a viable alternative or accompaniment to crisis services and longer-term inpatient care. Also, to develop national that states can use as foundation to state civil commitment practices and process in creating guidelines and develop best practices to share.

Dr. Cornette presented revised but low priority

Recommendation 2:5 Establish standardized assessments for level of care and monitoring of consumer progress,

There has been significant progress the National Institute of Mental Health (NIMH) has made in this area and the Office of Emergency Medical Services is very interested as well. Further, there are implications for standardizing workforce training within this recommendation.

Dr. Cornette presented revised but low priority

Recommendation 2.6 Prioritize early identification and intervention for children, youth, and young adults.

A lower priority due to the efforts in this area, including:

- SAMHSA's Early SMI/ SED Treatment Locator
- SAMHSA Grant program: Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis. The Notice of Funding Opportunity (NOFO) is accepting applicants until April 18, 2022.
- Youth Blueprint for Suicide Prevention (American Association of Pediatrics, American Foundation of Suicide Prevention, NIMH & partners; March 2022) focuses on guidelines for pediatricians and screening for suicide risk and children.

A revision opportunity for this recommendation includes continue to focus on early identification and intervention for children, youth, and young adults.

For both Recommendations 2.5 and 2.6, the working group noted they want to support learning healthcare systems, such as the Early Psychosis Intervention Network known as EPINET:

<https://nationalepinet.org/>

Dr. Cornette presented revised but low priority

Recommendation 2.7 Use telehealth and other technologies to increase access to care.

More than 25 states have an interjurisdictional agreement allowing psychologists to work across state lines free from licensing restrictions. The hope is to retain this flexibility and other advancements as the field returns to in-person services and continue to address barriers to telehealth, such as infrastructure in rural and tribal communities.

CDR. Barry presented revise and retain as high priority

Recommendation 2:8 Maximize Capacity of Behavioral Health Workforce. It impacts the entire continuum of care. For example, lack of workers creates a barrier to access. The group plans to review the nine elements of the recommendation and address the gaps. Ongoing work includes:

- Advances and availability of continuing education workshops to include virtual learning
- Implementation of bills directly addressing provider education and coverage of services in some states (Georgia's House Bill 1013)
- Federal grants allowing grantee outreach to identify potential behavioral health staff and provide incentives to promote hiring.

Revision opportunities include grow behavioral health workforce, applying incentives to encourage individuals to join and retain behavioral health workforce that also apply to providing services to the underserved. Prioritize sub-elements of recommendation 2.8.

Revise but a low priority

Recommendation 2.9 Support family members and caregivers

Work can be done outside of the ISMICC. Specifically, existing resources should be disseminated to a wider audience and federal offices should promote relevant information. Also, other organizations like the National Association for Mental Illness (NAMI) and Mental Health America may be the best for promoters of resources.

Revision opportunities may include federal offices of communications promoting relevant information across multiple platforms and public, non-profit organizations may be positioned to promote family members and caregiver resources.

Revise but low priority

Recommendation 2:10 Expect SMI/SED screening to occur in all primary care settings

Federal programs, such as SAMHSA grant program, Promoting Integration of Primary and Behavioral Healthcare, and its National Center of Excellence for Integrated Health Solutions are addressing this area.

Revision opportunities include identifying resources or guidance that can promote the uptake of integration activities in the medical setting and potential technological solutions readily utilized in primary care.

In closing, CDR. Barry explained that collaboration with all groups is important; specifically, Justice (2.1 and 2.2) and Finance, where all three priorities align.

ISMICC Discussion, Deliberation, and Acceptance of Focus Area 2 Recommendations ISMICC Members

Dr. Brian Hepburn asked about a focus on children. Dr. Cornette stated the working group did not focus on this population yet; however, there is a focus on youth at SAMHSA and a guide is being compiled to address crisis youth services. She noted that Winona Sprague is a working group member and, with her focus on youth, it will most likely be addressed at future meetings.

Mr. Earley asked if the revised language captures the original intent of the focus area. Dr. Cornette replied that they are open to revising the language. Mr. Earley stated that parents and caregivers are focused on HIPPA and commitment issues and implied the group should address HIPPA issues. CDR. Barry stated the ISMICC would need to provide guidance since the revision is significant. Ms. Kemp suggested sending the HIPPA issue back to the working group for development. Mr. Covington suggested prioritizing 2:9 as another option.

Judge Leifman asked the group to review a crisis report from the National Council that would enhance this focus area before finalizing the recommendations.

Ms. Kemp summarized the discussion:

1. Ensure an emphasis on youth
2. Include crisis care
3. Prioritize Recommendation 2:9
4. Review the crisis report from the National Council

Dr. Delphin-Rittmon entertained a motion to accept the recommendations with the added items summarized above by Ms. Kemp and the recommendations were accepted.

Focus Area 3 - Treatment and Recovery Working Group Report Out

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

Doug Slothouber acknowledged the members of the workgroup and provided a summary of the first meeting in March 2022. During that meeting, the group reviewed the history and purpose of the ISMICC and the 10 treatment and recovery recommendations from the 2017 *Report to Congress: The Way Forward*. They also identified additional federal agencies to collaborate with, such as Department of Education (ED), Department of Housing and Urban Development (HUD), and the Centers Medicare & Medicaid Services (CMS). Their next meeting is scheduled for April 13, 2022.

The Treatment and Recovery Recommendations are:

- 3.1. Provide a comprehensive continuum of care for people with SMI and SED.
- 3.2. Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation.
- 3.3. Make coordinated specialty care for first-episode psychosis available nationwide.
- 3.4. Make trauma-informed, whole-person health care the expectation in all our systems of care for people with SMI and

SED.

- 3.5. Implement effective systems of care for children, youth, and transition-aged youth throughout the nation.
- 3.6. Make housing more readily available for people with SMI and SED.
- 3.7. Advance the national adoption of effective suicide prevention strategies.
- 3.8. Develop a priority research agenda for SED/SMI prevention, diagnosis, treatment, and recovery services.
- 3.9. Make integrated services readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders.

The group chose to revise and prioritize *Recommendation 3.1: Provide a comprehensive continuum of care for people with SMI and SED*. Of the 10 sub-elements, 3.1b, 3.1c, and 3.1g were highlighted as follows:

- 3.1b Maximize the use of peers as an integral component and not a peripheral add-on; tie into Focus Area 2: Access.
- 3.1c Update social services to reflect work underway and align with SAMHSA guidelines by increasing the emphasis on employment supports (IPS supported employment grants, customized supportive employment).
- 3.1g Emphasize on all core elements of crisis response, including 988, facility-based and mobile crisis teams, continuum of crisis care options (23-hour, crisis care stays, innovative approaches); tie into 3.7 Suicide Prevention.

Recommendation 3.2. Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation should be revised to incorporate a lifespan approach with screening at every age.

Recommendation 3.3. Make coordinated specialty care for first-episode psychosis available nationwide was retained with priority. Efforts have grown since 2017 with every state having a program, though services may only be available in a specific locale, rather than statewide. Further, other than federal support, funding is an issue and insurance has not kept up so there is an opportunity to work with CMS on this effort. Lastly, relevant elements need to be adapted across lifespan.

Recommendation 3.4. Make trauma-informed, whole-person health care the expectation in all our systems of care for people with SMI and SED was retained to build on progress to date.

Recommendation 3.5. Implement effective systems of care for children, youth, and transition-age youth throughout the nation needs revision and representation from and collaboration with the ED to ensure mental health services are available in schools as an essential building block. Currently, services are minimal or non-existent.

Recommendation 3.6. Make housing more readily available for people with SMI and SED was retained as a priority as it is an essential component of recovery. This recommendation has

strong potential for interagency collaboration, particularly with HUD as well as with the Access and Finance working groups.

Recommendation 3.7. Advance the national adoption of effective suicide prevention strategies was retained and would benefit from consulting with SAMHSA's Zero Suicide team and continued support in adopting proven models as well as 988.

Recommendation 3.8 Develop a priority research agenda for SED/SMI prevention, diagnosis, treatment, and recovery services is broad and could be more focused. Further, the significant potential for collaboration among agencies with a mental health research portfolio, including the National Institutes of Health (NIH), SAMHSA, the VA, and others, is recommended to allow for research agenda coordination and gap identification and avoiding duplicative efforts.

Recommendation 3.9. Make integrated services readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders was retained but considered a lower priority but progress should continue. This goal has benefitted from large increases in SUD funding since 2017 as well as greater adoption of integrated care as a principle.

Recommendation 3.10. Develop national and state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI and SED requires revision and is a priority. Past attempts to develop national standards have not been fully successful, the group suggests: focusing on translating proven models to widespread practice; using implementation science to support national and state capacity to disseminate and support implementation of models and practices; and seeing effectiveness of implementation as important as fidelity in evidence-based practices.

The group suggests collaboration with the Access working group to expand integration of peers as essential rather than peripheral team members. They also suggest collaboration with Access and Finance working groups around insurance coverage to support expansion of the First Episode Psychosis and Coordinated Specialty Care (CSC) models of care and supported housing.

For next steps, the group plans to seek participation from HUD, ED, and CMS, collaborate with Access and Finance working groups, and reconvene to adopt guidance from the full ISMICC. Lastly, there is almost immediate benefit from identifying research gaps and coordinating efforts around research agendas.

ISMICC Discussion, Deliberation, and Acceptance of Focus Area 3 Recommendations **ISMICC Members**

Corey Minor Smith noted that the Secretary of HUD issued a memo on April 12, 2022, directing HUD leaders to review HUD policies related to criminal records to decrease barriers to housing for criminal justice involved individuals who often live with mental health challenges. They are also working with permanent supportive housing programs to create at least an additional 20,000 units.

Dr. Marion “Taffy” McCoy asked if rural, urban, ethnic pockets were part of the deliberation and urged the groups to keep sight of the issues specific to these areas. Mr. Slothouber stated it was an element during the discussion on CSC and other topics.

Dr. Delphin-Rittmon entertained a motion to accept the recommendations with the addition of an increased focus on rural, urban, and cultural areas and the recommendations were accepted.

Focus Area 4 - Criminal Justice Working Group Report Out

Karen Gentile, LCSW-C, JD, Senior Public Health Advisor, Office of the Director, CMHS, SAMHSA; Maia Banks, MS, Chief, Homeless Programs Branch, Division of Service and Systems Improvement, CMHS, SAMHSA

Maia Banks acknowledged working group members and that the goal of the first meeting was to establish group cohesion and level setting. She explained the group reviewed the 2017 recommendations and completed pre-work templates. The co-stewards received templates from almost every member. The diversity of responses also spoke to the need to build cohesion.

In the first meeting, they discussed two recommendations fully and began discussion of the third. Key priorities will be established once the group reviews each recommendation.

The Criminal Justice Recommendations are:

- 4.1. Support interventions to correspond to all stages of justice involvement. Consider all points included in the sequential intercept model.
- 4.2. Develop an integrated crisis response system to divert people with SMI and SED from the justice system.
- 4.3. Prepare and train all first responders on how to work with people with SMI and SED.
- 4.4. Establish and incentivize best practices for competency restoration that use community-based evaluation and services.
- 4.5. Develop and sustain therapeutic justice dockets in federal, state, and local courts for any person with SMI or SED who becomes involved in the justice system.
- 4.6. Require universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail.
- 4.7. Strictly limit or eliminate the use of solitary confinement, seclusion, restraint, or other forms of restrictive housing for people with SMI and SED.
- 4.8. Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities.
- 4.9. Build on efforts under the Mentally Ill Offender Treatment and

Crime Reduction Act, the 21st Century Cures Act, and other federal programs to reduce incarceration of people with mental illness and co-occurring substance use disorders.

Karen Gentile noted that *Recommendation 4.1: Support interventions to correspond to all stages of justice involvement. Consider all points included in the sequential intercept model* covers all points, zero to five, of the Sequential Intercept Model. They suggest revising the recommendation to emphasize the inclusion of all intercepts and de-emphasize zero intercept by removing “Pay particular attention to the “zero intercept”—the avoidance of initial arrest” and adding language about spanning all intercepts. They also suggest adding language about overarching issues such as workforce, including peer workforce, and the enhanced use of technology for information-sharing.

The group proposes to table *Recommendation 4.2: Develop an integrated crisis response system to divert people with SMI and SED from the justice system* and *Recommendation 4.3: Prepare and train all first responders on how to work with people with SMI and SED*. Co-stewards will reach out to the Access working group to discuss the disposition of crisis recommendations and potential collaboration. They also considered whether 4.2 should remain a stand-alone recommendation or whether ISMICC should develop one early diversion recommendation covering intercepts zero and one and combining recommendations 4.2 and 4.3.

The group requests acceptance on the following six-month plan:

- Revise 4.1 to emphasize all intercepts and to add language about addressing workforce needs and the need to enhance the use of technology for information-sharing.
- Consult with the Access working group on disposition of 4.2 and decide whether to recommend to retain, to revise or to retire the recommendation.
- Discuss whether to retain, revise or retire Recommendation 4.3.
- Discuss combining 4.2 and 4.3 into one early diversion recommendation covering Intercepts 0/1.
- Discuss whether to retain, revise or retire Recommendations 4.4 to 4.9.
- Identify which recommendations should be prioritized.
- Draft language for any recommendations the group seeks to revise.
- Begin to develop draft action items for each retained or revised priority recommendations.

ISMICC Discussion, Deliberation, and Acceptance of Focus Area 4 Recommendations

ISMICC Members

Judge Leifman explained he has been working with a group on model laws to develop appropriate pathways for those who intersect with civil and criminal justice. He stated competency restoration drains resources and puts mental health directors at risk for litigation. The Council of State Governments Justice Center issued a report called “*Just and Well*”, offering alternatives that should be considered and incorporated into these recommendations.

Specifically, competency hearings should be limited to felonies and those looking at long-term incarceration, while all others should be diverted to treatment.

Trinidad Jesus Arguello agreed with the concept of categorization, adding there is also a need to differentiate those who continually have contact with law enforcement. Judge Leifman replied that the report does not consider frequency but rather criminogenic risk factors. Further, it is important to also modernize civil commitments laws and eliminate silos between the civil and criminal systems. Judge Stroud concurred, stating there also needs to be a focus on those who have not been diagnosed or who have never dealt with their diagnosis because they need treatment not incarceration.

Ms. Gentile explained the group will be considering these issues in future meetings.

Ms. Kemp summarized the discussion:

1. Emphasize the issue of competency restoration
2. Differentiate between first-time offenders and “those who have been there longer term” and consider risk factors
3. Modernize civil commitment laws
4. Focus on a path to treatment instead of jail

Dr. Delphin-Rittmon entertained a motion to accept the recommendations with the addition of the summarized items listed above by Ms. Kemp and, the recommendations were accepted.

Focus Area 5 - Finance Working Group Report Out

David de Voursney, MPP, Director, Division of Service and Systems Improvement, CMHS, SAMHSA; Christopher Carroll, M. Sc, Public Health Advisor, Office of Intergovernmental and External Affairs, SAMHSA

David de Voursney acknowledged group members from their first meeting on April 4, 2022. An internal meeting was held prior to the April 4th meeting.

The group decided that all eight recommendations were priorities needing revision and there is potential for additional recommendations.

The Finance Recommendations are:

- 5.1. Implement population health payment models in federal health benefit programs.
- 5.2. Adequately fund the full range of services needed by people with SMI and SED.
- 5.3. Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.
- 5.4. Eliminate financing practices and policies that discriminate against behavioral health care.

- 5.5. Pay for psychiatric and other behavioral health services at rates equivalent to other health care services.
- 5.6. Provide reimbursement for outreach and engagement services related to mental health care.
- 5.7. Fund adequate home- and community-based services for children and youth with SED and adults with SMI.
- 5.8. Expand the Certified Community Behavioral Health Clinic (CCBHC) program nationwide.

Mr. de Voursney explained the group agreed *Recommendation 5.1 Implement population health payment models in federal health benefit programs* covers important aspects and some members believe the recommendation may need to be broken into separate recommendations. The group agreed the recommendation needs more detailed language to address private health coverage; the role of alternative payment models since some changes require legislative action; the role of quality measurement; vocational rehabilitation and social security. Funding sources outside of healthcare should also be considered.

Recommendation 5.2 Adequately fund the full range of services needed by people with SMI and SED should be revised but the changes will require legislative action and cannot be addressed within current federal authorities. Work through 1115 waivers and other areas under Medicaid since 2017 may provide more details. Language around private health coverage and around the importance of other services outside of health and mental health care, such as vocational rehab and social security may add to this.

Mr. de Voursney introduced working group member Amber Rivers to discuss *Recommendation 5.3 Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses*. Ms. Amber Rivers stated that Employee Benefits Security Administration at the Department of Labor is responsible for issuing regulations and guidance for group health plans, including the rules relating to mental health parity. They are also responsible for enforcing roughly two million health plans covering about 136 million Americans.

Activities and major legislative enactments that have impacted and shaped the ongoing work include the Parity Task Force's recommendations on data-sharing related to enforcement. Five annual reports have been issued and enforcement data is issued annually. The task force also provides additional guidance for entities subject to the requirements through 67 FAQs, a self-compliance tool for plans and insurance companies to evaluate their compliance with parity, and the upcoming Notice of Proposed Rulemaking.

Lastly, the task force recommendations also called for expanded capacity to conduct audits related to mental health parity. The recently enacted Consolidated Appropriations Act includes critical tools and resources related to parity enforcement and new requirements for plans and health insurance companies. Departments are also required to conduct at least 20 audits annually where there are potential violations. The task force is also required to report to Congress

annually with their first report being submitted in January 2022 detailing their efforts since the law was enacted.

Federal action and legislative changes have had significant developments since 2-17. Therefore, the second half of the recommendation will need to be rewritten. The recommendation will need to be reframed to focus less on items like the White House Policy Taskforce which is less relevant now in the area of parity.

For *Recommendation 5.4 Adequately fund the full range of services needed by people with SMI and SED*, the group discussed the IMD exclusion, change to which would require legislative action. However, developments through 1115 waivers and managed care at the state level may allow for strategies outside of legislation action. The lack of beds and financing disparities in the workforce are also critical issues that could be included in this recommendation.

The group noted that payment disparities are also a parity issue under *Recommendation 5.5 Pay for psychiatric and other behavioral health services at rates equivalent to other health care services*. They recommend consideration of risk adjustment issues and relevant funding for the behavioral health workforce. Services that are not covered should also be addressed in this recommendation. Other programs shifting payment in behavioral health, such as the CCBHC program may also fit into the work under this recommendation. Additionally, other issues may need to be addressed in this recommendation- like services that are not covered because they don't include patient contact or don't fit the traditional view of what a "medical" service is.

Under *Recommendation 5.6 Provide reimbursement for outreach and engagement services related to mental health care*, funding for outreach and engagement and exploring return on investment, incentives across the current systems that discourage engagement, the missed opportunity of engaging those with psychotic disorders, and how states are addressing mental health parity are points of consideration raised by the group. By engaging people in care and reducing involvement across public systems there may be positive impacts on costs across systems.

Recommendation 5.7 Fund adequate home- and community-based services for children and youth with SED and adults with SMI is a very important focus and necessary for states to meet their obligations under Olmstead as well as to build a supportive system for independent living in the community for those who wish to pursue recovery.

Since 2017, there have been many activities related to *Recommendation 5.8 Expand the Certified Community Behavioral Health Clinic (CCBHC) program nationwide*. Updates needed include expansion and extension of the CCBHC Medicaid demonstration, the development and growth of SAMHSA's CCBHC expansion grant program, and the emergence of independent state CCBHC programs, all of which are expanding the use of this important law.

Lastly, collaboration is needed with the working group in Focus Area 2 around financing crisis systems and the development of the 988 system and several major developments related to the financing of crisis systems.

Recommendations for the ISMICC are:

- Review and refine existing recommendations
- Present revised recommendations to the broader ISMICC before the next meeting
- Work to include additional federal representation
- Identify priorities for action

ISMICC Discussion, Deliberation, and Acceptance of Focus Area 5 Recommendations

ISMICC Members

Jennifer Higgins stated her group also discussed CCBHCs and they look forward to collaborating on this important topic.

Dr. Arguello stated there are no psychiatrists in rural northern New Mexico due to the decrease in Medicare reimbursement for psychiatric care. She urged the working group to address psychiatric services in rural communities during their discussions.

Dr. Delphin-Rittmon entertained a motion to accept the recommendations with the inclusion of consideration of rural psychiatric services, and the recommendations were accepted.

In closing the report out, Dr. Delphin-Rittmon thanked all participants for their efforts and interest in collaborating and Ms. Kemp asked the ISMICC if the meeting format worked well. Ron Bruno completely supported the format and offered his appreciation.

Public Comment

Pamela Foote, Designated Federal Official, ISMICC

Before proceeding with this agenda item, Dr. Delphin-Rittmon called on Mr. Earley, who reassured all involved, that those who share during public comment periods matter and their voices are heard. Dr. Delphin-Rittmon concurred emphatically and stated those voices inform policy.

Ms. Foote opened the meeting for public comment. She stated those who called in and requested to speak would be called upon in the order that requests were submitted. All public comments would become part of the official and written record of the meeting minutes. Participants were as follows:

1. Yulia Mikhailova, Ph.D.
2. Al Galves – no response
3. Scott Zeller. M.D. - no response
4. Leslie Carpenter
5. Mel Batchelor

Ms. Foote once again called on those who had not answered earlier and still received no response.

Ms. Foote thanked each caller, adding that all submitted written comments, including those unread, would be available in full, as part of the official and written record of this meeting. Ms. Foote 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

Dr. Delphin-Rittmon thanked all participants and those with public comments, noting the work is moving closer to the President's vision for transforming and addressing mental health and substance use change in America.

Ms. Foote adjourned the meeting at 4:01 p.m.

Public Comments – April 13th ISMICC Meeting

1. Yulia Mikhailova, PhD,

Dear ISMICC Chair Delphin-Rittmon and Committee Members,

I am the chair of the faculty Mental Health and Wellness Committee at New Mexico Institute of Mining and Technology, a member of the Committee on Mental Health of the Comprehensive Health Council for Socorro County, NM, and a mother of a person with a lived experience of psychosis. I am very grateful for this opportunity to provide written public comment to the Interdepartmental Serious Mental Illness Coordinating Committee, and I am excited to see the SAMHSA's and this committee's commitment to mental health recovery and collaboration.

I applaud your recent efforts, and I advocate for developing further collaboration with all stakeholders and for more public outreach, because I am concerned about the extremely low trust in the mental health system among young people, college students in particular. As a college professor and a mother, I am observing first-hand the alarming trend documented by numerous researchers who found that mistrust often originates from a negative experience with mental health services, whether personal or that of friends and classmates.¹ Evidence is mounting that, among the younger generations, the mental health system is increasingly perceived as oppressive, secretive, and untrustworthy.

Taking public comments is a great way to combat this perception. I propose taking further steps, such as:

- publicizing information about the ISMICC meetings more widely;
- reaching out to student, consumer and other grass-root organizations active in the area of mental health;
- establishing policies and procedures for engagement and follow-up with the citizens and organizations who submit their comments.

However, the most urgent task for rebuilding trust in the mental health system is to create a more positive experience for consumers. Evidence-based methods to achieve this goal include:

- EmPATH emergency room units;
- Soteria Houses;
- Peer-run respites;
- Open Dialogue.

The innovative method of ER care – Emergency Psychiatric Assessment, Treatment and Healing unit (EmPATH) – helps alleviate **workforce and bed shortages**, and to create true mental and physical healthcare **parity**. Currently, an emergency psychiatric condition is the only case for

¹E.g., Jones, N., Gius, B.K., Shields, M. (2021). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Soc Psychiatry Psychiatr Epidemiol* 56, 2017–2027. <https://doi.org/10.1007/s00127-021-02048-2>. Rodrigues R, Anderson KK. (2017). The traumatic experience of first-episode psychosis: a systematic review and meta-analysis. *Schizophrenia Research* 189:27–36. <https://doi.org/10.1016/j.schres.2017.01.045>.

which hospitalization is the default treatment. [EmPATH creators seek to rectify this anomalous situation](#). They demonstrated that most psychiatric emergencies can be resolved in less than 24 hours with appropriate intervention; however, for this intervention to be successful, it is necessary to have a separate, specially equipped ER unit.² To give a cost estimate, one such unit was recently constructed in a central Minnesota hospital with a \$1.2 million grant from a private charitable foundation.

Patients, whose crisis cannot be resolved within 24 hours and who need a longer-term help, often recover successfully in a Soteria House or a peer-run respite.³ Making these opportunities widely available will ensure that hospital beds are saved for those with the most serious conditions. Finally, the Open Dialogue treatment of a serious mental health crisis, such as psychosis, has proved successful, whether practiced in a hospital, in an alternative facility, or in an outpatient setting. So far, there is only one teaching facility in the U.S. that specializes in providing Open Dialogue training, and expanding the number of Open Dialogue practitioners will go a long way in improving the mental health services on all levels.

Most importantly, these and other non-coercive methods recommended by the World Health Organization encourage people with serious mental illness to be willing to seek help and reduce the **problem of non-adherence to treatment**. Comments submitted by desperate parents to the previous ISMICC meeting show how the current overreliance on involuntary hospitalization and court-ordered treatment often tears apart families and drives people with mental health disorders into homelessness.

It is a truly tragic situation, when a family has no way to help a loved other than working to obtain a court order against them. It is equally tragic when people choose to live in the streets rather than comply with their treatment. Your Committee has the power to change this tragic situation by promoting efficient and humane methods that will make the use of force with individuals having mental health disorders a rare emergency measure, as it was originally intended to be.

I would like to end by sharing my personal experience. My daughter, a University of Michigan student, had a psychotic episode on campus. She was delusional and hallucinating, but not

²Zeller S. (2010). Treatment of psychiatric patients in emergency settings. *Primary Psychiatry* 17(6):41-47. Zeller S, Calma N, Stone A. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West J Emerg Med.* 15(1):1-6. doi:10.5811/westjem.2013.6.17848.

³Calton, T., Ferriter, M., Huband, N., Spandler, H. (2008). A systematic review of the Soteria paradigm for the treatment of people diagnosed with schizophrenia. *Schizophrenia bulletin*, 34(1), 181–192. <https://doi.org/10.1093/schbul/sbm047> Bevin Croft, B., Ísvan, N. (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services. *Psychiatric Services* 66(6):632-7. <https://doi.org/10.1176/appi.ps.201400266>. Greenfield TK, Stoneking BC, Humphreys K, Sundby E, Bond J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *Am J Community Psychol.* 42(1-2):135-144. doi:10.1007/s10464-008-9180-1. On the Soteria program implemented by the Israeli Ministry of Health, see Friedlander, A, Bitan, DT, &, & Pesach Lichtenberg, P. (2022). The Soteria model: implementing an alternative to acute psychiatric hospitalization in Israel. *Psychosis: Psychological, Social and Integrative Approaches*. Published online: 01 Apr 2022. <https://doi.org/10.1080/17522439.2022.2057578>.

violent or aggressive. Police took her to the ER after somebody called a helpline; from there, she was sent to a hospital, where she deteriorated dramatically. Her condition was becoming worse by the day, and the doctor said that if it lasted some more time, this would mean that she had schizophrenia. He was sure that she had a serious disorder that would require life-long medication and possibly guardianship.

With great effort, I was able to obtain her discharge from the hospital. After that, I embarked on reading medical literature about the most efficient treatments for psychosis, which made me aware of Open Dialogue. Fortunately, I found an Open Dialogue practitioner, under whose care my daughter has recovered completely. Now, more than two years later, she is not taking any medications, does not have any diagnosis, is healthy and thriving, and is graduating in May. She is a shining example of mental health recovery. I shudder to think what may have happened if I had not found information about recovery-oriented, rights-based treatments, such as Open Dialogue. This experience is now driving my efforts to advocate for wider availability of non-coercive methods backed by research.

Thank you for your ongoing efforts to improve mental health care and recovery for all Americans.

Sincerely,
Yulia Mikhailova, PhD.

2. Al Galves

The most effective treatments for psychosis are Soteria Houses, Open Dialogue and Healing Homes. These approaches share the following five characteristics:

They are based on the understanding that psychosis is a move by a wounded psyche towards survival, healing and recovery.

They provide the patient with safety, support and affirmation as s/he goes through the psychotic experience towards healing and recovery.

They invoke the self-healing properties of the patient.

They use affirming connection and support as the primary modality of treatment.

They do not use psychiatric drugs as the primary modality of treatment.

I urge and encourage SAMHSA to study these approaches and, if it finds evidence of their effectiveness, to provide financial support to the widespread creation of Soteria houses and Healing Homes programs and the widespread use of Open Dialogue as treatments for psychosis in the United States.

Following are sources of information on these approaches:

Soteria Houses

Bola, J. & Mosher, L. (2003). Treatment of acute psychosis without neuroleptics: Two-year outcomes from the Soteria project. *The Journal of Nervous and Mental Disease*, 191(4). Pp. 219-229.

Open Dialogue

Seikkula, J et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. *Psychotherapy Research* 16(2), pp. 214-228.

Healing Homes

Hakansson, C., *The Extended Therapy Room – Coming from an Authentic Place*. Jyvaskla, Sweden: University of Jyvaskla.

Hakansson, C., *Ordinary Life Therapy*. Taos, NM: Taos Institute Publishers

Film by Daniel Mackler – available on Daniel Mackler’s YouTube channel

You can also get information by putting Soteria, Open Dialogue or Healing Homes into a search engine on the Internet.

3. Scott Zeller, M.D.

To the Advisory Committee:

Every year in the US, millions of individuals with serious mental illness (SMI) who are experiencing a psychiatric emergency will end up in general hospital Emergency Departments (ED), where their usual only option for continued care is referral to an inpatient psychiatric hospital bed. Even when there's a robust “community” crisis system in place, this community system is most often self-described as serving the ‘subacute’ crisis population, and thus SMI individuals in a psychiatric *emergency* are just 'too acute' for these community programs -- perhaps because they are on involuntary holds, are acutely agitated or violent, have a comorbid medical issue including being after an overdose, or they are acutely substance intoxicated or in substance withdrawal – so the crisis system is designed for these individuals to go to general hospital EDs for evaluation. Then, with the only option for continued care in most EDs being a referral to inpatient psychiatric beds, due to limited bed availability, the acute SMI patients are often stuck 'boarding' in the ED for long hours, even days, awaiting a bed opening, and during these long hours they receive little or no treatment, in an uncomfortable environment. And according to new research published this month in the *Journal of the American Medical Association - Psychiatry*, the numbers of behavioral health patients coming to EDs across the USA only continues to increase, disproportionately affecting minorities, to the point that these patients are now one in every seven patients seen in EDs in this country, ranking with chest pain, lacerations, trauma, and other traditional medical emergencies, in terms of overall percentages of patients in EDs.

Unfortunately, most current federal attention on improving crisis services appears only to support funding for the crisis services located in “community” settings outside of hospitals -- but crisis services should not end at the hospital doors, because there's incredible success for acute crisis care for SMI patients in hospital outpatient “emergency psychiatry” programs. The vast majority of even involuntary and highly acute behavioral health patients in EDs -- 70% to 80% -- can be stabilized and returned home in less than 24 hours, where hospital-based emergency psychiatry programs are operating.

These programs effectively offer prompt, targeted care in a soothing, therapeutic environment with appropriately-trained personnel, with excellent outcomes and very high patient satisfaction. And yet, hospitals struggle to get CMS reimbursement for providing this quality emergency psychiatric care for acute SMI patients, whom they are legally required to evaluate and treat under EMTALA law – this lack of reimbursement is the exact opposite of parity! Why does Medicaid and Medicare pay for emergency patient care in the ED for chest pain, shortness of breath, and lacerations, but in many locations, not for a psychiatric emergency?

In recent years there's been the creation of dozens of a great model of hospital-based emergency psychiatric care created across the USA, known as EmPATH Units (Emergency Psychiatry Assessment, Treatment and Healing Units), with many more currently in

development. EmPATH is an academic acronym well known in the literature, not a brand name or license. Here is a link which concisely explains the humane, non-coercive and patient-centric EmPATH model, in about a 3-minute

read: <https://www.psychiatryadvisor.com/home/practice-management/empath-units-as-a-solution-for-ed-psychiatric-patient-boarding/>

There's also solid, evidence-based, peer-reviewed studies published in major medical journals demonstrating the efficacy and wonderful benefits of EmPATH units. Last month one of the top Emergency Medicine journals, *Academic Emergency Medicine*, published research on an EmPATH unit as their lead study, titled "Emergency psychiatric assessment, treatment, and healing (EmPATH) unit decreases hospital admission for patients presenting with suicidal ideation". The study reports that the EmPATH unit at the University of Iowa Hospital, one year after opening, demonstrated these amazing improvements compared to the metrics the year before EmPATH opened:

- *Reduced Emergency Department (ED) overall length of stay for behavioral emergency patients from an average of 16.2 hours to just 4.9 hours (70% reduction)
- *Reduced inpatient psychiatric admissions from the ED from 57% of patients to just 27% of patients
- *Reduced 30-day psych patient return to ED (recidivism) by 25%
- *Improved the outpatient follow-up of patients from 39.4% to 63.2% (60% improvement)
- *Reduced inpatient length of stay for patients who went through EmPATH first
- *Almost Zero Use of Physical Restraints or coercion in its comforting environment

The study is linked here: <https://pubmed.ncbi.nlm.nih.gov/34403550/>

The improvements for hospitals themselves are clear, but even the overall SMI mental health care system benefits from the calming, collaborative, therapeutic alliance approach, with staff seen as allies rather than adversaries, as noted by the dramatically improved numbers of community connections after discharge.

SAMHSA and CMS need to recognize that emergency psychiatric treatment can be successful for acute SMI individuals in hospital-based emergency psychiatric units, even for involuntary patients, as in an average of more than 75% of cases these individuals are discharged home in less than 24 hours, and avoid an unnecessary, expensive psychiatric inpatient hospitalization. This leads to incredible savings for CMS of millions, perhaps billions of dollars annually, at a fraction of the cost, while providing more timely and vastly improved care. Let's please get emergency psychiatric care in hospitals reimbursed just like all other emergency medical care, this will encourage more hospitals to engage in this care, and then there will be true parity, and our SMI patients will no longer be abandoned in EDs, untreated, waiting for an inpatient psychiatric bed they most often wouldn't have even needed.

4. Leslie Carpenter -

Good afternoon. My name is Leslie Carpenter, and I am a co-founder of Iowa Mental Health Advocacy and a member of the National Shattering Silence Coalition. Today I am providing comments on behalf of our NSSC members which include people living with serious brain

disorders, family members, providers, judges, and others who are the voices for 14.2 million adults and 8 million children living and dying far too young from serious brain disorders. We urge you to add your committee's powerful voices in calling for the end of the IMD Exclusion. This policy was enacted in hopes of ending atrocities occurring at our large state psychiatric hospitals by prohibiting Federal Matching Medicaid funds from being used by any facility with more than sixteen beds for people with "Mental Diseases" who are aged 18 – 64. This well-intentioned policy has been a legal form of discrimination on this population of people who have brain illnesses, which are not their fault, and no one chooses, and no one deserves. It didn't end the atrocities, it both relocated them and worsened them. It has resulted in 169,000 people being left untreated and under-treated across our country on our streets and unsheltered. In addition, 383,000 people with serious brain illnesses are in our jails and prisons, where far too many are untreated and, in many cases, in solitary confinement. And many more are dying every single day. They are clearly not better off "in the community."

The sheer fact that 51% of people with Bipolar Disorders and 40% of people living with Schizophrenia are untreated, totaling 4.2 million people should shake everyone on this committee and those listening to the core.

Representative Grace Napolitano's bill, HR 2611, would end the IMD Exclusion, so that federal matching Medicaid funds could be accessed for not only hospitals, but also many other facilities along the continuum of care up to and including true #HousingThatHeals. This bill now has fourteen co-sponsors and is gaining momentum.

A recent article in "Psychiatry Times" is titled, "Psychiatric Care in the US: Are We Facing a Crisis?" Are you kidding me?

We have had a humanitarian crisis for decades for people with the most serious psychiatric illnesses! Sadly, too few people know it is happening, and even fewer seem to care.

We implore you to help us to bring this crisis both to the attention of the country and to help us to bring it to an end. It is well past time.

5. Mel Batchelor

Greetings,

I am writing in support of expanding peer-led, community-based mental health resources for those diagnosed with serious mental illnesses while eliminating coercive, traumatic, and isolating "treatment."

As you are aware, many of those who develop serious mental illnesses like schizophrenia are trauma survivors. Forced psychiatric treatment is a degrading continuation of trauma which furthers our mental distress: the antithesis to healing and recovery.

Please consider this statement from the former U.N Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment, published in 2013: "I believe that the severity of the mental illness cannot justify detention, nor can it be justified by a motivation to protect the safety of the person or of others. Furthermore, deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering falls under the scope of the Convention against Torture. In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, should be taken into account...States should impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of

psychosurgery, electroshock and mind-altering drugs, for both long- and short- term application. The obligation to end forced psychiatric interventions based on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation. Forced treatment and commitment should be replaced by services in the community that meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned.”

It is easy to dismiss those deemed psychotic, delusional, and seriously ill. However, if you were experiencing mental distress, would you want to be isolated, restrained, force medicated, and dismissed as “paranoid” and “non-compliant” when you resisted?

We cannot continue to fund psychiatric services that have been proven ineffective, if not outright harmful. We must expand upon the already existing innovative and effective approaches to treating psychosis, including Open Dialogue.

Police intervention during a mental health crisis can be dangerous, if not deadly. As outlined in The Ruderman White Foundation on Law Enforcement Use of Force and Disability (2020), “Disabled individuals make up a third to a half of all people killed by law enforcement officers.” We need to minimize police involvement and emphasize approaches to crisis response like the CAHOOTS model, proven effective in Eugene, OR.

In the tradition of the disability right’s rallying cry “nothing about us without us,” we should prioritize the insight and knowledge those with lived experience can provide. We should expand upon peer-led resources in the community.

A six-year, placebo-controlled study on antipsychotics revealed that only 14% of those who took an antipsychotic (versus the placebo) had a “good response,” with only a little over half had any “minimal” response. We need to look critically at who is behind messages promoting antipsychotics and other psychiatric drugs as the primary treatment option for serious mental illness. We cannot allow widespread misinformation and corporate greed to overshadow the very real consequences that long-term use of antipsychotics can have. We need to prioritize talk therapy and other treatment options for psychosis that are not reliant on medication, especially in places like forensic hospitals where therapy is scarce while medication is abundant.

Thank you for your time.

Mel Batchelor