INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS COORDINATING COMMITTEE (ISMICC)

October 29, 2024

9:00 a.m. to 4:00 p.m. (Eastern Time Zone)

Substance Abuse and Mental Health Services Administration (SAMHSA)

5600 Fishers Lane

Rockville, Maryland 20857

Meeting Minutes

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Call to Order, Committee Roll Call

Ms. Pamela Foote called the meeting of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) to order. After conducting roll call and establishing a quorum, she turned the meeting over to Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA) and Chair of the ISMICC.

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

Designated Federal Official:
Pamela Foote, Designated Federal Official, CMHS, ISMICC

Federal Members Present:

- Secretary of the Department of Health and Human Services (DHHS) Designees: Joel Dubenitz, Ph.D., Social Science Analyst/Psychologist, ASPE; Meena Vythilingam, CAPT, USPHS, Ph.D. Senior Advisor for Mental Health, HHS/ASPE/OASH
- Assistant Secretary for Mental Health and Substance Use: Miriam E. Delphin-Rittmon, Ph.D. SAMHSA
- Attorney General Designee: Mariel Lifshitz, MPH, Senior Advisor, Substance Use, Opioid, and Mental Health Policy, Department of Justice
- Secretary of the Department of Veterans Affairs Designee: Sandra Resnick, Ph.D., Associate Director, Northeast Programs Evaluation Center, Office of Mental Health and Suicide Prevention
- Secretary of Department of Defense Designee: Elle Marie Schollnberger, MD, PhD, Commander, Medical Corps, United States Navy, Director for Mental Health, Health Services Policy & Oversight (HSP&O), Office of the Assistance Secretary of Defense for Health Affairs, Defense Health Headquarters (3M613)
- Secretary of the Department of Housing and Urban Development (HUD) Designee: Corey Minor Smith, J.D., Senior Counsel, Office of General Counsel
- Secretary of the Department of Education Designee: Meghan Whittaker, MSW, J.D., Policy Advisor, Office of Special Education and Rehabilitative Services
- Secretary of the Department of Labor (DOL) Designee: Jennifer Sheehy, Deputy Assistant Secretary Disability Employment Policy, representing Taryn Williams, M.S., Assistant Secretary of Labor for Disability Employment Policy
- Administrator of the Centers for Medicare and Medicaid Services (CMS) Designee: Kirsten Beronio, J.D., Senior Policy Advisor on Behavioral Health Care, Acting Deputy Director, Center for Medicaid and CHIP Services
- Administrator of the Administration for Community Living (ACL) Designee: Andrea Callow, J.D., Program Analyst, representing Alison Barkoff, J.D., Acting Administrator and Acting Assistance Secretary for Aging
- Commissioner of the Social Security Administration Designee: Marion (Taffy) McCoy, Ph.D., Social Science Analyst

Non-Federal Public Members Present:

- Trinidad de Jesus Arguello, Ph.D., LCSW, PMHRN-BC, Director, Compostela Community and Family Cultural Institute, Arroyo Seco, New Mexico
- Ron Bruno, CEO, Crisis Response Programs and Training
- David Covington, LPC, MBA, CEO/President, RI International (DBA for Recovery Innovations, Inc.)
- Brian Hepburn, M.D., Executive Director, National Association of State Mental Health Program Directors
- Jennifer Higgins, Ph.D., CCRP, MBA, Owner, CommonWealth GrantWorks
- Steven Leifman, J.D., Associate Administrative Judge, Miami-Dade County Court Eleventh Judicial Circuit of Florida
- Amanda Lipp, B.S., Director and Filmmaker, Lipp Studios
- Adjoa Smalls-Mantey, MD, DPhil, FAPA, Assistant Clinical Professor of Psychiatry, New York, NY
- Sue L. Smith, Ed.D., CEO, Georgia Parent Support Network, Inc.
- Winola Sprague, DNP, CNS-BC, Medical Director, Children's Advantage, Ravenna, OH
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court
- Arc Telos Saint Amour, Executive Director, Youth MOVE National
- Sarah Vinson, M.D. DFAPA, Director, Child and Adolescent Psychiatry Fellowship Program
- Katherine Warburton, D.O., Medical Director and Deputy Director of Clinical Operations, California Department of State Hospitals
- Anitra M. Warrior, Ph.D., Licensed Psychologist, Morningstar Counseling and Consultation

Welcome

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

Dr. Delphin-Rittmon welcomed members, in-person and online, and expressed her gratitude for their service before turning the meeting over to Pamela Foote, Designated Federal Official.

Consideration of March 27, 2024, Meeting Minutes

ISMICC Members

Ms. Pamela Foote invited comments and questions regarding the March 27, 2024, Meeting Minutes. Hearing none, she invited a motion to accept the minutes. Judge Steven Leifman moved to approve the minutes, Corey Minor Smith seconded the motion, and the minutes were unanimously approved. She then turned the floor over to Dr. Miriam Delphin-Rittmon.

Opening Remarks: SAMHSA

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

Dr. Delphin-Rittmon welcomed everyone and thanked them for their continued commitment to and support of the ISMICC and asked each member when introducing themselves to share one word that describes the ISMICC for them. Their responses included, among others:

- Hope, recovery, opportunity, passion, collaboration, help, coordination, together, critical, important, motivation, cooperative, transformative, connection, progress, advancement, supportive, possibility, champions, impact, caring, advocacy, promise, self-determination, awareness, commitment, driven, partnership, innovation, thoughtfulness, vision, perseverance.

Dr. Delphin-Rittmon then welcomed and introduced the newest ISMICC member, Dr. Adjoa Smalls-Mantey. She then asked for a moment of silence in memory of the legacy of former ISMICC member Adrian Lightfoot, who passed away on August 22, 2024. Dr. Delphin-Rittmon began her update with an overview of Recovery Month activities.

National Recovery Month: Dr. Delphin-Rittmon recognized the recovery team and partners who convened, attended, and celebrated recovery month. Activities included the annual recovery walk in Washington, D.C., which brought together over 200 people. The online recovery gallery received over 200 submissions of artwork showing peoples' personal depictions and representations of recovery. On September 24, 2024, SAMHSA hosted the Trailblazers award ceremony, honoring those who continue to do innovative recovery work and help spread the message and vision of recovery.

988/Crisis Care: SAMHSA celebrated the first 988 Day on September 8, 2024, the theme of which was "No Judgment. Just Help." An integral part of the celebration was the 988 Wall Highlights where people posted different digital shareables on ways that they were celebrating and honoring 988. Over 1 million posts and impressions across different social media platforms and approximately 4,600 posts were received.

Suicide Prevention Month: As part of Suicide Prevention Month, SAMHSA unveiled the new suicide prevention web page, held a number of webinars, released a blog, and created media graphics to help raise awareness around suicide prevention. SAMHSA also released the 2024 National Strategy for Suicide Prevention (NSSP).

Crisis Care and the 988 Lifeline: The two-year anniversary was celebrated for 988, and Dr. Delphin-Rittmon shared current metrics showing that people do see 988 as a viable resource. As of July 2024, there were over 10 million calls, texts, and chats to the lifeline. That includes a 34% increase in calls and 51% increase in texts. Looking ahead, there are plans to integrate geo-routing into the lifeline to allow people to be connected immediately to localized support and services. Currently, there is a formal evaluation underway related to 988, looking at metrics to ascertain what is working, where there are areas of improvement, and where additional work might be beneficial. For the first time, paid awareness campaigns are being used to help get the word out, focusing particularly on under-resourced and at-risk populations.

2024 National Strategy for Suicide Prevention: The recent release of the NSSP includes input from individuals with lived experiences, a focus on equity, the intersection of substance use and suicide, the impact of social media on youth, and advancements in the field and emerging issues. An important part of the NSSP is the action plan, with over 200 items that are being implemented across the federal government. The action plan can also be used at the community level to help identify potential areas of focus and target interventions.

Kids Online Health and Safety (KOHS) Task Force: The KOHS task force represents a cross-government collaboration, co-chaired by Dr. Delphin-Rittmon and U.S. Department of Commerce Assistant Secretary Davidson. The task force released a report with recommendations for family members, industry, and school personnel that incorporates work that the Center of Excellence on Social Media and Mental Wellbeing (SMMW-CoE) has created, such as a family media plan. The media plan helps families work together to develop a social media usage plan that balances screen time with other activities. Content was developed based on listening sessions with young people about the benefits and harms of social media. The plan also includes content related to body image, exposure to violent content, the importance of promoting educational content, etc.

SAMHSA Youth Summit: Dr. Delphin-Rittmon recognized the Youth MOVE team for their role in the summit. The summit itself represented an entirely youth planned and led conference that resulted in recommendations around how to help in terms of young peoples' overall mental health (MH) and wellness. A central theme, "Nothing about us without us," emphasizes the importance of having youth at the table. The youth also emphasized the need for safe spaces to talk about MH and share and support each other. As a result, SAMHSA mentors are working with various teams from the summit to implement the recommendations.

2023 National Survey on Drug Use and Health (NSDUH) and GPRA: The 2023 NSDUH includes infographics to communicate the data in a more digestible and manageable way. The data continue to show the work that needs to be done. One in four adults continue to struggle with mental illness, and one in 18 with serious mental illness (SMI). About one in 20 adults report having serious thoughts of suicide. SAMHSA will be releasing subsequent reports to disaggregate other aspects of the data. SAMHSA is also working to streamline the GPRA tool to reduce the completion time to 30 minutes or less. The goal is to improve the data quality while reducing the burden of collecting and reporting it. Also, content related to social drivers of health, core recovery outcomes, client level goals, behavioral health history/screenings/diagnoses are also planned. The changes are scheduled to go out for public comment by the end of 2024, with the implementation planned for October 2025.

Behavioral Health Navigator Tool: Dr. Delphin-Rittmon explained that the new interactive Navigator Tool allows users to select a state and see the different behavioral disciplines and the requirements needed to work within each state. The intent is to decrease the confusion and increase the ease for those who seek to work in the behavioral health field in a particular state.

State Opioid Response (SOR) and Tribal Opioid Response (TOR): Dr. Delphin-Rittmon announced that the TOR grants are being extended from two to five years, based on input from tribal communities that the two years are not enough time to accomplish all their goals. In addition, SAMHSA awarded TOR funding to more than 150 tribes and tribal communities. They also extended SOR grants from two to three years. SOR grants have provided services to nearly 1.3 million people and recovery support services to 1.4 million. She mentioned in particular the creative work within the states via the Naloxone saturation work that has resulted in responding to over 550 overdoses.

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

CCBHC Expansion: Dr. Everett began with a brief history of the Certified Community Behavioral Health Clinics (CCBHCs). Through the nine required services, the CCBHCs are designed to provide a full range of services to anyone in need of treatment. There are currently approximately 500 CCBHCs throughout the U.S. that make up a national model that creates a consistent level of care and array of services. One of the original ISMICC recommendations is that the CCBHCs be strengthened, and they continue to grow and evolve. In 2024, 10 new states were selected for demonstration projects; in 2025 an additional 15 planning grants are to be awarded; 2026 will see 10 additional demonstration states added; and additional demonstration states are planned to be added every two years from 2027 forward.

Select CMHS Crisis Activities: Dr. Everett focused on the CMHS assets that support the development of the crisis services system. Central to this is the framing concept that focuses on the three things someone in crisis needs: someone to contact, someone to respond, and a safe place for help. SAMHSA's Community Crisis Response Partnership mobile crisis team grants show that nearly 75% of situations can be addressed where they occur, avoiding referral onto an emergency department, inpatient care, or other higher levels of care. The Mental Health (MH) block grant also has a set-aside that requires states to spend 5% of their grant funds on crisis services. The CCBHC expansion grants require crisis services as one of their nine required services. SAMHSA's 988 Office has a series of grants that focus on phone, text, and chat crisis support. And, finally, CMHS' Community Support Response Partnership program supports mobile crisis teams.

Dr. Everett also shared 2023 data from a report on how states are funding crisis services, which shows that states are using a variety of sources to build up their statewide crisis systems. The plan is to gather the data annually. She also shared data showing that states collectively plan to build out or add to 27 new children's mobile crisis teams and 23 children-specific crisis receiving centers in the future. The report data also show that approximately 1,800 mobile crisis teams have been developed in the past couple of years. She briefly described the impact that the 25 Community Crisis Response Partnerships (CCRP) grant program has had on stimulating the development of mobile crisis teams across the country.

Local Behavioral Health Crisis System Mapping Policy Academy: CMHS' local behavioral health crisis mapping policy academies bring teams together from local entities (often counties or city governments) to map out what is currently available in crisis services, where they'd like to go, and where their gaps are in their community, starting from the perspective of the person in need. National experts help them create a plan they can build upon in their communities.

Serious Mental Illness Training and Technical Assistance Center (SMI TTAC): Dr. Everett reported that, SAMHSA now has a contract that continues the work of the former SMI Advisor in a new Serious Mental Illness Training and Technical Assistant Center. This allows SAMHSA to be even more robust in their work with SMI and acknowledges the importance of this TA Center and community concerns about its sunsetting.

NASEM Report on Expanding of Behavioral Health Care Workforce Participation in Medicare, Medicaid and Marketplace Plans: Working with CMS, CMHS has engaged the National Academy of Science Engineering and Medicine in a year and a half long study that looked at suggestions and recommendations regarding how to enable a wider spectrum of behavioral health providers to work with public payers (Medicaid, Medicare, and the marketplace insurance plan). Very few training programs expose their trainees to individuals with highly complex needs, as seen with the Medicaid population. One of the barriers found by the report involves the reimbursement structures, which vary across states. Another barrier is the loss of reciprocity across state lines that occurred during the recent pandemic and has not been sustained by many states. CMHS and CMS will be aggressively working on these and other recommendations that are within their statutory authority from this report together, which can help to create a roadmap to look at what might be done to increase overall capacity of behavioral health professionals to serve individuals across the spectrum, particularly those who depend on public payers.

General ISMICC Updates
Dr. Billina R. Shaw, M.D., MPH, FAPA, FASAM, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA; Joel Fuentes, M.A., Public Health Advisor, Office of Policy Coordination and Innovation, CMHS, SAMHSA

Joel Fuentes began the update by introducing ISMICC's first non-SAMHSA steward, Dr. Sandra Renick, as well as welcoming two new group members: CMDR Katie Hagar and Michael Watson. He also acknowledged the work of ISMICC members ending their terms.

Dr. Shaw then provided a brief description of the *2024 Report to Congress Building on Progress: Federal Action for a System That Works for All People Living with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and Their Families and Caregivers* and thanked the members for their assistance in creating and publishing the document. The document is designed to be a user-friendly introduction to the ISMICC and includes summaries of the major advances in the field, how they relate to work being done in the government, and how they have interfaced with the public growth and expansion of the space. Overall, the 2024 recommendations build on and modify the original ISMICC recommendations. She also described the new logo, which highlights the five working groups and emphasizes the cross-governmental nature of the ISMICC as a federal advisory committee.
Finally, Mr. Fuentes pointed out changes to the ISMICC website that include videos of past meetings and the release of a quarterly newsletter. He also described resources available via the SAMHSA website. He announced the spring ISMICC meeting is scheduled for March 19, 2025.

SAMHSA Suicide Prevention and Crisis Guidance Updates
David Barry, CAPT, USPHS, Psy.D., Director, Division of Suicide Prevention and Community Supports, CMHS, SAMHSA; Billina R. Shaw, M.D., MPH, FAPA, FASAM, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA

CAPT Barry provided an overview of the National Strategy for Suicide Prevention, which was released April 2024, the result of a collaborative effort by the interagency workgroup and federal contributors. The guide is based on the U.S. Department of Veterans Affairs' National Strategy

for Suicide Prevention and received input from an advisory group for social media and youth MH, as well as the Surgeon General's previous calls. The strategy incorporates a wide variety of recommendations and directions in the field which modernize the approach to suicide prevention and includes relevant topics for today. The strategy is designed to be a guide to motivate and promote coordinated suicide prevention, recognizing that suicide prevention must be a multi-pronged approach on all levels. The report has a strong community and lived experience focus that emerged from the 2017 recommendations. These resulted in a bold 10-year plan for the NSSP and a three-year federal action plan. The NSSP focuses on lived experience with an emphasis on tribal members, youths suicide prevention, and equity.

CAPT Barry then provided a brief comparison of the current strategy compared to the 2012 and 2017 versions. A new strategic direction focusing on equity was created, and there is a strengthened focus on upstream prevention and comprehensive approaches. There are new goals addressing 988, lethal means safety, and workplace suicide prevention efforts, focusing on states, Tribe, communities, and territories. The increased relevance of social media and digital technology is reflected, both beneficial and harmful. The strategy looks at substance use and adverse child experiences and focuses on strengthening the objectives for community care, specifically regarding continuity, care transitions, and provider training. The strategy is broken into four strategic directions, which CAPT Barry briefly explained:

- community-based suicide prevention,
- treatment and crisis services,
- surveillance, quality improvement, and research, and
- health equity in suicide prevention.

The 10-year federal action plan includes over 200 actions across the federal government to be taken over the next three years in support of the NSSP goals and objectives. The plan is organized to clearly list each goal, the related objectives, and actionable items in support of them. The action plan provides a way for federal agencies to operationalize the NSSP and be able to assess how they can be engaging at the federal level to promote community and suicide prevention. The hope is that at the end of the three years, the goals and objectives set forth in the federal action plan can be achieved.

Dr. Shaw continued discussing crisis-related updates with an overview of the work on the model definitions for crisis services, including an implementation guidance document and mobile crisis toolkit. States, counties, and communities have begun to recognize the importance of crisis care, but there is an inconsistent use of terms resulting in the inability to establish quality metrics and identify expectations for what level of care is required. This also contributes to inconsistent compensation. This lack of consistency results in barriers to access for individuals/families experiencing a behavioral health crisis. In addition, there is a need to streamline and simplify system navigation for individuals in behavioral health crisis and their families and clarify expectations regarding levels of care. With consistent nomenclature, they can begin to establish clinical quality assurance metrics/measures and support a pathway toward sustainability of essential behavioral health crisis services: funding mechanisms, billing structures, and payor coverage.

The goals of the Model Definitions and Standards include refining proposed definitions and standards for all behavioral health crisis services within SAMHSA's three Crisis System Pillars (Someone to Contact, Someone to Respond, A Safe Place for Help), categorizing services to be included within each crisis system core component, defining levels of care appropriate to specific services, and constructing service definitions that encompass provider, client, payor, and regulatory needs. On a practical level, the goal is to balance the vision with the current state of the crisis continuum so as not to disassemble what has happened already. It is also important to align with the national existing standards where they may exist for some services, but also acknowledge there may be a need to modify them for this purpose and not necessarily adhere to every tenant of them. Throughout the process, it was deemed to be important to honor the voices of the partners throughout the creation of the documents. After six months of work, drafts are being submitted for internal clearance, and the group is working toward getting them cleared for public comment as soon as possible, with a goal of completion by the end of 2024 or early 2025.

Dr. Shaw next provided an update on the update of the National Crisis Guidelines. The approach to updating the guidelines includes foundational work, such as landscape scans based on the transformation transfer initiative that states have been working on. There has also been a literature review of best and promising practices and state and local examples to think about practice-based evidence in the field. A summit was also convened to guide the work. Overarching principles were developed that emphasize that the work will be in a systems-based approach, person-centered, family-focused, safe, effective and high quality, equitably accessible and responsive to diverse needs, trauma-informed, recovery-oriented, evidence-based/informed, and will provide the right level of care at the right time. She emphasized that all of this is subject to change, as it is still under development.

Finally, Dr. Shaw emphasized that there are core areas of the Coordinated Crisis System of Care that are important to build and develop so there is an accountable entity to steer the development of this work at a system-based approach. They have developed draft documents and are incorporating all of the feedback from their discussions.

Discussion:

David de Voursney commented that, regarding discussion about the success of the group and the work that's been done, when they started in 2017, they had not seen a reduction in the overdose death rates since 1999, other than a brief "blip" in 2018. The approximate 10% reduction seen in the in the 2024 report is the bending of that curve. Mr. de Voursney commented that it was a remarkable move to see the beginning of a real impact and that the same positive impact is hoped to be seen for suicide prevention.

Dr. Jennifer Higgins asked if the 988 data are publicly available. Drs. Shaw and Everett responded that there is a dashboard online that is updated regularly, which reports the number of calls duration, call time it takes to answer the phone, and the types of diversity that people select. There are data, also, for Spanish-speaking and LBGTQI+ individuals and veterans, as well as a video phone for American Sign Language.

Parity Updates

Beth Baum, J.D., Senior Advisor, U.S. Department of Labor, Employee Benefits Security Administration; and Kirsten Beronio, J.D., Senior Policy Advisor, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services

Ms. Baum provided an overview of the final parity rules that were released the previous month. The proposed rules received over 9,500 very detailed public comments. The final rules have two aims: to strengthen the existing parity requirements and to provide guidance to group health plans and health insurance issuers on the requirement to perform and document comparative analyses of non-quantitative limitations (NQTLs) that apply to mental health (MH) or substance use disorder (SUD) benefits required under the Mental Health Parity and Addiction Equity Act (MHPAEA) amendments. She then provided an overview of some of the highlights of the final rules:

- The addition of a purpose section to reiterate that the fundamental purpose of parity is to ensure that individuals don't face more restrictive limitations or requirements when accessing MH or SUD benefits compared to medical surgical benefits. The section is meant to guide plans and issuers as they work to comply and ensure that they keep the person in mind when they're complying with all of the different requirements.
- In the definition section, changes have been made to existing definitions, and new defined terms have been added. Among these are changes to the definitions of medical/surgical benefits, MH benefits, and SUD benefits that retain some of the previous flexibility to define those benefits but stress that discretion has to be exercised in a manner that comports with generally recognized independent standards of current medical practice. When defining a condition disorder or procedure as being MH, SUD, or medical/surgical benefits the plan/issuer must follow the most current version of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM). There are also new definitions of ICD and DSM that provide details on what is the most current version of each resource as of the effective date of the rules and when a new version must be followed. The final rules note that eating disorders, autism spectrum disorder, and gender dysphoria are all considered MH conditions for purposes of parity. Definitions for processes, strategies, evidentiary standards, and other factors have also been added.
- Under the final rules, to qualify for the NQTLs overarching plan, called the restrictive requirement, issuers must comply with two sets of rules: the design and application requirements and the relevant data evaluation requirements. Ms. Baum described each in more detail.
- The final rules add new requirements that prohibit the use of any discriminatory factors when a plan or issuer is designing an NQTL to be imposed on MH or SUD benefits. For purposes of the rule, a factor or evidentiary standard is discriminatory if the underlying information, evidence, sources, or standards on which it is based are biased or not objective in a manner that discriminates against MH or SUD benefits as compared to medical/surgical benefits.
- Another requirement states that if a plan/issuer does the analysis of the underlying information, evidence, sources, or standards, and they determine that their factor or evidentiary standard used to design the NQTL is discriminatory, they can take steps to correct, cure, or supplement anything that starts out as biased or not objective, and if the information is no longer biased but is now objective, it can be relied upon.

- The relevant data evaluation requirements are focused on application. A plan/issuer must collect and evaluate relevant data, determine whether the data suggests that the NQTL contributes to material differences in access to MH or SUD benefits compared to medical/surgical benefits, and if there are material differences in access, they must take reasonable action to address those material differences to ensure compliance in operation with MHPAEA. Finally, they must document in their comparative analysis what reasonable actions they have taken or if they are addressing any material differences in access that exist.

Ms. Baum then focused on a subset of NQTLs that relates to network composition. They are particularly concerning because the composition of a network can have a direct impact on access to benefits. Under the data requirements, network composition NQTLs are going to work a bit differently. All the data for all network composition NQTLs will be collected and evaluated together. Expected reasonable actions where there are material differences in access were also identified, including making special efforts to contract with a broad range of available MH and SUD providers, which may include greater compensation or other inducements; plans and issuers expanding telehealth arrangements to manage regional shortages; and ensuring that network directories are accurate and reliable.

She also highlighted other changes to the existing MHPAEA requirements regarding the meaningful benefits standard, which strengthen the requirement regarding what would be considered meaningful for purposes of parity. Under the 2013 parity rules, if a plan/issuer provides any benefits for a MH condition or a SUD in one of the six benefit classifications used to analyze parity, the plan/issuer must provide benefits for that MH condition or SUD in every classification in which medical/surgical benefits are provided. In response to comments, the term "meaningful benefits" is defined as a core treatment. A new regulation on comparative analyses that are required under the Consolidated Appropriations Act of 2021 has been published which lays out details of the six content elements for comparative analyses to determine compliance/noncompliance. If a final determination is issued, a plan/issuer must notify all participant beneficiaries and enrollees in the plan or coverage within seven business days after the determination of noncompliance. They must also make copies available to state authorities, as well as participants, beneficiaries, and enrollees. She also highlighted that, under MHPAEA, self-funded non-federal governmental plans, which are mostly state and local government plans, can no longer elect to opt out of compliance. HHS also included provisions in the rules to apply the same standards in the MHPAEA package for group health plans and group health insurance coverage in the individual market.

Lastly, Ms. Baum provided an overview of the applicability dates for group health plans and group health insurance coverage, including the delayed dates for the meaningful benefit standard, the prohibition on discriminatory factors and statutory standards, and the relevant data evaluation requirements, as well as any of the content elements related to those requirements in the provisions for comparative analyses.

Ms. Beronio provided an overview of the work of the Center for Medicaid and CHIP Services to ensure improved compliance with parity in Medicaid and CHIP, which have a separate set of regulations to implement MHPAEA. The documentation requirement part of the regulations results is complex and results in lengthy narrative text because states are not clear regarding what

they should provide. Efforts are underway to standardize the information and streamline the review process, as well as improve the protocols and mechanism for a coordinated review within CMS. To this end, templates and instructional guides have been developed and were posted on the Medicaid website on September 9, 2024. Comments on the templates are due by December 2, 2024. A webinar is available to help walk through the templates, which are very comprehensive and include much interactive functionality.

She also briefly reviewed that most of the provisions of MHPAEA apply to coverage provided to enrollees of Medicaid managed care organizations and Medicaid Alternative Benefit Plans, which are generally used for the Medicaid expansion population under the ACA, as well as separate CHIP programs. Because of how the statute links to parity requirements for Medicaid, those parity requirements for the general Medicaid population do not apply when benefits are provided only through a fee-for-service approach or through specialized managed care plans or prepaid ambulatory health plans. However, states are encouraged to ensure compliance with parity across the board.

Discussion:

David de Voursney added that when MHPAEA passed, Assistant Secretary for Planning and Evaluation (ASPE) did a lot of work to look at the impact on the marketplace and found that, overall, plans moved almost immediately into compliance with quantitative treatment limit requirements. The application of the non-quantitative treatment limits is much more complicated and much more opaque. He then recognized the large effort at the DOL in reviewing smaller plans not covered by MHPAEA to ensure they are incompliance. Over the last two years, DOL has worked with federal partners on authorization review requirements.

Dr. Everett asked if either of the speakers could provide a very high-level view of the plans for enforcement in response to a comment in the chat about the difficulty with enforcement of the actual regulations, especially now that the new ones will be coming into play.

Ms. Baum responded that enforcement has been very difficult, especially because of the non-quantitative treatment limitations -- even though plans and issuers are now required to perform and document an analysis. Her agency, the Employee Benefit Security Administration (EBSA), has reported that those analyses are not at the expected level of detail or thoroughness; therefore, it is difficult to get sufficient comparative analyses to understand compliance with MHPAEA, let alone to ensure that there is compliance. EBSA is also starting to work on updates to the MHPAEA self-compliance tool to reflect the requirements of the 2024 final rules and hope to issue additional guidance to help plans and issuers comply as the rules begin to take effect. Finally, the DOL Employee Benefit Security Administration has a staff of benefits advisors in the regional offices across the country that respond to questions, complaints, and concerns from plan participants and beneficiaries. They can access a toll-free phone number or submit through a web form, and staff help people call their insurance companies or plans to try to get them the benefits that they're promised.

Ms. Beronio added that the templates previously discussed are a first step to improve compliance with parity in Medicaid and CHIP. The Medicaid program is run as a partnership between the federal and the state governments. CMS engages with states regarding how they administer the program at the state level. One way is through review and approval of their managed care contracts. In this regard, in June 2024, they issued guidance and an informational bulletin to remind states about their requirements and specifying and clarifying CMS' expectations and plans to incorporate more reporting on parity compliance as part of the regular and increasing accountability mechanisms being put in place around managed care. They are also working with alternative benefit and CHIP oversight to make sure they are aligned and strengthened. The ultimate goal is to move to more of an outcomes-based approach to ensure there is compliance with parity.

Focus Area 5 – Finance Working Group
David de Voursney, MPP, Director, Division of Community Behavioral Health, CMHS, SAMHSA; Michael Watterson, Psy.D., M.A., M.S., Policy Fellow, Division of Community Behavioral Health, CMHS, SAMHSA

Mr. de Voursney introduced the stewards and members of the working group, which meets monthly. He began with a focus on one priority recommendation that requires a vote on a change to the language:

5.3. *Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse disorder services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.*

- The working group will be asking for a vote to change the word "abuse" to "use."

He then highlighted the triumphs related to the working group's priority recommendations, including:

5.3 Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance abuse disorder services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.

- The final Mental Health Parity and Addiction Equity Act regulations were released.

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.

- The National Academy of Medicine study, which relates to the recommendations that limit providers participating in Medicare and Medicaid.
- The group is working to fully enforce parity, looking at eliminating financing practices and policies that discriminate against people receiving behavioral health services.
- They are looking at payment for psychiatric and other behavioral health services at rates equivalent to other health care services.

5.7 Fund adequate home-and community-based services for children and youth with SED and adults
with SMI.

- SAMHSA's Center for Financing Reform and Innovation (CFRI) has produced a paper on supported employment programs, looking specifically at how supported employment can improve health and functional outcomes for individuals beyond employment outcomes. These interventions are important, not only to boost employment outcomes, but they are actually core health services. Gathering the evidence in that area will be important to having subordinate services covered as a part of health services more broadly.
- A study is also in development by the CFRI on supported employment, as a result of the working group's proposal.
- The group is also working to expand access to and fund home and community-based services.

5.8 Expand the Certified Community Behavioral Health Clinic (CCBHC) program nationwide.

- CCBHCs continue to expand through a recent NOFO for 15 new State Planning Grants. It is especially important to have providers included in networks to improve finance of care, especially in Medicare and Medicaid and the marketplace plans that are important to people who are vulnerable and need access to services.

Mr. de Voursney then introduced Deena Fox, J.D. Deputy Chief, Special Litigation Civil Rights Division, U.S. Department of Justice, which is responsible for implementing the Olmsted Act.

Deena Fox, J.D. Deputy Chief, Special Litigation Civil Rights Division, U.S. Department of Justice

Ms. Fox provided a brief overview of the Civil Rights Division, which conducts investigations and seeks remedies to address alleged unconstitutional conditions in facilities and institutions operated by or on behalf of state and local governments. Under the Civil Rights of Institutionalized Persons Act (CRIPA), the division is entitled to investigate if there are constitutional rights violations at a psychiatric hospital run by the state, for example. They can also enforce Title II of the Americans with Disabilities Act (ADA) and, in particular, the Olmstead decision and the integration mandate within the ADA.

She then focused on two cases that highlight some of the themes that relate to financing services in this area. Both are cases she is working on that address the adult and the children's MH systems in Nevada and Missouri. The Nevada case relates to children who are unnecessarily being hospitalized and placed in residential treatment because they are not able to access the needed community-based MH services. As a result, psychiatric hospitals have become the primary source of behavioral health services for children and a gateway to the longer-term residential placements of children. Many of these placements are out of state and could last for months to more than a year. Upon returning home from a long residential stay, the children are not connected with the services that they need to avoid a future stay in a hospital or a residential service provider. Although Nevada's Medicaid plan includes a framework in place to prevent unnecessary institutionalization, in practice, the services are not available in all parts of the state. Also, the provider network is not sufficiently robust enough to provide the service for a long wait

list for accessing a service like wraparound or peer support exists. The Civil Rights Division hopes to reach an agreement with the state to address the underlying issues in the community-based MH service system to enable children to avoid those placements.

In Missouri, they found that thousands of adults with SMI are unnecessarily confined in nursing facilities, about half in high-volume facilities where more than 50% of the population are people with SMI. About half of them are under 65. These individuals often remain for years in the facilities, lacking choice in their daily needs, what they eat, the ability to leave, etc. These facilities have become the default placement for those who have a history of hospitalizations or have not been compliant with offered treatment options. Often, people are placed under guardianship, who then turn to nursing facilities as one of the few solutions to the service needs of the individuals who are under their guardianship, even though the facilities are not actually providing MH services to those individuals. The state has implemented the CCBHC model, which presents an opportunity in terms of implementation. However, access to key services like assertive community treatment, supported employment, mobile crisis, crisis stabilization, is not consistent across the state and often is not seen as an option for these individuals. The Civil Rights Division is hoping to work with the state to reach an agreement to resolve this problem so there is greater and equitable access across the state to important services and that people are being identified and connected to those services through assertive engagement.

Ms. Fox emphasized that, overall, there needs to be work to engage people in an ongoing way and then to help them access the services that that will support them in the community and give them the choice and opportunity to live an integrated life. The challenges involve actually getting the services that states have implemented to the people who need them and making sure that those key services are being required throughout the state. The goal is to make sure that the funding model works for people who are in rural settings. Similarly, funding models that support crisis services are needed, since not all people will necessarily be Medicaid enrolled. A key issue is figuring out seamless braiding of funding streams for states that are not only going to rely on Medicaid dollars in order to offer that key service to the people.

Discussion:

Mr. de Voursney facilitated the group discussion based on the following questions:

- With a number of recent Olmstead cases being pursued by the Department of Justice, there is a clear need to support states to meet their obligations under the Americans with Disabilities Act. What steps should we take to help states finance comprehensive community supports for people with SMI and SED?
- Are there any other items that you want to discuss following our report out – Parity, Supported Employment, Certified Community Behavioral Health Clinics, or the NASEM study and provider participation in Medicaid and Medicaid?

A question was asked about the how prevalent the issues are or if they are isolated to the states the Civil Rights Division is currently looking at. Ms. Fox replied that these are not isolated issues, and they have multiple investigations in other states and have reached settlements and court orders with others. They also have investigations into adult care homes and more traditional hospitalizations. In all states, there continues to be a need to ensure that the higher

intensity services needed by individuals who have struggled with traditional services are available throughout the state.

Seeing no further comments or questions, Dr. Delphin-Rittmon called for a vote to approve the working group's report, which was unanimously accepted. She then asked for a vote regarding the change to Recommendation 5.3, which was also approved unanimously.

Focus Area 2 – Access and Engagement Working Group
Tara Andrews, MPA, Public Health Advisor, Office of the Director, CMHS, SAMHSA; CAPT David Barry, Psy.D., Director, Division of Suicide Prevention and Community Supports, CMHS

Tara Andrews introduced the stewards and members of the working group and recognized two new members: Anitra M. Warrior, Ph.D., Licensed Psychologist, Morningstar Counseling and Consultation and Arc Telos Saint Amour, Executive Director, Youth MOVE National. The workgroup meets quarterly.

CAPT Barry and Ms. Andrews highlighted the triumphs related to the working group's priority recommendations, noting that the NSSP is a triumph woven through many of the working group's priority recommendations.

2.1 Define and implement a national standard for crisis care.

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.

- The release of the NSSP, as well as being an overall triumph, has a goal to improve the quality and accessibility of crisis care services, including promoting effective community engagement for those at-risk for suicide during/between healthcare transitions and between levels of behavioral healthcare.
- 988 continues to be a successful component of growing and transforming the crisis services continuum. Successes include 988 Day and the release of the Partner Toolkit and other marketing materials.

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

- March 2024: The National Training and Technical Assistance Center for Early Serious Mental Illness (ESMI TTA Center) launched. The center fosters recovery-oriented early intervention programming for individuals who experienced early SMI.
- August 2024: SAMHSA released the Early Recognition and Effective Treatment of Early Serious Mental Illness Brochure. The brochure emphasizes the importance of early detection and intervention in SMI, the need for prompt attention at the first onset of symptoms, and the importance of youth and family engagement and early intervention services and supports.
- October 15, 2024: The ESMI TA Center, as part of the TTA center's monthly webinar series, launched a 12 series webinar session. The series addresses topics related to early SMI, including clinical high risk for psychosis and first episode psychosis. The webinars are

designed for a broad audience, including state MH authorities, practitioners, providers, peers, family members, individuals experiencing early SMI, and other stakeholders.

2.8 Maximize the capacity of the behavioral health workforce and 2.8a. Include coverage of peer and family support specialists in federal health benefit programs.

- University of North Carolina BH Workforce Research Center is jointly funded by SAMHSA and HRSA and supports and disseminates rigorous research that strengthens evidence-based policy and enhances the understanding of issues and trends in the behavioral health workforce. In the past two years, the center has completed 188 projects. Recent projects include exploring the pipeline to graduate social work education, preparing and retaining behavioral health workforce and safety net clinics, how educational experiences relate to work satisfaction and retention, and access to advocacy of peer support training and to those providing MH and substance use services. The center plans to complete eight more projects, two of which focus on payment as a critical aspect of workforce and will build upon recommendation 6 of the NSSP report.
- On July 9-10, 2024, SAMHSA's Office of Behavioral Health Equity (OBHE) hosted the Embedding Equity and Building the Suicide Prevention Workforce for Underserved Communities Technical Expert Panel (TEP). The panel's goal was twofold: to identify gaps and opportunities for embedding equity in suicide prevention and to build the suicide prevention workforce to reverse the current suicide rate in under-resourced communities. Over 90 behavioral health experts participated.
- One immediate outcome of the TEP was that SAMHSA-funded Centers of Excellence developed and disseminated five population-specific Suicide Prevention Resource Guides as a means to advance equity among traditionally underserved populations.

Although not a priority recommendation, CAPT Barry also provided an update on:

2.4 Reassess civil commitment standards and processes.

- ASPE released on August 8, 2024, the Evaluation of the Assisted Outpatient Treatment (AOT) Grant Program for Individuals with Serious Mental Illness. The evaluation finds that AOT is associated with improvements with treatment adherence, clinical functioning, and social outcomes. The evaluation also suggests that AOT involvement led to increased treatment engagement in comparison to other groups.
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National Academies of Science Engineering and Medicine Report Update

In addition, Ms. Andrews provided a brief overview of the nine recommendations made by the National Academies of Science Engineering and Medicine's Committee focusing on current perceptions and experiences among behavioral healthcare professionals and trainees, the current administrative and process barriers or policy barriers that produce a perceived burden, and infrastructure requirements.
The recommendations serve as a blueprint for increasing behavioral health provider participation and in increasing access to beneficiaries.

Discussion:

CAPT Barry facilitated the group discussion based on the following questions:

- With the NSSP release, and the recommendations for crisis care, does ISMICC have interest in the Workgroup 2 exploring synergies between ISMICC recommendations and the NSSP's goals and objectives?
- Is ISMICC interested in exploring the NASEM Report recommendations related to access to behavioral health services and enhancement of behavioral health workforce?

A member commented that 2.6 was added on early identification but asked if that also includes early identification of trauma. If not, would the group consider adding language about trauma? A discussion followed about the many nuances of language changes and complexities around language and how deeply the group should get into those changes. A formal recommendation was made that the working group draft a modification to the recommendation around developing language that could be reviewed at the next meeting. A motion was made and seconded and was unanimously approved.

Joel Dubenitz asked if it would be possible to consider connecting some of the ISMICC goals with the NSSP to harmonize the projects. He encouraged the members to review the existing documents and connect the dots. Dr. Everett noted that individuals with SED and SMI are at very high risk for dying, so there is a connection in the NSSP in the context of SMI. In response, another participant mentioned that a task force on crisis care workforce was being launched by the National Action Alliance for Suicide Prevention, co-led by SAMHSA's 988 office. As part of the triumphs, the participant went on to describe the impact that 988 has had on expanding access to crisis services and support, including SUD and intellectual and developmental disabilities discussions. The scale of work in local communities with mobile crisis and crisis facilities presents an opportunity to integrate with the states. The participant emphasized taking advantage of the current momentum to move forward, both from an operational impact as well as addressing the stigmas and discrimination.

Arc Telos "Tay" Saint Amour mentioned that CDC just reported that one in four transgender youth are attempting suicide. There is much that could be done regarding the multitude of anti-youth queer and trans bills making their way through states. It is important when talking about trauma to also consider environmental factors – the things that come before suicide. Their tribal nation is in Texas, where police are arresting queer and trans youth in their homes because they're going against state laws. They emphasized the need to address systemic issues through funding and initiatives to states and through block grants. In response, CAPT Barry acknowledged that the working group could look at the broader trauma-informed element and language to include in recommendation 2.6 but should also be mindful that the fourth pillar in the NSSP focuses on those that are disproportionately affected, where there is a lot of work to be done – particularly regarding any equity-specific element in the recommendations. Other participants pointed out the issues of psychiatric boarding, unnecessary law enforcement involvement, and unnecessary hospital medical department involvement.

A final comment was made by Judge Leifman, who described a recent visit to Trieste, Italy, to study their mental health system and recommended that focus should be on the larger system in general. The Trieste system has very few civil commitments because people are in a recovery

model system that has continuity of care. People are integrated into the community and not judged for their illness. He suggested that the group look at that system as a successful model.

Seeing no further comments or questions, Dr. Delphin-Rittmon called for a vote to approve the working group's report, including the motion that was previously voted on, which was unanimously accepted.

Focus Area 3 – Treatment and Recovery Working Group
Doug Slothouber, M.A., MSW, Chief, State and Homeless Programs, Division of State and Community Systems Development, CMHS, SAMHSA; Nancy Kelly, M.S. E.D., Director, Division of Children and School Mental Health, Acting Chief, Mental Health Promotion Branch, CMHS, SAMHSA

Doug Slothouber introduced the stewards and members of the working group, which meets approximately monthly. He next highlighted 10 recommendations under Focus Area 3, which were included in the ISMICC Report to Congress. The recommendations are comprehensive, encompassing all of MH treatment and services. Therefore, the working group decided to focus on promoting evidence-based practices that have a strong evidence base but are underused and could result in wider implementation. Three topics were chosen: supported employment (SE), supportive housing, and early SMI, including First Episode of Psychosis (FEP) treatment.

He then highlighted the triumphs for each topic:

Supported employment (SE)
- In FY23, a policy academy for states was held on supported employment.
- In FY24, a yearlong learning community was held for policy academy attendees to build on the academy and implement and share lessons learned.
- A new policy academy was held on the provision of SE through CCBHCs.
- A guide on Coordinating and Leveraging Resources to Increase SE was developed under the ASPIRE initiative and released.
- The two policy academies were inter-federal efforts, involving SAMHSA, DOL, and multiple other participants.

Supportive housing
- Strong interagency efforts continued, including the ALL INside initiative, coordinated by USICH, HUD, SAMHSA, ACL, and others.
- A yearlong Housing Supportive Services Partnership Accelerator learning collaborative with a focus on supportive services and housing needs was led by HUD with interagency support, along with ACL's Housing Services Resource Center. Many states were brought together to support ongoing implementation efforts coming out of lessons learned. Another collaborative is being considered for next year.
- SAMHSA is working on developing or updating several resources for the intersection of SMI/SED and homelessness. There has been a lot of congressional and White House interest around these issues and a lot of interagency response.

Early Serious Mental Illness (ESMI)

- The topic was chosen in part because Congress revised the set-aside in the Mental Health Block Grant from specifically for first episode psychosis to a more broad focus on early SMI. While this work includes FEP, it also gives attention to less developed treatment and supports for other early Serious Mental Illnesses that lack a psychosis symptom.
- The ESMI Training and Technical Assistance (TTA) Center has begun providing direct technical assistance to service providers, as well as holding Technical Expert Panels to make recommendations for the development of TA resources and learning communities. This includes a focus on first episode of psychosis and coordinated specialty care as a model, but more broadly looking at other SMIs, the onset of clinical high risk of psychosis, and various related aspects.

Discussion:

Mr. Slothouber facilitated the group discussion based on the following questions:

- FEP is well researched and has well supported treatment models (CSC). How can federal efforts identify and support innovative and best practices for the onset of all SMIs, not just those with symptoms of psychosis?
- How can federal ISMICC members work more effectively with non-federal members to create linkage and feedback between federal interagency initiatives and private systemic priorities and innovative development?

One member observed that the second question is answering the first, because communities are going to be able to speak best for themselves, and it makes the second question far more important, which is how to do that work. He pointed out that there are many members of ISMICC who are not federal members and could help with gathering some of the feedback or help recognize the sort of peer support groups that can be contacted. A second question raised by a member was how the recent Supreme Court ruling is going to affect the work on supportive housing. Mr. Slothouber responded that the structures of the federal programs are not at odds with the ruling; however, there is a potential for a larger impact on what other systems might be doing in the community. Since the SAMHSA programs work collaboratively with communities, there may be a need to adapt at times regarding how communities are approaching homelessness services and how to implement in a context of criminalization of activities that are inescapable from being without a home. The member followed up with the comment that individuals with SMIs have disproportionate rates of homelessness, so if that is now being criminalized, community organizations are going to be at overcapacity. That could affect programs in a major way.

Seeing no further comments or questions, Dr. Delphin-Rittmon called for a vote to approve the working group's report, which was unanimously accepted.

Focus Area 4 – Criminal Justice Working Group

Gregory Crawford, M.S., Public Health Advisor, Office of Technical Assistance and Coordination, CMHS, SAMHSA; Maia Banks, M.S., Supervisory Public Health Advisor, Office of the Director, CMHS, SAMHSA

Maia Banks introduced the stewards and members of the working group, acknowledging CMDR Katie Hagar's new role as co-steward of the working group. The working group meets every two months. She then briefly described the recommendations that support the use of diversion at all points in the sequential intercept model to provide quality treatment and recovery supports. Although the working group collectively decided to continue to prioritize the entire sequential intercept, they have recently focused discussions on the following:

4.1. Support interventions to correspond to all stages of justice involvement. Consider all points in the Sequential Intercept Model (SIM).

- This addresses the need to prioritize diversion at all intercepts in the SIM in favor of trauma-informed MH and treatment recovery services and care that is accessible, culturally and linguistically competent, and developmentally appropriate for adults and youth.

4.2. Monitor federal legislation relevant to those with SMI, SED or COD at risk for, involved in, or released from the criminal and juvenile justice systems in order to identify opportunities for innovative or improved federal activities and interagency coordination.

- This addresses the need for agencies to continually analyze currently applicable and new federal legislation to identify opportunities and collaborate to address these issues at all points of the SMI.

4.3 – 4.8

- Address specific intercepts in the SIM, prioritizing diversion and access to quality care throughout.

Gregory Crawford highlighted the working group's triumphs:

- The working group has continued to work collaboratively to develop a resource that highlights funding opportunities across all intercepts and helps guide communities on how to access these resources. The group hopes to share more about it at the next ISMICC meeting.

- A supported employment policy academy was held for CCBHCs and included sessions on the critical aspects of addressing justice-involved individuals' employment challenges and support needs, including employment as peer supports.

- The working group continues to research judicial training to identify gaps and/or if there is a need for further investment to develop new resources for judges and court teams to better work with individuals with SMI. They have conducted a full environmental scan and literature review and are currently working on a document.

- The working group continues to strengthen coordination and collaboration that ensure the integration of criminal justice in SAMHSA-related products.

Discussion:

Mr. Crawford facilitated the group discussion based on the following questions:

- What is one way local, state, and federal partners can work collaboratively to improve outcomes for individuals with SMI and/or SUDs and minimize arrest and or justice system involvement?
    - SIM 0-1 space (Community/Law Enforcement/Emergency Services)
    - Crisis Intervention Services
    - Jail Booking / Screening and Assessment
- Is there anything that the working group can do to help move those, areas along in terms of evidence-based practices?

A member commented that when looking at SMI we are often dealing with an individual who has no awareness of their illness. Therefore, they can go further into the criminal justice system. He referenced Judge Leifman's report on the Italian model, which does not base civil commitment on danger but instead on need. If the U.S. could adopt that model many people could be diverted from the criminal justice system based on the needs related to their mental illness.

Another member recommended that they look at the recently passed task force report on MH from the Conference of Chief Justices, Conference of State Court Administrators. In that report, they adopted a recommendation that talked about establishing new pathways. Current thought is that if someone gets arrested, they need to stay in the criminal justice system for treatment, but that is not necessarily the case. New pathways can be created for individuals who are considered lower risk of criminal justice involvement that may include transferring those cases to a probate division for handling. That decreases the risk that the individual will then have a criminal record that can make it harder for them to get employment and housing.

Another member focused on the portion of the question about minimizing arrests and suggested that more local, state, and federal work with law enforcement and state agencies, including uniformed officers, could avoid arrests in the first place. Talk about trauma-informed de-escalation movements, plain-clothes officers, peer support specialists, etc. Judge Leifman expressed a need for more co-responder models, so law enforcement is only responding to calls that involve weapons or violence. In Miami, standard operating procedures still require officers to handcuff the person in the back seat of a car, which can be humiliating for an 18-year-old with first episode of mental illness because it looks like he is being arrested when he is not. If there was an emergency response like there is with heart attacks, it would help avoid a lot of different situations. He suggested adding a recommendation about decreasing the use of co-responder types of models and using law enforcement as secondary when appropriate. Judge Rhathelia Stroud seconded that comment, saying that the misdemeanor MH court she presides over and diversion help because once a participant completes their court, the solicitor general restricts the record so no employer, university, or mortgage company, etc., can see that they were in the criminal justice system. Charges are dismissed with successful completion of the program and are certified by the state of Georgia.

Dr. Meena Vythilingam asked about the threshold for intervening being need and not a danger to self or others or gravely impaired. What would it take to shift the law, since it gets into nuances of individual rights and needs. Judge Leifman responded that in Trieste very few cases actually end up going through civil commitment because they do a great job at the front end. There is a

need to make sure we have both of those things, so that people don't decompensate to the point where they need hospitalization. As for civil commitment, it's done very differently in Trieste. Two independent doctors file a petition, which does not go before a judge but instead to the mayor, who in Italy is considered responsible for the population. If he signs off on it, the court only makes sure the actual application is adequate. Change in the U.S. would have to be done state-by-state, which makes it more challenging. Using a need for treatment has passed constitutional muster, and Michigan is an example. The state has a need for treatment that has been upheld.

Dr. Sue Smith shared the case of a 60-year-old man who is facing being discharged from his job after working at it approximately 20 years because his most recent background check has determined that he is unfit for his job due to some property damage he did connected to an early childhood psychosis. Consequently, the state of Georgia said he must be terminated. Cases like this underscore the important work being done by the working group and ISMICC to prevent unnecessary law enforcement engagement and impact of that engagement for people with SMI and SED.

Dr. Sarah Vinson reported that, as a child psychiatrist, she does community MH work with children. There is a lot of talk about the school to prison pipeline, but there's also an expulsion to prison pipeline. They are seeing a lot of reactionary, zero-tolerance policies in the schools related to the substance use epidemic and overdoses. These children are often "self-medicating" with substances, and it is important to not have school policies that feed a youth to into those systems. Dr. Everett asked Judge Stroud if she has any information about how common those laws are at the state level. In addition, she suggested that the working group can conduct a state survey to determine how many states have those policies and make states aware of useful resources.

Judge Stroud responded that Georgia has accountability courts that provide the opportunity to expunge a record, and they have been codified in the state of Georgia. This applies to misdemeanor courts and some very minimum felonies. However, she is not aware if they exist in other states. She asked Judge Leifman if Florida has a similar program in its courts. Judge Leifman responded that all states have laws allowing for diversion. In Miami-Dade, for felonies and misdemeanors, if someone completes the program, they drop charges and seal the record. However, many courts require the person to take a plea before being accepted into a program, which is vacated and dismissed if they successfully complete the program. This puts the person at higher risk and sends a message that they need to plead guilty to get treatment. The Miami-Dade program is voluntary, and individuals can leave and get tried at any stage. However, that is rare. The other positive impact of the program is that it avoids competency evaluations because they are not pursuing charges. There's no constitutional requirement that an individual has to get evaluated for restoration, so that burden has been significantly reduced. Individuals just have to have the cognitive capacity to voluntarily agree.

Dr. Delphin-Rittmon agreed that additional recommendations may be beneficial, including an environmental scan around what it looks like at the state or county level with respect to record expungement and the different terms used. Also, it should include what processes are in place to have that happen. It speaks to the possibility of best practices and what might those best practices look like.

A motion was made for the working group to develop additional recommendations that align with some of the current discussions and present them at the next meeting. The motion was passed unanimously.

Seeing no further comments or questions, Dr. Delphin-Rittmon called for a vote to approve the working group's report, which was unanimously accepted.

Dr. Shaw later commented on the previous trauma-specific recommendation and the whole person care recommendation (3.4) that already exists. Trauma-informed whole person healthcare is the expectation of the entire systems of care for people with SMI and SED. Therefore, it might be beneficial for working groups two and three to come together and talk about how these ideas that were discussed at the meeting overlap, and potentially increase specificity, and/or revise any of them collaboratively.

Focus Area 1 – Data & Evaluation Working Group
Sandra G. Resnick, Ph.D., Associate Director, VA North East Program Evaluation Center (NEPEC), Department of Veterans Affairs, VA Central Office; Nima Sheth, M.D., MPH, Senior Medical Advisor, Office of the Director, CMHS, SAMHSA

Dr. Nima Sheth introduced the stewards and members of the working group, she also introduced two new members: Dr. Sarah Vinson and Dr. Jennifer Higgins. The working group meets every two months. She next provided an overview of the three priority recommendations, two of which (1.6 and 1.7) require new activities, as well as the triumphs associated with each:

1.1. Improve ongoing interdepartmental coordination under the guidance of the Assistant Secretary for Mental Health & Substance Use

- Their working group on Data and Evaluation brings together a federal team from across DHHS and the VA that have expertise in measurement-based care (MBC) and a focus on its implementation in the area of behavioral health, some of the work pertaining to ISMICC.
- They also have a federal working group that is specifically devoted to improving interdepartmental coordination on MBC which meets alternate months from the Focus Area working group and is currently working on a charter to guide its work. This collaboration is the only interdepartmental federal government effort focused primarily on MBC, and it has allowed the group to make progress regarding priority recommendations 1.6 and 1.7.

1.6. Use data to improve quality of care and outcomes.

- The focus for this priority over the past two years has been on MBC, with a long-term goal of supporting further integration of MBC and evidence-based clinical processes in community-based settings providing behavioral health services. MBC is a best practice that uses data to inform and improve the quality of care and outcomes.
- The working group's brief report has been published on the ISMICC website. The report focuses on MBC 101.
- SAMHSA sponsored a convening on facilitators and barriers to implementing MBC. A number of themes emerged, including workforce and workflow barriers and successful models. Speakers shared how they're implementing MBC in various settings, including

hospitals, child-focused settings, behavioral healthcare settings, schools and behavioral health clinics.

- They have integrated the recommendations for use of MBC into SAMHSA's updated CCBHC certification criteria.
- Activities related to research on financing of MBC, which come up in the convening as a theme around how to reimburse and fund MBC activities. These include:
    - A report on financing options for MBC in the provision of behavioral health services in community settings is being developed in partnership with SAMHSA's Center for Financing Reform and Innovation (or CFRI). This report, which draws on both literature and discussions with experts in the field, is expected to be released before the end of the year and will be accompanied by a webinar with highlights of the report and a panel discussion.
    - A new center is launching, called the National Center for Mental Health Dissemination, Implementation, and Sustainment. The technical assistance center is established to assist communities, as well as SAMHSA grants, and provide support around process improvement and change management. The center also has the capacity to do hands-on implementation support for the MBC resources that they've provided through what are called MTAs or the sub-regional components of the center.
    - A required activity of the center is to establish and maintain a national repository of Patient-Reported Outcome Measures (PROMs) appropriate for use in MBC that are vetted by experts, provide guidance on how to implement and use MBC to enhance patient-centered care, and improve patient outcomes (e.g., organizational and provider buy in, resources, funding, personnel, training).
    - They also are convening a Technical Expert Panel with MBC experts. At least one or more persons on the technical expert panel has to represent MBC as their area of expertise.

1.7. Identify and work to build on previous efforts to develop a quality measure that measures use of MBC in community-based behavioral health settings.

- At the last ISMICC meeting, there was a vote to make this recommendation a bit more focused on MBC, and the working group is tracking that around current linkages that are occurring with the efforts in 1.6. Therefore, with ISMICC approval, Recommendation 1.7 now focuses on quality measures specific to MBC implementation in community settings providing behavioral health care. This is intended to strengthen the focus on MBC and not dilute it by focusing 1.7 activities on quality measures too broadly.
- The working group has continued to better understand the lack of general quality measures focused on use of MBC. They have continued to have conversations with stakeholders, such as the American Psychiatric Association on what the barriers are and what the working group could do to further this issue.

In response to a request, Dr. Sandra Resnick defined measurement-based care as a clinical process that uses quantitative data from patient-reported outcome measures as the foundation for tracking progress in mental health treatment over time and helping to set the direction of clinical work. MBC is not algorithmic, nor is it a performance measure. MBC is a clinical process that provides a platform for having transparent, collaborative, shared decision-making discussions

between mental health providers and clients. This model can be an integral part of patient-centered care.

Discussion:

Dr. Sheth facilitated the group discussion based on the following questions:

- If we were developing quality measures focused on use of MBC in behavioral health, what measures would be most needed or useful?
- Any other suggestions from this group as we move forward in our work on MBC?

Shawn Terrell mentioned that there is a lot of emphasis in the report on person-centeredness. National Committee for Quality Assurance has a measure on directly measuring person-centered goals that people use for goal attainment scaling. Using goal attainment scaling is currently on the CMS Measures Under Consideration (MUC) list and has been tested with the people who participate in community care or clinics. Therefore, it might be worth looking at as a set of measures that would be consistent with the broader goals of the report. Dr. Resnick agreed that it was a good idea and asked for a link to the report.

Dr. Jennifer Higgins commented that there has been fine work on integrated care, but she wondered about the quality measures for integrated care, specifically those that are non-billable. When people come together for multidisciplinary meetings there are non-billable case assessments, etc., involved. Therefore, she suggested making quality measures with respect to integrated care, specifically non-billable types, billable.

Dr. Everett reported that CMHS' National Advisory Council has a sub-committee looking at work on ideas for optimizing the CCBHC model and how data might be used on a national scale. She also mentioned the potential use of artificial intelligence (AI) to enhance or tailor MBC to the person and their experience. This could make it less burdensome for clinicians or staff to have to enter information in a data base that collects it over time.

Dr. Higgins shared that there might be an interesting analysis done between non-AI versus AI outcome measures and a quality assessment that could be done as a study, too. Another member commented that when we talk about MBC, it's about the people who are continuing to engage in services rather than those who are no longer part of the system. It might be useful to engage people whom the system didn't serve well enough to keep them engaged, including in MBC.

Judge Leifman responded that they are actually piloting a predictive analytic case management system that is not only going to gather psychiatric data but also look at primary AI. A new facility about to be opened has all these services and, as a requirement of the providers, they must agree to share all of that information. They are a large, fragmented community, so the hope is that using this technology they can get a better idea of who is doing a better job and why, what triggers emerge, and what the primary signs are that were missed because there was no integration. Dr. Sheth added that the group hasn't discussed AI very much, so it is something to consider. There are AI interventions that have been shown to reduce bias in certain settings and be better for people of different racial and ethnic backgrounds.

Dr. Delphin-Rittmon commented on quality of life and whether people's lives are improving based on self-reporting. Also, is there a way to get to some of the recovery components, like health home purpose and community, that align with some of the social determinates?

Further comments on AI included the fact that it isn't yet known what AI can do. It is well established that computers have helped make it easier to collect and interpret information for providers and people using care. The value is to make sure that when AI is developed it serves everyone as well and as seamlessly as possible. We can speculate about how AI might work, but the value is in making it as easy as possible.

Seeing no further comments or questions, Dr. Delphin-Rittmon called for a vote to approve the working group's report, which was unanimously accepted.

Public Comment
Pamela Foote, Designated Federal Official, ISMICC

Ms. Foote opened the meeting for public comment. She stated that those who called in and have requested to speak will be called upon in the order that the comments were submitted and reminded speakers that they each had three minutes. Unedited comments were as follows:

Dr. Edmund Creekmore, Jr. Hello, I am Dr. Edmund Creekmore, Jr. I'm a licensed clinical psychologist and independent forensic examiner at a private community hospital where I do an independent assessment evaluation and the commitment court in that judicial venue. I'm also the National Shattering the Silence policy action co-chair.

The NSSC is a bipartisan organization of family and adult care volunteers dedicated to support their adult, seriously mentally ill loved ones. The NSSC advocates for enhanced Medicaid 115 waiver funding for provision of a broad continuum of care for the seriously mentally ill with the active support of their families and adult peers in their own homes who have histories of schizophrenia, bipolar disorder, and related psychological disorders, which are known to recur and remit over time.

A broad continuum of care is what is needed in our organization's view. This includes provision of crisis support services made available in-home settings when necessary, by co-response teams with diversion whenever and wherever possible of the SMI charged with misdemeanor offenses from the criminal justice system to fully-funded, outpatient treatment resources in the community.
In this endeavor, our organization advocates for enhanced funding for expanded use of assertive community treatment teams and forensic community teams, to include assisted outpatient, AOT, that is, treatment over objection for those individuals suffering from lack of insight into their illness, or anosognosia, who are too sick to know that they are too sick to give legal consent to treatment yet who may have a capacity to abide with the aid of a civil outpatient court order with community-based treatment and MH support. Home-based psychiatric care offers many advantages over traditional inpatient psychiatric care, which often necessitates removing those with severe MH disabilities from their families and homes.

Modern point of care technologies, including many telehealth solutions, are already implemented in place during the COVID-19 pandemic, offer efficiencies of scale. Home-based psychiatric care avoids many of the problems reported by peer organizations such as missed appointments due to often unreliable Medicaid gap services as well as the emotional trauma due to the untimely and, in many instances, avoidable removal of loved ones in a MH crisis from their homes by the police.
These technologies offer real promise for the future in receiving evidence-based medical care when and where they are needed based on the model already being implemented in the United Kingdom, Canada, Australia, and around the world.

With critical housing and workforce shortages, states across the nation should take notes be considering home-based, remote psychiatric care as an option, one tool in the toolbox available for use along a broad spectrum of care. The wider application of modern point of care technologies offers the prospect in the not-too-distant future of healing the breach that often exists between physician and patient that acute psychiatric hospitalization in the commonwealth and across the nation currently poses with fewer HIPAA privacy complaints about inadequate communication and lack of prior notice of discharge made by concerned family members of the adult mentally ill services, in many instances, are directly provided in the home.

Many traditional psychiatric inpatient services provided with 24-hour nursing care support in acute psychiatric hospital settings can be provided safely with adherence in principle with fidelity standards as established by evidence-based CCBHC standards in homes of many of these at-risk populations with telehealth and expanded ACT team support.

Home-based psychiatric care with telehealth support is an old idea with a modern point of care technology whose idea may have finally come, though no one treatment strategy is likely to suit the special circumstances of all adults with SMIs in their families.

It is our organization's opinion that home-based remote psychiatric care with enhanced remote technological support is one tool in the toolbox that should be seriously considered by SAMHSA and ISMICC for SAMHSA demonstration grant funding. Thank you very much for your time.

Ann Corcoran, Executive Director, National Shattering Silence Coalition

Good afternoon. As executive director of the National Shattering Silence Coalition, our volunteer organization comprised of those with lived experience, families, caregivers, and professionals, I wanted to share a few of the stories I have heard from families over the past year.

Ryan was a 32-year-old who left his family home this past winter while in psychosis and was found in the spring in the streets. Unfortunately, Ryan lost his life two weeks later while hospitalized. He died from an infection.

Nick is a 21-year-old with schizoaffective disorder who attempted to take his father's life while psychotic. This was after being involuntarily committed to a hospital and ordered held up to six months but released to the streets after just five weeks. Because of his mother's fierce advocacy, Nick was given probation and released to the streets. Still, the worry remains about who will be

next if Nick doesn't adhere to his treatment, which is very likely as he doesn't believe he has a mental illness.

Bob left his son Brett after he walked in front of a train. Brett lived with schizoaffective disorder, and he was living on the streets.

Bob attended a press conference two days before he buried his son to advocate across the state of Maine for enhanced education around the progressive treatment program, which is Maine's version of AOT, which could have saved Brett's life. His family, the hospital, and law enforcement had no idea that such a law had existed for 22 years, or the process needed to implement this life-saving program.

These stories represent just a handful of families throughout the country. We are seeing increased funding for MH, yet the results remain dire. Our country and this committee continue to fail those living with severe mental illness. We are not doing enough to help those who are unfortunate enough to experience both psychosis and anosognosia.

Psychosis is when someone hears, sees, or believes something to be 100 percent true despite it making no sense to those around them. Anosognosia is a symptom of these illnesses that prevents one from recognizing that they're ill.

The best first episode psychosis programs do no good to those who don't believe they are ill. The recent evaluation of the SAMHSA AOT grant program conducted by RTI International Policy Associates, Inc. and Duke University School of Medicine presented new findings about AOT's effectiveness across six study sites. These findings include high levels of satisfaction from family members and participants, improvements and outcomes, and a return on investment for AOT programs. These types of programs need more funding, not less as we saw in fiscal year 2024.

SAMHSA just released a new brochure that emphasizes the crucial role of early detection and intervention in SMIs, emphasizing the need for prompt attention to the first onset of symptoms. Why is the critical information about anosognosia and available treatment options like AOT not mentioned as a solution when psychosis and anosognosia are present? AOT can be the lifeline for families who cannot otherwise get their loved ones help to keep them safe.

In closing, I ask that the members of ISMICC see the unseen and start focusing on real solutions that will improve the outcomes for those with SMI. Families like mine are counting on you.

And just as an aside, I want to say that I'm very hopeful in the discussions that I'm hearing today, and I think it's the first time I've ever heard somebody mention what do we do for somebody that isn't able to recognize their illness? These are the people that we need to really focus on. Thank you.

Darrell Herrmann: I've been living with diagnosed schizophrenia very successfully for over 40 years. The most prominent feature of schizophrenia is psychosis. To be psychotic or in psychosis means the person is experiencing hallucinations and delusions, but because that person believes

those delusions are reality, he acts in ways and makes decisions that make no sense to those around him.

The medical model of schizophrenia is a consensus view of modern psychiatry of schizophrenia; it states that schizophrenia is a result of biological differences in the brains of schizophrenics. Treatment is usually addressed by what is known as the biopsychosocial model. The biology of the illness is treated with antipsychotic medications. The psychological part of the illness is treated with psychotherapy to address dealing with residual symptoms that medications do not relieve and help with social functioning in premise to the illness. Social treatment revolves around forming a social environment that is conducive to recovery, which usually involves lowering stress levels in the work and/or social environment of the patient.

Since this is the consensus view of psychiatry, anyone who does not accept the medical model is by definition antipsychiatry. There are many antipsychiatry groups who exist today at the state and local level. There are also some that are international.

I'm going to address only three. They are the Hearing Voices Network USA, the National Poverty Center, and Inner Voice. Members of the Hearing Voice Network are usually referred to as voice hearers because the most common symptoms they describe is hearing voices, although other hallucinations are also reported.

Inner Voice is the international parent organization of Hearing Voices Network. National Poverty Center is a U.S.-based organization that receives significant funding from SAMHSA. Lawrence Cohen is the chief operating officer of National Poverty Center and also a former board member of Hearing Voices Network.

All three of these organizations support the idea that voice hearers experience psychosis. They also adamantly oppose the medical model, making them anti-psychiatry. Inner Voices even campaigned to have removed the diagnosis of schizophrenia from the DSM, saying that it is a normal part of the human experience and not an illness.

I've read dozens of accounts of voice hearers experiencing hallucinations, but none of the voice hearers experiencing delusions are losing touch with reality. The main page of the Hearing Voice Network website lists an article from the Lancet Psychiatry March 2015 edition on their experience. This article describes many instances of hallucinations, but no evidence of delusion or loss of touch with reality. I see no evidence of voice hearers actually experience psychosis despite many have schizophrenia diagnosis. Hallucinations alone do not mean psychosis.

These people are popularly represented in the (inaudible) movement and almost complete control of it. SAMHSA lavishes a lot of support on that. They advocate tirelessly against any coercion or involuntary treatment of the mentally ill.

As someone who has experienced psychosis, I know that coercion and involuntary treatment is often necessary due to psychosis. They have a saying, nothing about us without us. It is clear that they have no knowledge or experience with psychosis. Why are they even allowed at the table when discussing issues of psychosis? They do not experience psychosis, so it is not about them.

SAMHSA is a major ally of the anti-psychiatry movement. SAMHSA recently cut funding for SMI Advisor which was a science-based program providing the best science available on psychotic illnesses. This is a clear indication that SAMHSA does not follow the science. Thank you for your time.

Mary Ellen Stuart: I just want to say thanks to everybody on the committee for your effort to provide solutions to mental illness in our country. We all know it's hard work and we're super grateful for your persistence.

In the March meeting and the meeting today, your esteemed committee member, Judge Leifman, advocated for decriminalizing mental illness. His status shows how expensive it is to have criminal justice be primary in handling people with severe mental illness. Judge Leifman also exposes that this is mostly ineffective and it's nobody's fault. Those punitive systems were never designed to offer complex, long-term medically necessary treatment.
We define the overall problem as mental illness, which has the word illness right in the name of the problem. That would suggest that medical intervention is required. Doctors and therapists can create effective treatment plans. The challenge is to get someone with SMI to actually follow them. The answer for many who suffer with mental illness is to live in excellent residential treatment, also called permanent supportive housing.

These quality programs provide the medical support to follow the doctor's orders, allowing the patients to attain medical wellbeing and achieve lasting stability. Stable people don't need law enforcement, they don't need crisis units, and they don't need hospitals.

Community-based organizations and services were mentioned several times today. Most of these are nonprofits providing evidence-based, medically necessary care. They operate on tight budgets because funding is so difficult to secure. Private donors and private foundations pick up the bulk of the costs. These community-based organizations are often referred to as housing that heals, supportive housing, and residential treatment, but what they really do is put supports in place to allow their residents to follow the doctor's wellness plan.

Their goal is to promote healing and stability, and they can demonstrate success. Directing funding to these organizations is a more responsible, much lower cost investment with high potential positive impact, and because the housing is long term, the recidivism rate can drop to single digits, unlike some of the limited term interventions in law enforcement.

There are government grants out there and some were mentioned today. In California, we even now have Prop 1 funds to address mental illness. I can personally tell you that all of this money is really hard to get. It's because the bar is set to a standard that is almost unattainable for a community-based organization that is really busy providing effective, supportive treatment. None have extra staff to constantly monitor funding opportunities and then assemble the endless documentation needed to apply. So, the money might be there, but it's not helping enough of the people that it's meant for. I'm hoping the ISMICC committee can help change that.

Focus group 3 today talked about identifying and supporting best practices in public-private partnerships. Focus group 1 talked about person-centered integrated care. These things really give me hope. Good community-based organizations can make real progress to improve the way that serious and persistent mental illness is treated in our country. They can also save money.

Please redirect some of the funding from the expensive police, courts, jails, crisis care, ERs, and hospitals to the lower-cost, boots on the ground services that are providing the effective, stabilizing care for people who suffer from mental illness. Stable people don't need expensive interventions. As a side note, it would make your job of being on ISMICC a lot easier. Thank you so much.

Judge Steven Leifman's reply: Can I follow up real quickly? I'll send them to you right now, we did a couple recent studies, we're getting ready to open this new facility. For the record, this is Steve Leifman. So, we get a list every day from our county on who is eligible for our diversion program. So, trying to figure out who is going to be first priority for the new facility, we went back and we looked at everybody that was on that list over the last five years.

We identified 16,000 people. They were arrested 32,000 times. Every one of them were eligible for diversion. They spent 1.2 million days in the Dade County jail. That's 3,400 years at a cost of over $414 million. So, her point is very well taken. Forget the cost, but the cost to the individual and society is ten times that amount. There just has to be a better way to do this. So, thank you.

Laura Craciun, Co-Chair, Policy Action Committee, National Shattering Silence Coalition: My name is Laura Craciun. I'm the co-chair of the policy action committee for National Shattering Silence Coalition. I am a peer, bipolar, I am an advocate, and I am a caregiver to an adult son, 22 years old, with schizoaffective disorder. I hear the horror stories from families who never made it to treatment before tragedy happened. When my son was hospitalized for trying to kill his father in extreme psychosis on December 27, 2023, I was in catastrophic stress.

But my shock had started the previous two years when his sudden onset of schizoaffective disorder turned our family upside down. At onset, Nick went endangered and missing for three months. He allegedly stole half a million dollars and then was seen passing it out on the streets in the poorer section of town, returning home starving with false fixed delusions about needing to climb trees naked to hear the voices in his head better.

We tried 16 attempts in two months for him to be hospitalized but succeeded only twice. That includes the 988 and the CCBHCs. The first was by police who had taken him by force and the ER said he had cannabis as his cause for his bipolar I with psychotic features mania episode.

The second was McLean who ended up committing him. McLean is the best hospital in the country for his illness but was frustrated at him taking his meds so they let him go after five weeks, saying we were lucky they let him stay for two months being so noncompliant, having no insight and having no participation in therapy or groups.

Nick was released to a homeless shelter as no family felt safe with him at that point and was given a one-month psychiatric appointment which Nick never showed up for, because he had the

belief, he had no mental illness and wanted to give his appointment to someone who needed it more than him.

Ten months later, without smoking cannabis for at least seven months straight, he had that extreme psychotic episode where he thought he could see and hear the devil, which almost ended his father's life, if police didn't pepper spray him off. He had bitten and beaten his father so badly, the neighbors were all outside watching in horror, as he headbutted him forehead to forehead while pinned to the sidewalk.

What turned out to be a shock from our son's new behaviors became a shock of this country's policies that have let dangerousness go to a new level before treatment is available.

It turns out, this has been the way for decades. Why? Because the wrong people have the microphone. The peer movement has to be with those who have either great knowledge about anosognosia from the most severe spectrum of the illness or ones who are in recovery and we have those peers in our advocacy group.

It turns out that NSSC is the only group I know of who seeks publicity as a cure. They gather the stories like mine together as a valuable, insightful, hard-learned learning tool, lessons that have to be listened to, otherwise we'll go another 20 years with the same exact situation we have now. I recommend to ISMICC there be data collection and analysis of the homeless and incarcerated populations that includes the morgues from suicide to determine the prevalence of anosognosia. By seeing the actual number, you will understand why it is the missing link. ISMICC can identify funding for this work and appropriate researchers to do the work. It should be your priority in order to stop the spread of death and trauma in families like mine across the nation.

As a side note, you were talking about measurement-based care. How can you measure data from a person who is homeless living in a different state altogether from their families, who have lost connection with their families? How are you ever going to get actual data?
My son was both in a diversion problem and a competency hearing and he is still unmedicated and in ongoing court cases to this day, two of them. The CCBHCs and 988 are useless for the population who are too sick to know that they are sick. I asked the CEO of that program to confirm, no one calls in with symptoms of anosognosia or family members. They need this bridge to care. They need AOT. Otherwise those great services that you have are not going to be utilized.

I asked peers adding to the conversation regarding laws around the most severe spectrum diagnoses of psychotic illnesses, not moderate or mild, those who know how the anosognosia feels like, looks like, acts like. This is not a psychological symptom, but a neurological one. Thank you for your time.

Mary Kramek

Please consider the following:

In Alachua County Florida, my loved one voluntary admitted himself to UF Shands Vista Hospital due to being suicidal. He was known to this hospital and staff as he had been admitted twice the previous year for psychosis related to bipolar medication changes. This was a similar situation as his condition deteriorated over 24 hours as the Dr. Assigned changed his Depakote level but didn't change his antipsychotic.

Unfortunately, my loved one attempted to slash his throat and wrist with the hinge of his glasses and chew his lens. Staff confronted him and my loved one lashed out causing a small laceration of a nurse's ear. He had never hurt any staff prior in the 20 years of his illness. The nurse pressed charges of assault and an arrest was made 12 hours later. This was something that Florida allows for to protect all healthcare professionals. I wasn't notified of the incident nor the lack of a Baker Act until 12 hours later when the arrest was made. I am the legal healthcare representative when my loved one is sick.

The arresting officer took my loved one to the county jail. He was placed in a mental health solitary confinement with no visitation allowed. I was not able to get any information from the company that is contracted for mental health services.

After bond was set at 1000 and I had secured a defense attorney I was able to bond him out 48 hours after he had need detained. He was frightened and deteriorated rapidly, requiring admittance into a different hospital for 30 days and a med change to Haldol and Depakote.

The cost to our family has been enormous. Both financially and emotionally. I was told by the defense attorney and the therapist I saw that numerous other instances of arrest were occurring frequently at the UF Shands Vista facility. My concern is that adequate staff training, de-escalation procedures and safety of patients in mental health facilities is not being maintained at this facility. I was told that even though my loved one slit skin on his neck and wrist that " he had a few scratches" by the attending doctor. Clearly, it was more than that and grounds for a Baker Act, rather than an arrest.

Gayle Giese

Repeal the federal IMD Exclusion that prevents Medicaid coverage for "Institutions of Mental Disease" (most psychiatric hospitals and clinics) that have over 16 beds.

Integrate Behavioral Health and Primary Care. This is vital to address health of the whole body and avoid diabetes and smoking-related illnesses.

FACT teams should include more than one Certified Recovery Peer Specialist per team that serves 100 people. FACT teams need good oversight and individual treatment plans for each member. Care should be welcoming and trauma-responsive. Include primary and dental care and provide recommended vaccinations to members.

More psychiatrists should be willing to prescribe clozapine for patients on the schizophrenia spectrum and understand how to titrate it off and on. Pharmacists and psychiatrists should understand how to use the FDA REMS and be aware of the danger of missed doses that cause psychosis.

People with SMI in jails and prisons should have access to the meds their doctors prescribe and should not be placed in solitary confinement. CRPS can help. Reinstate Medicaid coverage 30 days prior to release to facilitate re-entry and recovery.

Move marijuana from a Schedule 1 to a Schedule 3 drug so it may be researched in the United States to show connections between THC levels and psychosis and onset of schizophrenia and/or cannabis-induced psychosis.

Dawn Stephens

Good morning,

I work for Mental Health America in Montgomery and we offer a free day-program (psychosocial clubhouse) for those in recovery from serious mental illness. I'm attaching a brochure for review.

We would like to suggest you consider funding for clubhouses and drop-in centers—they aren't traditional "treatment" services but they do so much to help people live successfully in the community and avoid hospitalization.

An example of this is Kimberly, one of our consumers who comes regularly to our program was struggling during the group. We could tell that something was wrong and her anxiety was very high. After talking with her she shared she was being evicted from her apartment in a week. We were able to help her secure another place to live and it prevented her from being on the streets and relapsing. We are a lifeline for these people.

Thank you for your time and consideration.

Ibis S. Carrión-González

Hi! I'm the daughter of a father with SMI since 1972, who died in 2015. I appreciate the Committee considering developing grants to provide behavioral health services for prevention, treatment, and recovery in the patients' homes and community. The illness affects the stability of the patients. They are inconsistent in assisting with the appointments. In addition, the dynamics of the patient's family are deteriorating, they require support to
provide appropriate management of the patient's symptoms and their consequences to have

wellbeing, as possible. The community needs to understand the SMI to be friendly with the community members suffering from SMI.

Therese

I am Terror:
The Criminalized Suffering of those Not Ill Enough

4AM. My alarm goes off. I jump out of bed with an excitement that I had only dreamed about. Admittedly, I was already awake, waiting to begin the day. My son didn't sleep all night. This is a day that he has waited for all summer. On this day, my daughter, son, and I are driving across country to bring my son to college: a 3-day, 30-hour road trip with our two overactive dogs. Friends told me I was crazy. I have never seen my son so happy as I did during the next week. Seeing your child so happy is perhaps the greatest feeling a parent has. Each mile on the road brought us closer to my son realizing his academic dreams.

After graduating from a top high school as salutatorian and with two associate degrees, our child went to college at a prestigious university in the east. He was excited about going to college and often spoke of his goal to earn a Ph.D. degree to do research and contribute to mathematics. He looked and acted the part, buttoning the top button of shirts, mocking students for falling asleep in class—questioning how someone could sleep during class—and never ever breaking the law, refusing to do something as simple as jaywalking.

He wasn't at the university very long before something seriously changed. He stopped bathing, attending classes, and withdrawing, expressing an interest in being homeless. He isolated in his dorm room with a flat affect that was frightening. He had gotten a tattoo on his forearm, a quote from the television series Mr. Robot:

> "I feel the sensation. Fight or flight. It's constant. I should just pick one. I, Elliot Anderson, am flight. I am fear. I am anxiety, terror, panic."

At some point our son cut off the majority of the tattoo and portions of his skin with nail clippers, leaving only the words, "**I am terror**."

Beginning his freshman year, I lost my son, but more tragically, my son lost his ability to live his dreams and became victim to a zealous legal system that protects individual rights of the severely mentally ill at the detriment of the real living rights of a human being.

With help from university administrators, our son took a leave of absence and returned home, which we hoped would be the start of a solution. We were wrong, and instead we lived in an unimaginable hell that is often experienced by desperate families who have a loved one with a serious mental health condition: incarcerations, revolving-door hospitalizations, homelessness, and frustrations in trying to navigate resources, legal institutions and mental health, to get our loved one's help. Police were called to our home three times, ending in the arrest of our son. I

filed for and was awarded emergency guardianship, thinking this was going to be the miracle that we needed, but again I was wrong. After a court hearing, our loved one ran away, violated his probation, and became homeless. He was eventually found, transported to an ER and was committed to a higher acuity behavioral unit in a hospital.

Upon arrival in the ER, our son received a psychosis diagnosis, yet after two days his psychiatrist recommended release because our son did not outwardly present the positive symptoms of psychosis, although our family had witnessed delusional thinking and paranoia. With my guardianship papers in hand, I quite literally begged to meet with his attending psychiatrist. My request was denied. As his legal guardian, I was shocked that I was never permitted to speak or meet with his psychiatrist. Our son's therapist, a licensed clinical social worker, told us, "It is not a crime to be homeless," making us question the validity of our concerns. The hospital released him.

American laws that guarantee release are rooted in definitions of harm to self or others, and in protecting adult independence beginning at the young age of 18, regardless of a person's ability to perceive their illness and make rational decisions. People with schizophrenia have a lack of insight, a symptom called anosognosia, that impairs their ability to perceive their illness. This lack of insight is not denial. Anosognosia is a reason why people with schizophrenia or severe mental illness refuse medications and do not seek treatment.

Our son's only apparent symptoms were negative, rendering him safe to himself or others, and not warranting any commitment that would restrict his independence. Commitment criteria, which vary by state, are rather nebulous, and often fall far short of helping patients. The severely mentally ill are dying with their rights on. We had hoped and expected that our son's doctors and therapists would intervene early to prevent further psychological deterioration and relieve him of his suffering. Instead, the therapist normalized our son's negative symptoms based on a misplaced ideal of individual freedom and personal development. It may not be a crime to be homeless, but this legalistic judgement fails to acknowledge the pathological depth of this symptom. Our son took off upon his hospital discharge, and today lives homeless back east and estranged from those who will always care for and love him. He has embarked on a perilous path, finding himself on the wrong side of the law for squatting and in a jail thousands of miles away from home.

As noted by Dr. Thomas Insel, a psychiatrist and neuroscientist, many prominent social issues today—homelessness, incarceration, poverty—are due in part to our nation's failure to care for people with mental illness. A meta-analysis found that the mean prevalence of any current mental disorder among homeless individuals was estimated to be 76.2%, where alcohol use disorder, drug use disorder, and schizophrenia spectrum disorder are the top three. Further,

the prevalence of all mental health disorders is higher among incarcerated people than in the general population.

Dr. Henry Nasrallah, Professor of Psychiatry, Neurology and Neuroscience at the University of Cincinnati College of Medicine, notes that schizophrenia starts out as a neurodevelopmental disorder, and then becomes neurodegenerative after onset, with each new psychotic episode leading to further damage, leaving patients with greater disability over time. Given that schizophrenia commonly presents in adolescence around the age of 18 or in the next few years, early intervention and treatment that would target the negative symptoms of psychosis could lead to additional improvement on psychosocial functioning and allow these adolescents a chance to realize their life goals.

Awareness and treatment provide an opportunity to intervene before further deterioration of a person's mental state. Without early intervention, many patients become a statistic in the homeless or incarcerated population, or suffer even worse outcomes. Intervention helps patients realize their goals and restore psychosocial functioning, reduces social problems, and helps families.

Over the past year, my family and I desperately tried to work within the legal and mental health system to get our loved one help. Our attempts have been dashed by a system that is rooted in fail-first and the criminalization of the mentally ill. The law preserves the individual rights as an abstraction to the detriment of the real and living rights of the individual. The system prevailed over our family and my son, and today, a brilliant and kind young man is homeless and eating out of dumpsters.

Katherine Seibel

On behalf of National Council for Mental Wellbeing (National Council), thank you for the opportunity to provide comment to the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) for the October 2024 meeting as described in the meeting notice, at 89 *Federal Register* ("FR") 79938 (October 1, 2024). National Council is a membership organization that drives policy and social change on behalf of nearly 3,400 mental health and substance use treatment organizations and the more than 10 million children, adults, and families they serve. We are committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery and we advocate policies to ensure equitable access to high-quality services, build the capacity of mental health and substance use treatment organizations and promote a greater understanding of mental wellbeing as a core component of comprehensive health and health care.
National Council is grateful for the ISMICC's work to advance care for people living with serious mental illness (SMI) and serious emotional disturbances (SED), evaluate the impact of federal programs related to SMI and SED on public health, and improve coordination of services

across federal agencies. Our comment uplifts the impact of Certified Community Behavioral Health Clinics, key areas in strengthening the behavioral health workforce, and considerations in reducing administrative burden.

Impacts of Certified Community Behavioral Health Clinics

As the committee considers federal programs that have an impact on public health in our nation, National Council wishes to uplift the incredible impact that Certified Community Behavioral Health Clinics (CCBHCs) are making. CCBHCs were established by Congress in 2014 under section 223 of the Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) and launched through a demonstration program in 2017. PAMA established that CCBHCs must provide services to anyone seeking care for a mental health or substance use condition, regardless of ability to pay, place of residence, or age. PAMA also provided for program requirements and directed HHS to establish criteria for clinics to be certified as CCBHCs; SAMHSA most recently updated the CCBHC criteria in 2023.1 In 2022, section 11001 of the Bipartisan Safer Communities Act (BSCA) expanded the demonstration program to add 10 new states every two years. And most recently, the Consolidated Appropriations Act, 2024 (CAA 2024) provided a definition for CCBHCs in Medicaid statute, permanently establishing CCBHCs as an optional Medicaid benefit.2 CCBHCs can be implemented and funded through the Section 223 Medicaid Demonstration, CCBHC Expansion Grants administered by Substance Abuse and Mental Health Services Administration (SAMHSA), or through independent state programs. And it is important to note that states participating in the Demonstration select one of four Medicaid Prospective Payment System (PPS) rate methodologies to establish payment rates for CCBHCs based on the expected cost of delivering care.3 Today, there are more than 600 CCBHC programs across 46 states and territories (offering services in 40% of all U.S. counties, covering 62% of the nation's population) serving an estimated 3 million people nationwide.4

Since launching in 2017, CCBHCs have been shown to dramatically improve access to a comprehensive range of mental health and substance use services to individuals in vulnerable situations; inclusive of 24/7 crisis services as a part of the 988-crisis system, hiring hundreds of new substance use-focused clinicians, expanding access to medication for substance use care, and reducing patient wait times. Data show that CCBHCs are making a difference in communities throughout our nation. For example, CCBHCs have shown decreased emergency room visits by 55%, reduced mental health care hospitalization by 55%, and decreased homelessness measured in the past 30 days by 31%.5 In a recently published peer-reviewed article, analysis shows that CCBHCs, specifically with the Medicaid bundled payment, significantly improve crisis care with a stronger behavioral health workforce and better array of crisis services that is needed for these populations.6 And CCBHCs have shown to improve timely connection to care as CCBHC criteria require CCBHCs to see clients for routine needs within 10 days of the initial call or referral, in contrast to the national average of 48 days; in fact, 80% of CCBHCs meet or exceed these timelines.7, 8 Furthermore, earlier this year, National Council released the 2024 CCBHC Impact Report demonstrating CCBHCs' advancements to improving wellbeing for people across our country. Findings include that Medicaid CCBHCs (CCBHCs that are certified by their states and receive a Medicaid PPS) reported a 33% increase in the number of individuals served.9 Specifically pertaining to access for substance use care, 60% of CCBHCs report the number of individuals engaged in medication for opioid use disorder (MOUD) has increased since becoming a CCBHC.10 CCBHCs also reported that the model has helped them to address Social Determinants of Health (SDOHs) in their communities through a

wide array of strategies from screening for unmet social needs to proactively assisting clients with finding or maintaining stable housing, and have been able to hire community health workers.11 Additionally, CCBHCs have shown to improve health care integration by working closely with primary care providers through multiple pathways that result in increased access to primary care across individuals served.12.

In the proposed CY25 Physician Fee Schedule, National Council was grateful for the Centers for Medicare and Medicaid Services' (CMS') attention to addressing CCBHCs' ability to bill Medicare under the proposed Calendar Year 2025 Physician Fee Schedule and we strongly affirm that the ability for Medicare to cover and pay for the full range of services under CCBHCs would have a significant and meaningful impact in strengthening access to care. Already, we understand that CCBHCs can bill Medicare if they are registered as a different provider type such as an Office or Community Mental Health Center (CMHC). However, we find that Medicare does not cover all required CCBHC services. It is also important to note that CCBHCs are already certified per federal and state Medicaid criteria and to the extent Medicare were to allow CCBHCs as a Medicare provider, we would strongly encourage alignment of any potential future Medicare CCBHC Conditions of Participation (CoPs) with existing Medicaid and state certification requirements. In a similar vein, National Council for Mental Wellbeing's Medical Director Institute issued a brief earlier this year highlighting issues regarding parity and evidence-based practices in the current CoPs for psychiatric hospitals and community mental health centers and it suggests updates to improve beneficiary access to services.13 Any CoPs that would be established for CCBHCs to furnish such services under Medicare should be aligned to Medicaid criteria with careful consideration of any additional administrative burden placed on organizations that could impede access to care. Additionally, there is also great opportunity to expand CCBHC service reach for Medicare and dual-eligible beneficiaries. ASPE's most recent annual report to Congress notes that aggregate findings showed 5% of clients served had Medicare and 62% had Medicaid, CHIP, or were dual enrolled in Demonstration Year 4 (Exhibit B.5.).14 National Council's 2024 Impact Report found that Medicare and dual-eligible beneficiaries are among the two least commonly reported groups to have expanded access to CCBHC services.15. These findings suggest that establishing CCBHCs as a Medicare provider type with access to a Medicare PPS for the full CCBHC scope of services could greatly improve access to care for Medicare beneficiaries.

CCBHCs also play an important role in strengthening the workforce. Medicaid CCBHCs have reported increased hiring, adding a median of 22 new positions per clinic.16 In the Impact Report, many CCBHCs reported that the model has allowed for improved staffing to serve more people, as well as support integrated care delivery with primary care from primary care physicians and physician assistants.17

Strengthening the Workforce

Key to improving access to quality care is ensuring a strong workforce as our nation continues to grapple with a significant mental health and substance use care workforce shortage. Roughly 122 million people across our country live in mental health professional shortage areas.18
In 2023, National Council launched the Center for Workforce Solutions in partnership with The College for Behavioral Health Leadership (CBHL) and Health Management Associates (HMA) to work towards building an equitable and sustainable workforce through a collective impact

approach. In May 2024, the Center for Workforce Solutions created a framework for multi-systemic levers of change required to drive action and cross-walked more than 400 recommendations from published reports by federal and state policymakers, national associations, foundations and many other partners. Under regulatory levers for change, key recommendations included: reducing restrictions on providers and promoting telehealth flexibilities, covering a continuum of behavioral health services under Medicare with increased rates for peers and licensed behavioral health provider types, expanding federal match and other funding mechanisms such as allowing states to use general match for workforce programs, innovating around workforce recruitment, retention, and reimbursement strategies, and enhancing quality of clinical data
to be more focused on meaningful accountability while reducing administrative processes and paperwork burden.19

Reducing Administrative Burden

Community mental health provider organizations face a vast and complicated set of paperwork requirements related to a wide array of funding sources. According to the National Association of State Mental Health Program Directors Research Institute (NRI), states used 23 separate sources to finance their CMHCs and CBHOs in 2020/2021.20 These sources encompassed three types of state general revenues, three different Medicaid options, four different Medicaid waivers, state veterans affairs funding, and four different federal block grant programs. Moreover, in many jurisdictions, local school systems, departments of juvenile justice, corrections and parole systems, and foster care can play a role in community mental health organization financing and service delivery. Many community mental health organizations also operate supported housing and vocational rehabilitation programs. The variation in licensing and certification standards, service definitions, target patient populations, programmatic requirements, and paperwork mandates across all financing streams contributes to creating a heavy administrative burden for providers.

Reducing administrative burden plays an important role in strengthening the workforce and ultimately improving access to care for individuals and families. Where it is possible, streamlining, aligning, and consolidating data reporting requirements for programs across federal agencies can help providers in alleviating administrative burden. A significant challenge that National Council members have shared is that some of the information being collected also gets collected across multiple systems which can further create administrative burden through needing to input and update information through multiple processes to meet various reporting requirements. In this vein, National Council appreciates SAMHSA's efforts in the recent notice of the proposed Unified Client-Level Performance Reporting Tool (89 FR 66429) to help streamline requirements across federal agencies and provide guidance on utilizing alternative data sources for gathering and reporting required data in a way that can help to alleviate administrative burden.

Access to additional resources also plays a vital role in ameliorating considerations of administrative burden. Where it would be statutorily permitted and subject to appropriations, National Council providers have noted that payment for grant data reporting based on the burden estimate would be helpful in ensuring that resources intended for client services are not reduced

due to capacity required for mandatory data reporting. It was noted that often mental health and substance use service reporting requirements require organizations to hire more administrative staff and increase data/IT resources; this can create disparities in operating capabilities between small and large sized organizations based on resources available to offset these needs. National Council members have noted that Electronic Health Record (EHR) systems are currently structured differently between primary care and behavioral health care settings, and it is difficult for provider organizations to have changes made to their EHRs as they are unable to do it themselves and it often costs additional time and resources for the EHR vendor to make the change. Consideration and potential cross walk of how data is currently documented across EHRs could be helpful to reducing burden. Moreover, one provider shared that due to capacity at times they are unable to pursue grant opportunities to increase access to direct client care because they do not have the capacity to also meet all related reporting requirements.
National Council appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact Reyna Taylor at ReynaT@thenationalcouncil.org. Thank you for your time and consideration.
Sincerely,

Reyna Taylor
Senior Vice President, Public Policy & Advocacy
National Council for Mental Wellbeing

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

Dr. Delphin-Rittmon thanked Pam Foote and the CMHS team for their work in putting the meeting together. She thanked the ISMICC members and those present for the robust discussions, comments, and feedback, and recognized the progress that each of the working groups has made. She expressed her gratitude for the committee's work and commented that one of the key themes heard today was collaboration, which was evident in the work and comments. She thanked everyone again and adjourned the meeting.

Certification

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

_____01.03.2025_____
Date

_____/Miriam Delphin-Rittmon, Ph.D./_____
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.