Public Comments - December 16, 2021 ISMICC Meeting

1. Sonja Burns

I would like to speak to parity issues re: the 190 day lifetime limit for inpatient psychiatric treatment under Medicare. We need to be collecting data on this group of people who have exhausted their allotted 190 days of inpatient psychiatric treatment to better understand the correlation of those cycling through the revolving door of trauma (incarceration, hospitalization, and homelessness/inappropriate settings) and one's ability (inability) to access the healthcare they need because there is no funding source for them. The collection of this data will drive better decision making at the local, state, and federal levels in how we fund mental health care and housing for our community members with the most complex mental and behavioral health needs.

I am also pushing for long-term care options for people living with the most complex mental and behavioral health needs - not a nursing home, not a jail cell, not the streets. We need residential treatment facilities with no time limits and a full range of housing options. In my opinion, these housing options should include intentional communities that are within and part of the greater community and have the structure and supports that some of our community members need in order to live with dignity and purpose - as a valued member of a community. CMS has a settings rule within Home And Community Based Services that does have the "heightened scrutiny" clause for more intentional settings - farmsteads, campus settings, intentional communities. The Federal Government needs to better identify and fund models of housing that promote a person's recovery and ability to live with dignity and purpose. We need a true range of options so that we are truly person centered AND fiscally responsible. There is not only greater opportunity for some of our higher needs individuals in having shared resources, there is also cost savings.

Lastly, I do think it is imperative that there be attention paid to the comorbidity of Traumatic Brain Injury (TBI) within the SMI population. There is growing evidence that people experiencing homelessness and/ or incarceration have a higher incidence of TBI. We cannot ignore this as we seek to improve systems of mental and behavioral healthcare.

Thank you ALL for ALL you do! It takes a village! -sonja

2. Jeanne Gore

To All Members of ISMICC:

We recognize the enormous scope of the task charged to your committee; and appreciate your vision statement. Your 2021 report demonstrates that collaborations between agencies, etc..are beginning to be functional and have made some progress. While all of this is great, more significant progress can only be made with acts of Congress. It’s not clear to us at the National Shattering Silence Coalition (NSSC) whether or not ISMICC is able to encourage Congress to act or not. If it is, encouraging them to repeal the IMD Exclusion would be a fabulous step forward towards ending the suffering.
It’s difficult for us to comment intelligently on your 2021 report to Congress because much data and the proposed action steps from your Committee were not available for us to review.

That being said, the questions we had at the inception of the ISMICC are still sadly the same:

- HIPAA reforms have been proposed, but when will they be enacted?
- Where are the incentives to grow the professional workforce?
- When will the IMD exclusion be fully repealed?
- Where is #HousingThatHeals? Just drive through any city or town in America and you will see record numbers of homeless, brain-ill individuals.
- When will full parity in medical insurance coverage be fully enforced? Including for the currently exempted state and local government employee plans?
- Why is proven, evidenced based, AOT not fully embraced and federally mandated? Anosognosia is the #1 reason people refuse treatment. Up to half of those with SMI suffer from anosognosia. To ignore this fact and not allow for treatment is cruel and barbaric.
- Why do families whose loved ones are suffering and in crisis still have to wait for them to become a danger to themselves or others before they can even hope to obtain treatment? Commitment standards must be reformed to allow for those who are obviously very ill to receive treatment.
- When will funding be adequate to implement MH courts everywhere?
- Why does one's access to evidenced based treatments depend on their zip code? We are not doing enough to see that everyone has access to treatment.
- Why is PAIMI still allowed to violate congressional mandates against lobbying, even lobbying against laws that would benefit our loved ones with SMI. (See Amanda Peter’s paper on this issue for what Congress can do to prevent this)

While you have made some progress, and we are grateful for that, the fact is, for the most seriously ill - the population which is your focus and ours - this humanitarian crisis decades long has only grown more desperate than it already was pre-COVID. Please do all you can to end the suffering and bring hope for recovery.

3. Diane Rabinowitz

Dear Ms. Foote,

I understand the Interdepartmental Serious Mental Illness Coordinating Committee's (ISMICC) is meeting on December 16th and I would like to submit my comments about unmet and met needs of people with serious mental illness.

First I would like to say that I am grateful that my son's needs are currently being met in a locked facility in California; an MHRC (Mental Health Rehabilitation Center) that is a locked facility with staffing, programming and psychiatric care that has made a huge difference in his life. After 13 years of being ill, drug addicted, homeless, and in jail, this is the first time he has been housed, communicative, and has his hygiene intact. He is safe and becoming stable. His symptoms are well-managed.
The gaps in care for most people with serious mental illness like his are so enormous. I don't even want to talk about what is wrong. I want to advocate for what is needed, which is more places like the place he's at. And once he's achieved a level of stability there that prepares him for discharge, it is critical that we have supportive housing in place that meets his needs to progress even further. My son is not alone. There are hundreds, maybe thousands like him throughout our state and country.

It is time that we develop systems of care that meet the needs of these folks who are living homeless on the streets. They may not be Einsteins, but they deserve being treated with the dignity of being human. They might not accept being locked up, but if the facilities meet their needs, they will respond. And eventually they will earn their way out of lockup and be able to live in a lower level of structure, providing there are still guidelines for positive behavior that are reinforced.

I hope I have provided at least a reason to act and a pathway to effective action.

Best regards,

Diane Rabinowitz

4. Doug Dunbar

During a career of nearly 30 years, I had the good fortune to work in the Maine Legislature, the Governor's office, the U.S. House and Senate, as Maine's Chief Deputy Secretary of State and in other capacities.

It came to an end in 2017 when I was jailed for several months. In a sense, my journey to incarceration began as a child. From my earliest recollections, I suffered from two brain illnesses: obsessive compulsive disorder (OCD) and anxiety.

Unable to tell anyone about these tormenting conditions due to stigma, I somehow managed my way through life utilizing routines, rituals and prayers. This changed September 11, 2001.

When the terrorist attacks occurred, I was Congressman John Baldacci's press secretary in Washington. From my apartment window, I could see smoke rise from the Pentagon for three days. My mental illnesses spiraled out of control.

On September 12th, I had dinner with a coworker. We drank a lot of wine. While never liking the taste of alcohol, I quickly concluded I couldn't function without it. As time marched on, the brain illnesses continued to be a secret, as did my self-medicating and the fact I became an alcoholic.

My first five arrests for OUI or related issues were also kept hidden from everyone in my life. But on my sixth arrest in October of 2017, I went to jail for 136 days followed by 15 months in the Penobscot County Adult Drug Treatment Court.
While incarcerated, my eyes were opened to the crisis of jailing people who suffer from brain disorders. Although the facility in which I spent a good deal of my time (Penobscot County Jail) is one of the most troubled in Maine, individuals with brain illnesses experience unspeakable harms every day in jails across the country.

As you likely know, when those suffering from these illnesses end up in our jails three harms are common. They remain incarcerated longer than others, their conditions worsen, and they're more likely to be the victim of abuse. It's reprehensible, but we can do something about it.

If the IMD exclusion is repealed, more options for safe, appropriate treatment will be available. States shouldn't be required to apply for a waiver to make sure their residents have a full range of therapeutic opportunities.

If we could finally arrive at true mental health parity in our health insurance marketplace, those sick with brain disorders will no longer be discriminated against. Their chances of receiving high-quality care will increase.

If mental health treatment courts are encouraged and financing is made available, many individuals caught in the revolving doors of our badly flawed criminal legal system will have a chance to heal and move forward in life.

Many other changes are needed and long overdue. We must do better. We need a greater sense of urgency. These problems are crushing for individuals, families and communities. The solutions aren't new. When will greater progress be made?

5. Ann Corcoran

Importance of Assistant Outpatient Treatment & Mental Health Courts

I am following up after having had the opportunity to tell my story during the last meeting which was open to the public. As a master’s prepared nurse and the mother of a wonderful adult son who lives with bipolar disorder, I made the hard decision to get my son arrested during a manic episode before letting his condition escalate to the point that he became psychotic and delusional becoming a danger to himself and others as had happened 7 times previously. I felt a sense of duty to protect him, my family and the public; a sense of duty to prevent a tragedy. Though the court ordered hospitalization proved to be quite beneficial, the aftermath of involving the criminal court system has caused a great deal of undue stress to both my son who lives with a serious mental illness and our family. Most criminal courts do not have a true understanding of what it means to have a serious mental illness, criminalizing it only further deteriorates one’s stability. The days prior to appearing in a criminal court setting, my son was stable and doing well. The stress of entering the courtroom quickly had a negative impact on his stability and his behavior became quite irrational. Fortunately the judge presiding over his case understood the needs of someone living with serious mental illness and in fact is trying to establish a mental health court. Allowing him to sit at a table with his lawyer, speaking to him in a calm manner
and being able to recognize that his arrest was the result of a mental health issue and not a criminal matter made all of the difference in the world. We need to end the criminalization of mental illness and in having mental health courts there is a degree of understanding and empathy that is greatly needed. Those with serious mental illness need comprehensive treatment not punishment for an illness that is no fault of their own. Mental health courts are a necessity for every courthouse, without them we will continue to see our jails replace our psychiatric hospitals.

Massachusetts does not have an AOT law, the unfortunate reality is that this same cycle will be repeated in the very near future. The Boston Courts have recognized the need to decriminalize mental illness and with a grant from SAMHSA, was able to develop an AOT program which has been extremely successful. Massachusetts needs true AOT laws in our state so that these services are available to everyone who lives with serious mental illness, far before an arrest, arraignment, criminal record, and in many cases, incarceration. AOT programs are vital for those living with serious mental illness as they reduce incarceration, homelessness, involuntary inpatient hospitalizations and death in many cases. With the success of many AOT programs throughout the country, I would strongly urge that AOT be fully embraced and federally mandated. To deny someone like my son treatment simply because he is too sick to recognize the need for treatment is inhumane, it’s inhumane to leave families having no option but to watch their child progress further into a psychotic and delusional state fearing for everyone’s safety. It’s inhumane to allow brain illnesses to go untreated - to grow progressively worse - causing irreparable damage to the brain and reducing the likelihood of recovery. We have proven solutions to address timely treatment and to end the criminalization of serious mental illness and I hope that recommendations are made that will help end the suffering for families like mine. Thank you!

Sincerely,

Ann Corcoran RN, MSN

6. Cheri VanSant

Ms. Foote,

I am the mother of a 45 year son who suffers from a severe brain disorder known as Schizoaffective Disorder. He was diagnosed at age 21, but showed signs of disfunction as early as 12 years old. Our son has been hospitalized often over the years but we had no say in his care other than to give information each time. He would then be discharged and consequently stop his medication. This was the constant struggle of treat, street and repeat that continued for a few decades. We have watched our son deteriorate, never returning to his previous baseline over and over, feeling completely helpless. Now that he is so ill that he qualified as a person needing a guardian as well as court ordered treatment he stays on his medication and is able to live a fairly good life with a lot of outside support. We pay for someone to clean and he has an ACT team with a good psychiatrist who has told us this may be as good as it gets for him. It is
known that if a person is surrounded with wrap around services and a good faith effort is made to find the right combo of meds at the first psychotic break a person has a much better chance of leading a productive life. Our son had none of that until it was too late. He sits in an apartment all day smoking and never bathing or brushing his teeth, and morbidly obese. His negative symptoms have never disappeared because his brain has been assaulted too many times by going on and off medication and drug abuse. Please do something to help change these horrific outcomes for those suffering from the most severe illness often accompanied by a complete lack of awareness of their illnesses, just like my precious son.

I am a retired RN and taught family to family classes for NAMI so was knowledgeable about SMI and still could not navigate the horror of our mental health system to help our son. Please listen to the cries of families across the USA that are struggling to help our beloved family members.

Thank you for hopefully caring,

Cheri VanSant, Scottsdale AZ
480-495-3310

7. Leslie Carpenter

Dear Committee Members,

I am writing today to thank each and every one of you for the work you have been doing on behalf of people living with serious brain illnesses and their families. As the mother of a 30 year old son living with a very severe and treatment recalcitrant schizoaffective disorder, I am imploring you to please raise the level of urgency with which we all work to improve the very broken mental “healthcare” system. The situation for millions of people living with the most serious illnesses is the most under-recognized social injustice and humanitarian crisis in our country. The time has come to demand actual changes that could solve this crisis and save lives.

I urge you all to advocate for the following solutions with every federal legislator, policy staffer, leader and lobbyist that you can:

1) Codify doctors decide how long a patient needs to be in both acute care hospitals and other step-down levels of care, NOT the insurance companies. Patients not being able to stay long enough for the meds to come to therapeutic blood serum levels to allow their brains to heal causes them to not be aware of their own illnesses and to stop their meds once released. This perpetuates the cycle of repeated hospitalizations, homelessness, incarceration, victimization and often, death. It does not save money, and results in terrible outcomes.

2) End the policy of stopping SSI/SSDI benefits if someone is hospitalized beyond 30 days. They still have rent or a mortgage to pay if they are sick and in the hospital. Stopping their income is one way we actually facilitate homelessness rather than prevent it.
3) Allow HUD to subsidize housing all along the continuum of care: residential treatment facilities, group homes, stabilization beds could all be more affordable and available with subsidizing. Housing alone, without treatment, does not help people living with mental illnesses (and/or substance use disorders). We need housing paired with treatment, and this action would help provide this.

4) Fund provider education about HIPAA regulations. Most providers are so afraid of revealing PHI, they do not realize they are obligated to communicate with families of people living with serious brain illnesses in the same way they already do for other patients with brain illnesses like our elderly living with Alzheimer’s Disease and Dementia. We recognize families are right to be concerned about their parents becoming unsafe an unable to care for themselves, and this same recognition needs to happen for families with adult loved ones living with these different brain illnesses that can also make them unsafe and unable to care for themselves.

5) Fund AOT (Assisted Outpatient Treatment) Programs and both Civil and Criminal Mental Health Courts to divert people to treatment, not jail. Fund jail diversion programs.

6) End the IMD Exclusion. The cost of NOT treating Schizophrenia is much higher than the cost of ending this nearly 6-decade policy that is a legal form of discrimination against people who happened to become sick with a brain illness, rather than cancer. See this study from 2020 for the costs of not treating Schizophrenia:

7) End the Medicare and Medicaid Lifetime Caps for inpatient treatment. Again, this is a form of discrimination exclusive to people living with brain illnesses which are not their fault. It is morally reprehensible and has caused too many people to suffer more than they have to, and to cost our country more than if we treated them in the first place. These illnesses are chronic and episodic, but with treatment, can be managed much more cost-effectively than if we do not treat them.

8) Raise reimbursement rates for Mental Health Professionals AND Direct Care Staff. This is difficult work, and we have too little workforce. Improving the reimbursement and wages for these providers, as well as making the agencies providing the services more financially viable is one of the ways to grow those serving the people who need treatment.

9) Fund Psychiatric Assisted Living Campuses that have multiple levels of care: acute care beds with First Episode Psychosis Programs, sub-acute care units, independent living units, group homes. We could have these on the existing State Hospital grounds. These are possible, we have created these for people living with Alzheimer’s, Dementia and Parkinson’s Disease. Certainly, we could create and fund these for people living with a different type of brain illness.

10) Fund Loan Forgiveness for MH Professionals of all sorts, including PA’s and NP’s who chose to specialize in caring for Psychiatric patients as part or all of their practices. Tie loan forgiveness to a requirement that these professionals accept patients who have Medicaid for insurance.

11) Fund expansion of Medical & MH Professional Programs of Multiple Disciplines
12) Fund more CCBHC’s (Certified Community Behavioral Health Centers). Some are getting grants, but more could use them to close treatment gaps and grow their workforce and services.

13) Allow Medicaid for people in the criminal justice system, so that people with brain illnesses can have the medications that treat their illnesses in all stages from incarceration to probation to parole to release.

14) End solitary confinement.

Thanks for considering my input. I am happy to be reached for any further questions you may have at 319-331-3949 or lcarpenter@iamentalhealth.com

Sincerely submitted,

Leslie Carpenter, Mom and Serious Brain Illness Advocate

8. Helen Anzelmo

My name is Helen Anzelmo,

About three years ago my son started to show signs of serious mental illness. He was found on the rooftop at a library in San Diego running back and forth screaming you'll never take me alive. The courts found the incident more mental than criminal yet no referral to mental health had been made and my son was instead placed on juvenile probation That being said we decided to move to Hemet in riverside and his probation was transferred. The attorney from San Diego called the judge of Hemet and explained Josephs' situation. At that time Joe stopped speaking he wouldn't respond wouldn't eat he just layed in his bed and stared at the ceiling and screamed in terror at night. I asked his probation officer please refer him to mental health court. She saw that he was catatonic still no help no referal.

I called mental health, police, hospitals I kept being told he is 18 he has to voluntarily go get help or be a danger to himself or someone else. As a parent having to watch your child suffer like that is like being forced to watch your child drown screaming your name and being unable to reach him. As others just stood there and watched.

Finally, I did the unthinkable I said he was a danger. The crisis unit picked him up it was heartbreaking to see your only child get tackled to the floor and taken away in handcuffs kicking and screaming.

This happened about 4 or 5 times, they would pick him up still unbalanced release him. He didn't think he was sick he would refuse meds 50 percent of the population that suffer from serious mental illness also suffer from anosognosia which affects the part of the brain that allows you to self-reflect. Delusional thinking is their reality.

To sick to know they need help. One day joe slit his throat right in front of me, he was taken to ER transferred to corona mental health, and 3 days later released.against my wishes. He was talking not making since and wanted to go outside that day, I remember thinking dont let him go
you may never see him again. I gave him a big hug told him I loved him. At 300 am the knock that no parent is ever prepared for came. The police notified me that my son was arrested for attempted murder the floor was pulled out from me and I fell to the ground unable to breathe. It's been 3 years since I held my son and 3 years to find him incompetent. He bangs his head on the cement walls of a jail cell screaming I just need help.

He is now at Attakadero state hospital not for help its to get him well enough to charge him and give him a life sentence. My son was a good kid who needed help because he was sick. The broken mental health system protecting the rights to be crazy enough to get a prison sentence.

Linda Mimms

To All Members of ISMICC:

Thank you all for your dedication to recommending and implementing policy changes to eliminate current barriers to medical treatment for people living with neurodevelopmental brain disorders/diseases.

Every person deserves to live their best possible life. If they are denied the medical care they need when they need it, terrible outcomes ensue. This is especially true for those living with no-fault serious brain diseases, who become homeless, incarcerated or worse, due to barriers to healthcare that our country installed decades ago based on antiquated notions of what these illnesses are. We now know through science that what we have been calling behavioral conditions, or mental illnesses, are organ-based diseases of the brain that need immediate medical attention, like strokes or heart attacks. Our laws governing the treatment of these brain diseases do not reflect today’s cutting-edge science and new medical protocols.

In August, I shared our family’s story of how our loved one ended up homeless, in psychosis in jail for a year with no medication, allowed to defend himself in psychosis because a judge deemed him competent to stand trial, how he disintegrated during the trial and, after the verdict of guilty, was then declared incompetent and sent for mediocre treatment in a state hospital. I cannot describe the utter feeling of helplessness that we could not get him the medical attention he needed before and during the events that took place.

I ask that you demand under the parity laws that schizophrenia be treated as a neurodevelopmental disorder and be treated with the same medical standards as other neurological disorders under the medical system of care, not the woefully inadequate behavioral healthcare system, which is still treating this disease with attorneys overseeing and overruling medical doctors’ recommendations. Classifying these brain diseases as the neurological conditions they are will hopefully have a cascading effect throughout the inadequate “system of care” that is actively denying sick people the prompt medical treatment they need.
I could point out the myriad policies we need to change in this country to knock down barriers to care, but I will leave that to the advocacy organizations I work with. As a trained policy analyst, I am choosing the single most important action that I think will provide the sea change we need now.

Thank you for your good works and attention. Thank you for lifting up this social injustice and trying to help our most vulnerable get the help they need to alleviate unnecessary suffering.

10. Mary Ellen Stuart

Dear Ms. Foote,

The National Shattering the Silence Coalition (NSSC) is encouraging its members to submit comments to your office regarding our experiences in the current system of health care for people with serious mental illness (SMI.) Our family’s frustrating journey through the mental health system is indicative of all others. However our story has two significant differences, which can be helpful in addressing this huge need to care for our mentally ill citizens in this country.

First, our family member who suffered from schizophrenia from the age of 23, did achieve a relatively stable and enjoyable life beginning in about 2003 until his death in 2017. There is a path to truly help those effected by mental illness, and alleviate the pressure the that untreated/undertreated put on our society. There are some avoidable human costs like death, homelessness, self-medication using illegal drugs, petty crime, etc. There are also ways to reduce monetary costs like police responses, incarceration, court time, unreimbursed emergency room visits, long term hospital stays by uninsured patients, county case workers and out-patient free clinics, to name a few. The way we found was through proven, successful residential treatment programs.

Second, we had an opportunity to experience the amazing physical Health Care system we all are so lucky to have in the USA, versus the completely broken Mental Healthcare system that is an embarrassment to the USA. Our family member, my brother Jim, got an aggressive cancer at the age of 51 and received the best treatment imaginable. This is our short story:

This week marks the 4th anniversary of my brother’s funeral. He had schizophrenia and managed to achieve stability with support from residential treatment provided by Rose Hill in Michigan, The Farm House in Davis, CA and finally the John Henry Foundation is Santa Ana, CA. He died at the age of 51 after battling an aggressive cancer. It was discovered at Stage 4, and it’s likely that he didn’t recognize many of the symptoms earlier due to his mental illness. He was so used to doubting his thoughts, and new information didn’t register with him the way it likely would with a mentally well person.

Reflecting on his 6-month journey through cancer treatment, it was amazing how much care and concern was given to him and our family by the medical world. His doctors, nurses, hospital
staff, treatment centers, American Cancer Society, and hospice care were outstanding. We felt as if they all united to wrap us in a support blanket.

It was such a stark contrast to the medical treatment we received in his 26-year journey with schizophrenia. In that medical world, there was, and still is, no support blanket. Families are left to find their own solutions. If you can find a successful residential treatment program, and are fortunate enough to be able to afford it, there is hope. City, County, State and National resources should go into funding these proven programs so that they can be available to everyone with mental illness, not only the ones with substantial wealth. Ultimately, the monetary and human costs to our communities would be far less than they are now. Money spent to successfully treat those with Serious Mental Illness (SMI) is much better than money spent on the consequences of untreated people with SMI such as hospitals, jails, law enforcement and ineffective clinics. The key is to find the programs that are really working, then expand them or replicate them throughout the country.

I am happy to share more details on the challenges our family faced, as well as the good things we discovered, while supporting my brother, Jim, in his struggles and victories with schizophrenia.

Thank you,

Mary Ellen Stuart
1440 Newporter Way
Newport Beach, CA 92660
949-375-9351

11. Marilyn Hartman
To Members of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC):

I have served and am currently serving on both Texas and Austin housing workgroups or committees, with a focus on the residential needs of our citizens with severe and persistent mental illness. Texas, and many other U.S. states, lacks a full continuum of care for this constituency, those with the most difficult cases of mental illness. Our society is not caring for them adequately, and as a result, they cycle through hospitals, emergency departments, jails, and/or homelessness, costly for taxpayers and for the ill individuals in terms of their potential recovery or stabilization. I know of people who have cost taxpayers several million dollars from as many as 70 hospitalizations and jail stays, and yet, over and over again, they are discharged or released to inappropriate placements, including back to homelessness. These situations are unacceptable from a humane perspective, and it is not a good return on investment; it’s pouring money down an endless abyss instead of investing in best-practice solutions.
We must recognize that there are individuals with such severe cases that providing SSI and SNAP benefits and expecting them to fend for themselves is folly. Even permanent supportive housing is not the correct solution because the supports are not sufficient. They need 24-hour supervision for medication management, prepared meals, activities of daily living (ADLs), such as cleaning, laundry, and self-care, and meaningful engagement, yet a nursing home is inappropriate. They need to be part of an intentional community – community is something all humans need – not stand-alone apartments where those around the ill person don’t want to engage with them.

So where are the government solutions that those with intellectual and developmental disabilities (IDD) have had for decades?

Such solutions include:

- step-down for those coming out of psychiatric hospitals who need further high-level support and are not ready or able to engage independently in the community at large. For some, particularly those with anosognosia (lack of insight in their illness), this could be long-term, so I would advise against time limits; these people need a high level of care and may need it life-long. Others may be able to progress to community-based permanent supportive housing or even independent living. Step-down would free up psychiatric beds, of which there is a great shortage, and be less costly. Step-down should be an intentional community with person-centered treatment plans and a range of activities, not an uncaring warehouse. It should resemble a residential treatment center with trained staff actively involved in helping people make progress towards becoming as independent as possible, with the possibility that they can move into a less restrictive placement.

- small-group homes with highly trained, 24/7 staff to work with individuals on their person-centered treatment plans and goals. The closest program currently in Texas is HCBS-AMH, but it is generally not robust enough for the level of care that is necessary. Again, this proposed model could free up high-cost hospital beds, needed for those truly in crisis.

Note that there are less restrictive models in the continuum that need funding as well if we are to break the backlog of people waiting too long for a hospital bed (FYI, 1900+ people are waiting in Texas, some for as many as 2 years). These include permanent supportive housing and independent housing affordable to people on SSI or other low-income sources.

On the front end, to prevent cycling and the criminalization of mental illness, diversion centers are a must; jails are not appropriate for those committing low level, non-violent crimes. Just as important is prevention through expanded First Episode Psychosis Programs (Coordinated Specialty Care). These solutions should be funded to the fullest, everywhere.

Lastly, please eliminate discrimination against those with mental illnesses: the 190-day Medicare lifetime limitation for inpatient psychiatric care and the Institutions of Mental Disease
Medicaid exclusion, causing some to be discharged before they are ready, with rehospitalizations inevitable, along, often, with jails and/or homelessness.

This country can do better for those with the most severe cases of mental illness. Often lawmakers look at the immediate costs of providing the correct solutions without considering the long-term costs when the correct solutions are NOT provided. These are our sons, daughters, siblings, wives, husbands, parents or other family members, and it’s about time we took proper care of them through methods that make their lives meaningful and worthwhile.

Thank you,
Marilyn Hartman
Member, NAMI Central Texas
Austin, Texas
512-470-7840
December 6, 2021

12. Linda Mikolajek

Dear committee members, representatives, and meeting attendees,

My name is Linda Mikolajek from Austin, TX. I am an active member of NAMI and a member of their advocacy committee and have testified before legislative sessions hoping to improve the lives of those affected by mental illness.

My 39-year-old son, Jason, has been afflicted with mental illness since the age of five. He is an intelligent, Hard-working, active churchgoing, civic minded Member of society, who also had obtained his Eagle Scout recognition.

Over the past four years he has become homeless, living out of his car, cycling through misdemeanor, nonviolent arrests and numerous hospitalizations. He is currently at Austin State Hospital for the past 20 months and suffers from schizo affective disorder and lacks insight of his mental illness and therefore he chooses not to take his medications.

I feel that there are several factors in Our treatment of people with SMI that have contributed to his and MANY others downward spiral and the mental illness crisis that our country faces. I will speak to only four of them due to time limitations.

1. There needs to be Court ordered mandatory psychiatric medications, that are actually enforced.

When a person has a serious mental illness where they cannot make proper choices for their well-being and safety and the safety of others; they need to be on medication. Part of the reason...
many people cycle thru jail, hospitals, ER’s and homelessness is because they stop their medication soon after they are released. Hundreds of thousands of dollars must have been spent on my son and quite likely without mandated med. compliance, he will stop his medication as soon as he is released. This is what he told me because he says he does not need it.

2. Assisted Outpatient Treatment

(AOT) works IF properly managed. It needs to become a standardized option in every state… modeled after the program in Miami Dade County. It saves millions of dollars, decreases recidivism, use of Police hours, ER’s and Jail’s for those with mental illness and more importantly, it saves lives!

3. Housing. A continuum of care is necessary for those with SMI. You cannot continue to release them to homelessness or to recycling through the systems. Supervised, housing is essential…. either short or long term. We need Long-term care options for people living with the most complex mental and behavioral health needs. We need residential treatment facilities with no time limits and a full range of housing options to help integrate people back into society.

4. HUD- - HUD Has a ruling that after you spend 90 days in a jail or hospital, you are no longer homeless. This is absurd and needs to change. My son, who had become homeless for 14 months before spending 20 months in the hospital, no longer qualifies for most housing help, Because he is considered to NOT be homeless.

I don’t understand how a hospital or jail can be considered Housing and disqualify you for help once released. His social worker cannot even try to get him into appropriate housing programs because he is considered to no longer be homeless!

Thank you for giving me the opportunity to speak and I would love to speak in depth with anyone who has any follow-up questions or concerns.

13. Jeff Mikolajek

Hello,

My name is Jeff Mikolajek. I am a member of NAMI Advocacy Committee residing in Austin, Texas, in Travis County. I would like to discuss five issues that affect the clients with serious mental illness (SMI).

Medicare clients only are allowed 90 days of inpatient psychiatric treatment. There is not much that can be accomplished successfully in 90 days of psychiatric treatment. This needs to be changed at least to six months or preferably a year of treatment maximum so that SMI patient can be successfully treated in our psychiatric hospitals.

Secondly, H. U. D. Has a law that when you are in a hospital or jail for 90 days, they no longer count you as homeless. My son has been treated twice for greater than 90 days in a psychiatric hospital and was released to the streets after his care. No one can maintain sanity living on the
street in our cities of United States today.. their apartments that they were in prior to being arrested or hospitalized will be released and they will have no place to stay. Clients in jails or treatments centers need to be considered HOMELESS when in a center for more than 30 days.

Three, medication compliance for documented psychiatric diagnosed SMI. The occurrence of clients refusing to take their medication’s after they leave the hospital may be as high as 65%. By mandating medication compliance throughout this country, we will reduce the incidence of people going back for psychiatric treatment and or being put in jails for their failure to to take their medicine. Medication compliance will keep our treated psychiatric patients doing so much better in our society.

Fourthly, national Assisted Out patient Treatment programs for SMI clients released from centers. Under this program, released SMI clients would be followed by judges to enforce medication compliance and supervised that they would follow treatment plans established by their releasing physicians. AOT was well established by Dane county judge in the Miami area. It is the established program that has seen the best results in our country.

Fifthly, we need residential treatment facilities with no time limits. Patient should be only released when they are able to function as safe citizens in our communities. A time limit on psychiatric care, varies way too much from patient to patient to be in effective means of regulating psychiatric care.

Thank you very much for your time and I hope you will greatly consider the points I have brought up!

Jeff Mikolajek

14. Janet Hays

Dear Members and Non-Federal Members of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), and participants,

I am board director and founder of Healing Minds NOLA, acting chair of Mental Illness Policy Org., board treasurer of Hope Street Coalition, and consultant for Assisted Outpatient Treatment Court of New Orleans.

I advocate for alternatives to death, incarceration, homelessness, jail and hospital revolving doors for people suffering with untreated and under-treated serious mental illnesses.

2021 marks the 5th anniversary of passage of provisions in the Helping Families in Mental Health Crisis Act, where the concept for the ISMICC was born. For the benefit of new members, I have attached a handout containing some of the original provisions that families in mental health crises strongly supported to address the need for a full continuum of coordinated
psychiatric treatment and care, INCLUDING those too sick to voluntarily seek and adhere to outpatient programs and services.

5 years later, it is disturbing that legal barriers still exist along with funding discrimination for people needing 24/7 sub-acute and long-term secured and unsecured care. We need to codify that doctors determine length of stay and medical necessity, not insurance companies.

Louisiana is a Medicaid Expansion State and, as such, is automatically eligible for the 15 day “in lieu of” IMD waiver. Louisiana also has “CEA beds”, meaning the state will reimburse hospitals for stays beyond 15 days if ordered by a judge. In our region, we're over-bedded with acute psychiatric beds. Yet still, we see people cycling in and out of AHCs at alarming rates which is traumatizing for both families and patients. Family members find it extremely distressing to force a loved-one into treatment only to see them released unstabilized. If a patient is unable to get a good diagnosis and treatment plan on the first commitment, families are less likely to want to repeat the experience. Consequently, the patient's health continues to deteriorate, and family relationships worsen. Repeated commitments exacerbate feelings of systems distrust for both individuals living with serious mental illnesses, as well as family members and friends.

Metrics by which we measure the effectiveness of federal mental health policies should be reductions in incarceration, homelessness, hospital and jail revolving doors and death. For this we need to fund an independent research organization to conduct a full study on the societal costs of untreated serious mental illness.

Earlier this year, the Schizophrenia & Psychosis Action Alliance (S&PAA) released a preliminary report on the societal costs of untreated schizophrenia. The numbers are staggering. The research revealed that schizophrenia cost the U.S. an estimated $281.6 billion in 2020, “with a significant amount of direct costs due to health care, incarceration, supportive housing and homelessness”. Such a cost benefit analysis is long overdue and would provide the economic insights needed for more humane decision making.

Thank you for the opportunity to speak.

15. Gordon Lavigne

Dear Members and Non-Federal Members of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), and participants:

On behalf of our organization, Schizophrenia & Psychosis Action Alliance <https://sczaction.org/> we respectfully submit the following as part of your December 16th meeting. We are proud to use our collective voice and stand with the millions of marginalized
and dehumanized people living with schizophrenia and psychosis spectrum disorders. We recognize the enormous scope of the task charged to your committee and appreciates your vision statement for mental health reform.

Your recent 2021 report to Congress demonstrates that collaborative work between agencies and other parties is advancing opportunities to improve the lives of people with serious mental illnesses. While we are grateful for the progress that has been made, we are specifically calling on ISMICC to encourage congressional action on repealing the IMD exclusion.

Given the enormity of the challenge, will would like to discuss with ISMICC a short to medium strategy to address the following topics:

Improving Access To Mental Health Care

* IMD: Conduct discussions with CMS about increasing Medicaid financing for IMD by expanding or moving beyond the existing Medicaid managed care guidance, while curtailing application of the IMD where plainly irrational or well beyond congressional intent as expressed in 1965. One example of the latter is enforcing IMD prohibitions against acute care crisis receiving and crisis stabilizations beds given the pending nationwide implementation of the 988 Suicide Prevention Lifeline.
* AOT: In a similar vein, interact with CMS about clarifying Medicaid financing of AOT. The larger behavioral health public policy question is: Why do families whose loved ones are suffering and in crisis still have to wait for them to become a danger to themselves or others before they can even hope to obtain treatment? Commitment standards must be reformed to allow for those who are obviously very ill to receive treatment.
* Mental Health Parity: Schizophrenia is a neurodevelopmental disorder and must be treated with the same medical standards as other neurological disorders. We strongly recommend to CCIIO that the President’s FY 2023 budget include the elimination of the exemption for state and local government employee plans.
* General Discussion: We are not doing enough to see that everyone has access to treatment. Why does one's access to evidenced based treatments depend on their zip code?

Related Issues: Housing/The Criminal Justice System

* Housing: With the implementation of the housing provisions of the Bipartisan Infrastructure Framework (BIF), ISIMCC should recommend that HUD follow the Housing That Heals approach to the issuance of new voucher and the construction of new housing for homeless persons with serious mental illnesses.
* Courts: There is a need for substantial additional financing for the SAMHSA Mental Health Courts Program, which we hope will be reflected in the President’s FY 2023 budget submission.

Earlier this year, we released a report <https://sczaction.org/insight-initiative/societal-costs/> on the societal costs of untreated schizophrenia within the United States. The numbers are staggering. The research revealed that schizophrenia cost the U.S. an estimated $281.6 billion in 2020, “with a significant amount of direct costs due to health care, incarceration, supportive
housing and homelessness”. Such a cost benefit analysis is long overdue and would provide the economic insights needed for more humane decision making.

Thank you for the opportunity to share our recommendations.

Sincerely,
Gordon Lavigne

16. Cindy Pearce

My name is Cindy Pearce & I am the mother of a 40 year old man with Schizoaffective Disorder. We have been struggling with his illness “with him” or I guess I should more accurately say “against him“ for 22 years. The reason I say against him is because he has anosognosia & as a result he thinks there is nothing wrong with him.

My requests for improvement in the community of the mentally ill are as follows:

1. Parity when it comes to hospital days covered by Medicare. 190 days in the treatment of a mentally ill person is used in a very short span of time. There should be no difference in coverage days of a mental illness & cancer or any other illness. This is actually discrimination against someone with a mental illness!

2. Housing for those who are mentally ill. This is seriously lacking everywhere & in Burnet County where we live it is nonexistent. Someone who is seriously mentally ill & unable to work certainly can’t be expected to live independently. Affordable & well-run group housing is extremely important. The mentally ill have needs for socialization & a sense of community. Most people get those through a job or friends. For those who have limited improvement even on medication & can’t work, there is isolation & loneliness which is piling a sad situation on top of a debilitating illness.

3. Mandatory outpatient medication for some mentally ill persons. A person with a SMI & anosognosia will most likely NEVER take medication voluntarily & therefore will be perpetually homeless with untreated mental illness or in a revolving door situation in & out of a psychiatric hospital. This is very expensive for the state & it has been proven that the on again & off again medication situation can actually result in the medication no longer working as well as it would have or not working at all. It isn’t logical for a person to be in control of decisions especially about medication when there is not comprehension of an illness. When it can be proven in court that there is no understanding, I believe the rights of a mentally ill person should be superceded by the greater good of mandatory medication. To do less is actually a disservice to the mentally ill person.

Thank you for your time.

Cindy Pearce
Thank you for the opportunity to contribute to this committee’s admirable mission. I have been a community based mental health participatory action researcher for 25 years (a fair share of my work has been funded directly or indirectly from SAMHSA). I am also a long-time mental health consumer. My primary purpose has been to assist and guide disenfranchised populations to use research methods to collect and introduce “data”, while embedding their own lived experience to change policy and practice. The biggest success has with young adults over 20 years ago and seeing where it’s gone now.

My recent foci have been on vocational services and disparities, and they came together in my recent NIDILRR Switzer Distinguished Researcher grant and resultant paper in the Psychiatric Rehabilitation Journal (with my colleague Dr. Leslie Adams) - “Barriers to and Facilitators of Vocational Development for Black Young Adults with Serious Mental Illnesses”, also located at https://www.growkudos.com/publications/10.1037%252Fprj0000505/reader.

I think our paper raises a number of important questions regarding services and supports for Black people, and I encourage that you to read it. For this commentary, I’d first like to illustrate one of many ways our current policy practices do not address the needs of Black people, and even may exclude them; that is that person centered care is not culturally competent care. First interventions available to staff may on their face systemically discriminate against disenfranchised groups (e.g., eligibility criteria). In addition, providers can be good listeners, but if they do not know how to deal with issues strongly connected to disenfranchised populations (e.g., criminal justice involvement), they are limited in how they can help clients of that group. Also, research often doesn’t include Black people in a substantial and/or identifiable way. And so on…

This brings me to the main theme I’m taking from the paper to discuss here. That is Critical Race Theory (CRT), with a definition that seems to depend on who is discussing it, and even from what social perspective. We did discuss CRT and its definition in the article, so I here just want to highlight a few insights in support of CRT’s use in conceptualizing health care research and services.

First, CRT starts with the recognition, and concern, that Black people face systemic discrimination TODAY regarding their own health status and in seeking care, and that this is a very heavy burden on them which is not being addressed. If you agree with this and want to make a difference, I highly recommend using CRT to develop both research, policies, and practices.

Second, my research partner on this is African American, and we worked effectively together because of a shared conception of CRT principles. We used CRT as a conceptual framework to conduct the study and interpret data, including the recognition that White people have inherent privileges that Black people do not have and the responsibility of White people to develop meaningful opportunities for Black people in these arenas.
Third, this study focused on Black people alone, centering them in the margins, to make sure that their experiences, stories and ideas are heard directly. This is very difficult to do in a general population study that Black people are included in, particularly when we know little about what these populations generally need and want.

Next steps for SAMHSA: In general, it makes sense to put money and control in the hands of developing minority run institutions/universities or other groups of BIPOC researchers and policy makers. Given that “treatment” is only one factor in a person’s health, and for research to make a real difference in Black people’s lives, these three theoretical lenses should be considered collectively: 1) Critical Race Theory, 2) Socio ecological Theory and 3) Community based participatory action research. And I have Black colleagues who can provide clear and meaningful evidence of the complacency of our health service system in its current state of inequity.

Barriers and Facilitators for Black y

Jonathan Delman

18. Julia Ehret

To All Members of ISMICC:

I have read and I fully support the written comments submitted to you on December 4th by the National Shattering Silence Coalition "NSSC". Below are my recent and personal observations as a mother of a seriously mentally ill and homeless adult daughter.

April 2021: Last April, my 32 year old daughter Stephanie, who is homeless with undiagnosed and apparent dual diagnosis symptoms, wound up at San Francisco General Hospital with heart attack and stroke symptoms. I received word from a family friend. At once I phoned the hospital and spoke with nurses, doctors, and social workers. I was not given any pertinent information because of the HIPAA law. I urged the social worker to evaluate Stephanie for mental illness while she was there for treatment. Because Stephanie refused they were unable to do so. Stephanie walked out of the facility 3 days later.

My willingness to be a part of Stephanie's rehabilitation has been constant her entire life. She refuses diagnosis and treatment. Every psychotic episode she suffers more irreversible brain damage.

October 13-16: After reading a blog from a person who calls herself a "Curbside Caregiver" to her SMI brother, I decided that is something I can do. So in October, I flew from Palm Springs to San Francisco and found Stephanie thanks to the help of a family friend who knows her stomping grounds. Stephanie stayed with me at my Ocean Beach Rodeway Inn hotel room Wednesday night and Thursday night. On Friday night, at 11:30pm, she began shouting
profanities and breaking her own things. She slammed the door repeatedly, walked in and out wearing only a sheet, pounded on the walls and ceilings, and would not stop. I was powerless to effect her behavior in any way whatsoever. It seemed to be a seizure that could not be interrupted. The police showed up, deemed her a non-threat, and left. Before they left, I asked if there is a crisis team who instead I could call to get "real help" and the police wrote me the telephone number for the crisis team who I could call in the morning because they don't work at night. Stephanie started up again 30 minutes later and so we evicted the hotel room in order to spare the other guests having to endure another round of the violent noise. The family friend came by and picked Stephanie up and returned her to her usual Golden Gate Park area stomping grounds and I flew home to Palm Springs the next morning.

October 26 - November 15: Stephanie was a "Missing Person". See attached flyer. The back story that she gave me was that it took her 3 weeks to hitchhike from Oakland to San Francisco because she was stuck on Treasure Island. She was hungry and thirsty the entire time she said.

November 23-27: Keeping with my "curbside caregiver" intention, I visited Stephanie again. She was unable to keep the Covid vaccine appointment that I made for her. She thinks she may have received the vaccine in April when she was hospitalized but she isn't cognizant enough to call and verify it even with my offer to help her do so. She was unable to attend the Thanksgiving dinner we were invited to at the family friend's home. She was simply not able to even get onto public transportation with me.

I plan to visit Stephanie again this month. Her birthday is Christmas day, December 25th. On that day, she becomes 33 years old.

Did you know that I am powerless to admit Stephanie to a dual diagnosis treatment program without trained professionals who will help me to escort her to one? Navigating public transportation with Stephanie is impossible because she is unwilling to get on a bus or a train. Driving with Stephanie is a dangerous to me and to her and to other drivers on the road because of her violent seizures. I need HELP for me so that I can help Stephanie. She is a danger to herself and to others because of her violent touret syndrome-like seizures. Although in the eyes of trained professionals who can get her into a healing environment, she is not welcome there! Unless she gets herself there willingly.

How many people on the streets are in this similar situation? How many families are powerless like me? I believe there are millions. If you have any power to effect this, please use it and please effect this. Please do everything in your power to get the IMD exclusion repealed and to get the HIPAA laws modified and to get more facilities open to diagnosis, house, and provide a long term continuum of care which is both inclusive and encouraging of family support. We need crisis teams 24/7 in every community. We need enough beds, we need enough professionals, we need enough welcoming and open doors. We need help for families when families ask for help. We need families to be included and not excluded. We need family unity to be encouraged and not discouraged.
Thank you for reading my comments. I am sending you blessings and gratitude for working hard to effect positive change.

Very truly yours,

Julia Ehret

19. Frances Musgrove

What I would like to say is it was good reporting good planning I like the idea of the quality of care of the sharing of the data. I do believe we need to consider the whole person the trauma the lived experience. I think risk assessments need to be done automatically I think the 190 days of hospitalization is awful there’s no other illness that has this cap. my son Can longer go to the hospital for mental illness or get any help for substance-abuse because of this. I also want to say that court orders mean nothing my son within the last year spent about a year in the hospital he gets a court order that says he must follow the treatment plan or can go back to the hospital and that is not true. Samhsa gives Aot a lot of money and they do not follow through they are only there for those that want to move forward and not people that have comorbidity. Thank you so much.

20. Elliot Pinsly

Dear ISMICC Chair Delphin-Rittmon and Committee Members,

It is an honor to provide written public comment to the Interdepartmental Serious Mental Illness Coordinating Committee. I lead the Behavioral Health Foundation, a nonprofit policy center in Nashville, TN, dedicated to advancing mental health, addiction care, and related criminal justice reform. We applaud your committee’s commitment to collaboration, evidence-based practice, and mental health recovery.

To remove barriers to accessing mental health care, increase diversity among behavioral health care practitioners, and help alleviate workforce shortages, we propose allocating federal funding for an expansion and replication of:

- services offering opportunities for peer support;
- evidence-based, voluntary methods of response, treatment, and prevention of mental health crises;
• effective community responder deflection programs, such as the highly successful CAHOOTS in Oregon.

Barriers for individuals with serious mental health disorders include: (1) difficulty accessing preventative care; (2) shortages of qualified mental health professionals; and (3) mistrust of mental health workers among the patients with a perceived negative experience of a psychiatric intervention. The number of such patients is especially high among racial and ethnic minorities, who are committed involuntarily at a higher rate than white patients and often perceive the mental health system as repressive.

For individuals experiencing acute mental health crises, barriers can be reduced by providing access to non-coercive programs approved by the World Health Organization, such as Open Dialogue and Soteria House, which provide long-term outcomes comparable, or even superior, to the outcomes of conventional psychiatric hospitalization, at a lower cost and with fewer side effects. Soteria was pioneered by American psychiatrists and shown to be a viable and voluntary alternative to inpatient care, but it is now severely underfunded in the U.S. Developing such programs will offer individuals and family members options for accessing high-quality mental health care.

Peer mental health workers have diverse backgrounds and unique ways to relate to patients and build trust. Since the peer-run Suicide Crisis Centre was open in the UK in 2013, it has not recorded a single suicide among its clients; this stands in contrast with higher rates of suicides among patients discharged from psychiatric hospitals. Peer Respites and peer-run prevention programs recently started in the U.S., such as Emotional CPR and Warm Line services, have shown promising initial results and warrant further funding and study.

To lower barriers to preventive services, we propose to support and expand (1) community-building programs, such as Self-Healing Communities, which achieved a 98% decrease in youth suicide and suicide attempts in Washington state, and (2) access to in-depth psychotherapy, which reduces psychiatric hospitalizations, ER visits, law enforcement encounters, and incarceration of individuals with mental health disorders. Great demand has been shown for such services by an overwhelmingly positive vote on additional property tax for funding the Kedzie Center in Chicago and by the success of Volunteers in Psychotherapy, where individuals can receive therapy free of charge in exchange for volunteer work for a charity of their choice.

To prevent the unnecessary arrest and incarceration of individuals experiencing a mental health crisis, we propose permanent, recurring funding streams for states and local communities to plan, pilot, and sustain community responder deflection programs in partnership with law enforcement (e.g., CAHOOTS in Oregon sends a mental health worker and medic in response to 911 calls, with police backup needed on less than 1% of calls). Such programs, with sufficient funding and training, have demonstrated strong safety records and tremendous return on investment. There is also a need to develop and
study community responder programs that employ peer support specialists as part of a multidisciplinary team.

We welcome committee members to reach out if we can be a resource to support the important work of this committee.

Thank you for your ongoing commitment to improving mental health care and recovery for all Americans.

Respectfully,

Elliot Pinsky, LCSW  
Chief Executive Officer  
BEHAVIORAL HEALTH FOUNDATION  
elliot@behavioralhealthfoundation.org

21. Annonomous

Public Comment for the Behavioral Health Board

Could we lead as a county and begin to debunk the myth that mental disorders are biologically-based for our generation and generations to come? The brain is not synonymous with the mind.

Increasingly studies are being funded that point us to many more wholesome ways which can help to restore order, particularly to young minds. Let us not continue to fall into societal traps purposefully fostered by pharmaceutical industries.

Calling it an illness was a convenient way for us to grow our body of research on pharmaceutical drugs and their impact on the body and the brain. When is enough going to be enough. Is pharmaceutical immersion and intrusion exactly what we want to perpetuate for our children and grandchildren?

Could we offer Neurofeedback for example to our children with high ACE scores?

Could we begin to incorporate somatic experiencing, mind-body, and brain spotting or EMDR curricula for our psychiatric doctors?

Could the county make Trauma research and Restorative Sleep curricula like CBT for Insomnia available for our doctors and eventually to our customers and clients?

Could we empower especially the younger generations of doctors and make new trainings available for them to pursue?

Does anyone else feel an urgency to turn back the tide of pharmaceutical dominance in our society?
Kaiser offers groups for adolescent and adult clients through their psychiatry departments. They offer a wide array of trauma education, including the STAIR curriculum and Seeking Safety both held once a week, over an eight-week period. The STAIR curriculum is also available on the VA website.

Could trauma recovery group education be incorporated into existing emergency and/or non-emergency services?

Could we collaborate and engage with local universities in longitudinal studies using MDMA, Neurofeedback, Polyvagal theory, Brain Spotting, EMDR, Somatic Experiencing, and Somatic Archaeology?
Public comment offered during the last Behavioral Health board meeting:

Tom and I worked this summer to revive the mission of the United Consumer Movement. In conjunction with Dr. Daniel Fisher of the National Coalition for Mental Health Recovery (NCMHR) and the National Empowerment Center (NEC), we fine-tuned our mission statement in advance of the statewide Peers conference in Sacramento this summer.

• Our mission and that of the UCM is to **Carry messages of recovery, empowerment, hope and healing to our peers with lived experience of being in extreme states, subjected to trauma, locked in institutions, and labeled with mental health diagnoses.**

• The primary difference we have from NAMI is that neither the UCM nor the National Coalition subscribe to the Broken Brain model.

• We collaborated with Reverend Cindy and the FaithNet team in an effort to elevate awareness of our peers in locked facilities. This included an outreach to 51 churches and synagogues.

- Tom and I offered individual and communal prayers whilst inviting prayer ministries to join with us in holding the folks in our psychiatric facilities in prayer. These facilities included Crestwood, Dycore, EPS, El Camino, Mission Oaks, Barbara Aarons, and San Jose Behavioral Health, among others.

This past fall too I participated in zoom calls with the architects for the new foster youth HUB project in my neighborhood. It is my understanding now that the Muwekma Ohlone tribe will be outreached to directly and invited to participate in the dialogue and visioning process. Thank you to the County for creating a neighborhood effort in support of and in collaboration with our youth.

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additional editing suggestions by Wesley & Terrence. UCM: 408-320-6323, voice or text.