U.S. Department of Health and Human Services

Minutes of the Interdepartmental Serious Mental Illness Coordinating Committee Listening Session

October 27, 2021, 1:00 p.m. to 5:00 p.m. (Eastern Time)
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane
Rockville, Maryland 20857
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Ms. Pamela Foote, Designated Federal Official, Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), called the meeting to order at 1:00 p.m. and a quorum was established.

Federal ISMICC Members or Designees Present

- Joel Dubenitz, Designee, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services
- Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Abuse, Substance Abuse and Mental Health Services Administration
- Maria Fryer, M.S., Designee, Policy Analyst, Bureau of Justice Assistance, The Attorney General, Department of Justice
- Sandy Resnick, Ph.D., Designee, Deputy Director, Northeast Program Evaluation Center (NEPEC), Office of Mental Health and Suicide Prevention, Virginia Central Office (VACO), Department of Veterans Affairs (VA)
- Rick Mooney, Designee, Department of Defense
- David Gonzalez-Rice and Chang Chiu, Designee, Designees, Department of Housing and Urban Development
- Christy Kavulic, Designee, Associate Division Director, Early Childhood, Office of Special Education Programs, Department of Education
- Taryn Williams, M.Ed., Assistant Secretary for Disability Employment Policy, Department of Labor
- Marion (Taffy) McCoy, Ph.D., Designee, Social Science Analyst, Social Security Administration

Federal ISMICC Members Not Present

- Judith Cash, Designee, Acting Deputy Director, Center for Medicaid and CHIP Services, Administrator of the Centers for Medicare and Medicaid Services
- Kenneth Richter, CDR, Designee, Department of Defense

Non-Federal ISMICC Members Present

- Trinidad de Jesus Arguello, Ph.D., LCSW, PMHRN-BC, Director, Compostela Community and Family Cultural Institute
- Yasmine Brown, M.S., CEO, Hope Restored Suicide Prevention Project, LLC
- Ron Bruno, Founding Board Member and Second Vice President, Crisis Intervention Team (CIT) International
Welcome and Introductions

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

Dr. Delphin-Rittmon, ISMICC Chair, Assistant Secretary for Mental Health and Substance Use, thanked Ms. Foote, greeted participants, and asked Dr. Anita Everett, Director of Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services (SAMHSA), and Cynthia Kemp, Deputy Director, CMHS, to introduce themselves.

Dr. Delphin-Rittmon explained that the feedback gathered during the listening session will be used to inform the second and final assessment report to Congress. The first report, submitted in 2017, entitled The Way Forward, detailed major barriers to treatment for individuals with serious mental illness (SMI) and children, adolescents, youth and their families. Laying out 45 recommendations within five key focus areas, the report paved the way for collaboration between federal partners. The second report will include a recommendation to Congress from Xavier Becerra, Secretary, Department of Health and Human Services, and Dr. Delphin-Rittmon about whether ISMICC should continue after its scheduled end.

Dr. Delphin-Rittmon stated the goals for this meeting: 1) share federal accomplishments thus far pertaining to ISMICC focus areas and recommendations and gather input around data and trends; 2) receive input from members about the specific existing recommendations and extending ISMICC after its upcoming deadline. Dr. Delphin-Rittmon is open to the extension and sees it contributing to and shaping the national direction of services programs and supports for individuals with SMI and serious emotional disturbance (SED).
Dr. Delphin-Rittmon turned the meeting over to Ms. Foote for the consideration of meeting minutes.

**Consideration of Minutes**  
*Pamela Foote, Designated Federal Official, ISMICC*

Ms. Foote allowed for a time of questions and comments. The August 27, 2021, meeting minutes were accepted unanimously.

**Review of ISMICC Context**  
*Anita Everett M.D., DFAPA, Director, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services (SAMHSA)*

Dr. Everett referenced the importance of narrative as she began her overview of the ISMICC, which has its origins in the 2014 report from the General Accounting Office. The report cited 112 different federal programs serving those with SMI and SED across eight different departments, representing about $5.7 billion in expenditures, and recommending Health and Human Services (HHS) establish a mechanism to facilitate intra- and interagency coordination. The report included actions that would assist with identifying the program's resources, potential gaps, and federal efforts to support individuals with SMI. These recommendations became part of the legislation in 21st Century Cures Act passed by President Obama and launched ISMICC, which is comprised of 10 federal government departments and 14 non-federal public members.

Dr. Everett stated that the listening session was convened to help decide the future of ISMICC and the best way to move forward. She then introduced her colleague, Cynthia Kemp, SAMHSA’s ISMICC lead coordinator, and one of the original focus area stewards of ISMICC.

**Overview of the Draft Inter-Departmental Serious Mental Illness Coordinating Committee 2021 Report to Congress**  
*Cynthia Kemp, MA, LPC, Deputy Director, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services (SAMHSA)*

Ms. Cynthia Kemp greeted participants and expressed her excitement about being involved in ISMICC once again. She explained three key deliverables are required for the second and final report to Congress: a summary of the advances in SMI and SED research; an evaluation of the effect federal programs have on public health; and specific recommendations for action. The report must also be accompanied by a recommendation from Secretary Becerra and Assistant Secretary Delphin-Rittmon on whether to extend the operation of ISMICC.

The report is laid out in three chapters. Chapter 1 will present advances in federal policy, programming, and collaboration related to focus areas and recommendations detailed in the first ISMICC report. Chapter 2 will capture national data and trends related to SMI and SED. Chapter 3 will detail specific recommendations for action. Currently, there are also three appendices. Appendix A covers recommendations from the 2017 report. Appendix B is a list of the ISMICC departments and the non-federal public members. Appendix C shows the federal agencies involvement in the five focus areas, which are:
Ms. Kemp presented a wheel graphic used throughout the upcoming report. The spokes of the wheel are the 10 federal departments and agencies involved in ISMICC, each with a consistent color throughout the report. Each focus area has the same format and its own page with corresponding federal departments and agencies addressing that area. The number of recommendations is listed for each focus area as well as the recommendations addressed by the departments and agencies. However, when a recommendation is said to be “advanced” or “addressed”, it does not mean that the recommendation was fully addressed or completed. A graphic indicates whether any of the federal department(s) or agencies self-report taking steps towards addressing recommendations. Each focus area also has three highlights showcasing some of the collaboration accomplished by the Federal ISMICC partners.

Chapter 2 focuses on the national data, particularly trends, relevant to adults with SMI and children and adolescents with SED and their families and caregivers. Currently, data topics include prevalence, or increasing rates of SMI, SED and co-occurring data; access to care; other data trends; areas advanced by ISMICC. The chapter also includes a section on challenges and opportunities, specifically the impact of the COVID-19 pandemic, the growth of telehealth, and the inequity of care.

Lastly, Chapter 3 will be based on input and feedback from the listening session and outline specific recommendations for future action.

Ms. Kemp turned the meeting back over to Dr. Delphin-Rittmon to facilitate the federal report out session.

ISMICC Federal Partners Report Out Session
Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use

Dr. Delphin-Rittmon stated that each department would report on their work over the last four years and future plans related to the five areas and the 45 recommendations. Because the work is completely voluntary, the collaboration is reflective of the commitment and natural intersection across departments. She added that many of the partnerships and connections have been strengthened over the last four years and continue to grow under the leadership of Secretary Becerra. After Dr. Delphin-Rittmon’s opening comments, Ms. Foote called on each department to share their accomplishments pertaining to ISMICC recommendations.
Focus Area 1: Strengthen Federal Coordination to Improve Care. Under the Department of Health and Human Services (HHS), SAMHSA commissioned and completed the Mental Health Substance Use Disorders Prevalence Study. Data collected through a pilot sampling methodology tracked prevalence of illnesses that fall into the SMI category with the goal of improving resource matching. The Agency for Healthcare Research and Quality (AHRQ) is expanding the content of several national surveys to include questions relevant to the lives of people experiencing SMI and SED. These surveys include the National Expenditure Panel Survey, the Healthcare Utilization Project, and the National Hospital Care Survey.

Focus area 2: Access and Engagement: Make It Easier to Get Good Care. HHS is rolling out projects to promote capacity in the 988 system, currently known as the National Suicide Prevention Lifeline, and provide those in crisis with someone to talk to, someone to respond, and a place to go. Though Americans can access emergency departments and hospitals through 911, people with SMI and SED are often best served in non-traditional, specialty receiving centers because they are better equipped to diagnose, treat, and manage crises for individuals with mental health conditions.

SAMHSA also manages the long-standing mental health block grant that now includes a five percent set aside dedicated to building up crisis services. Though in debate, the set aside may increase to 10 percent. SAMHSA also anticipates an increase for first episode psychosis (FEP), which will be available to states to create FEP teams. In the last several years, the program has grown from a small number of FEP programs in less than five states to a program in every state, with a total of 360 programs nationally. They have also made changes to 42-CFR (Code of Federal Regulations) to facilitate information sharing by providers about substance use disorder, which is often a co-occurring component for individuals with SMI as well as being a standalone condition.

Focus Area 3: Treatment and Recovery: Close the Gap Between What Works and What is Offered. SAMHSA has a number of grants and a discretionary grant portfolio. In partnership with the National Institute of Mental Health (NIMH), SAMHSA manages a relatively new program known as the Serious Mental Illness Early Psychosis Network. They have also worked with the Department of Homeland Security, the Department of Education, and the Department of Justice to expand and maintain www.schoolsafety.gov, a government-wide, publicly available resource addressing many current issues including developing climates for the health and social-emotional education and access to school-based medical services.

Focus Area 4: Justice: Increase Opportunities for Diversion and Improve Health Care for People with SMI and SED Involved in the Criminal and Juvenile Justice Systems. The 988 emergency numbers fall into this focus as well, allowing mobile crisis mental health units to respond with or without law enforcement, depending on the situation. SAMHSA also supports the GAINS (Gather, Assess, Integrate, Network, and Stimulate) Center, which focuses on opportunities for diversion from justice involvement.
Focus Area 5: Finances: Develop Finance Strategies to Increase the Availability and Affordability of Care. Focusing on parity, SAMHSA maintains a strong partnership with other departments, including the Department of Labor and Centers for Medicare and Medicaid Services, to ensure parity of payment and services.

Centers for Medicare and Medicaid Services
Judith Cash

[No response]

National Institute of Mental Health (NIMH)
Dr. Robert Heinssen, Ph.D., Director, Division of Services and Intervention Research, National Institute of Mental Health (NIMH)

National Institute of Mental Health (NIMH) published 28 funding opportunity announcements and 11 notices of interest from 2018 through 2021, soliciting research to address 10 ISMICC recommendations across four of the focus areas. For Recommendation 3.7: Advance the national adoption of effective suicide prevention approaches, NIMH published 14 initiatives to support research to improve identification, prevention, and treatment of individuals at risk for suicide in a variety of healthcare settings for various populations, including black youth and youth from underserved populations. These initiatives reflect a major emphasis of the NIMH strategic plan, which is to produce research that leads to measurable reductions in suicide rates in the United States.

Another significant investment has been Recommendation 2.6: Prioritize the early identification and intervention for children, youth and young adults. NIMH published eight funding initiatives for research addressing the needs of youth, who are at a clinical high risk for psychosis, including research on early identification and delivery of evidence-based treatment to this population. For individuals experiencing FEP, NIMH established the previously mentioned Early Psychosis Intervention Network (EPINet), which includes 100 FEP teams that are supported through the Mental Health Block Grant. EPINet explores the “principles of learning healthcare” and represents the nation's first learning healthcare system for early SMI. The network uses standard measures for integration into routine care, monitors the progress of individuals in treatment allowing for quality improvement efforts, and provides NIMH and SAMHSA with best practices in treating this population.

Assistant Secretary for Planning and Evaluation (ASPE)
Joel Dubenitz, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services

ASPE is a primary advisor to HHS Secretary Becerra providing policy coordination, policy research, and evaluation functions. ASPE’s work in support of ISMICC began with identifying relevant programs at HHS. ASPE participated with staff members in various working groups to
consider ISMICC goals when developing new research, evaluation, and other policy
development and coordination efforts. Current research and policy efforts focus on monitoring
tele-behavioral health policies and outcomes; improving the use of measurement-based care for
measuring gaps in treatment; access and network adequacy; minimizing disparities and accessing
treatment; understanding continuity of care after discharge from coordinated specialty care;
expanding access to evidence-based suicide prevention practices.

Other activities include a report on state oversight of residential treatment for behavioral health
conditions; a brief on the mental health consequences of COVID-19 looking at social
determinants of health; a brief on child and adolescent mental health during COVID-19; a chart
book on the behavioral health treatment demand and provider capacity; a brief on crisis services
and the behavioral health workforce. ASPE also leads the evaluation of the Certified
Community Behavioral Health Clinic Medicaid demonstration. The reports about the evaluation
and early implementation findings, as well as the other reports, are available www.aspe.hhs.gov.

Lastly, ASPE is part of a very wide collaboration with numerous federal departments to produce
a report on the increasing trends of deaths from suicide among black youth entitled, The African
American Youth Suicide Report to Congress 2020, which is posted on the NIMH website.

**Department of Housing and Urban Development (HUD)**

*David Gonzalez Rice*

Several programs within the Department of Housing and Urban Development (HUD) pertain to
Focus Area 3 and serve people with disabilities, including those with SMI. As noted in the
previous report, specific disabilities are difficult to target due to fair housing laws; however, new
routes of implementation promote access to housing interventions. For example, when at least
one member of a household has a qualifying disability, mainstream vouchers subsidize rents in
private market housing. HUD requires that the public housing authority use mainstream
vouchers for individuals with disabilities that are leaving institutions, at risk of being
institutionalized, or transitioning from or at risk of homelessness. Data indicates these vouchers
are currently underutilized with approximately 25,000, or 28 percent, of 91,000 vouchers are yet
to be awarded. Since April, HUD and HHS have collaborated on joint technical assistance to
increase utilization of vouchers.

HUD strives to strengthen partnerships between housing authorities and Centers for Independent
Living, strongly encouraging housing authorities to consider admissions preferences specifically
for people with disabilities who are leaving institutional settings. Further, HUD’s Section 8
funding program increases the supply of accessible rental units for individuals with disabilities
by integrating units into existing, new, or renovated multi-family housing developments. On
November 30, 2020, HUD announced an award of over $54 million in Section 11, Capital
Advance, and project assistance grants to 15 organizations to expand the supply of affordable
rental housing for extremely low-income persons with disabilities. As of October, HUD
announced awards of $115 million in Section 8 rental assistance to 19 state housing finance
agencies to support them with operating costs necessary to develop permanent affordable
housing. Additionally, HUD expects to issue a new Section 11 funding opportunity later this fiscal year.

One in five people experiencing homelessness are reported to have a severe mental health condition, and nearly half of those are experiencing unsheltered homelessness. HUD programs serve this population through continuing care, emergency solutions, and grants programs. On August 18, 2021, HUD announced $2.656 billion in Continuum of Care (COC) funds available to collaborative applicants, an increase of more than $150 million since 2020. The COC competition process requires that proposed new units of permanent supportive housing be dedicated to people with a qualifying disability and chronic homelessness. However, in 2017 accessibility expanded to DedicatedPlus, facilitating transitions between housing programs. Individuals with a public housing history totaling 12 months or more, but who do not otherwise meet the technical definition of chronic homelessness, are now accommodated. The 2021 COC competition provides bonus points to applications demonstrating coordination between housing providers and healthcare organizations.

HUD continues to collaborate with Veterans Affairs (VA) to provide supportive housing through the HUD-VASH (Veterans Affairs Supportive Housing) program. HUD housing vouchers, combined with supportive services provided by the VA, help homeless veterans find and maintain permanent housing. Leadership issued a joint statement on ending veteran homelessness. To that end, meetings are underway to improve utilization and outcomes for veterans.

Notably, Secretary Marcia Fudge is committed to the Housing First model enabling people reconnect to care and their recovery goals, which is critical to mental wellness.

Department of Housing and Urban Development (HUD)
Office of Fair Housing and Equal Opportunity
Chang Chiu

The Fair Housing Act affords all persons the opportunity to enjoy housing without discrimination, including people with SMI who need a safe and stable environment. HUD protects these rights through the Office of Fair Housing and Equal Opportunity (FHEO), which investigates complaints of housing discrimination, including disability cases and SMI. An example of this discrimination is when, in September 2021, charges were made against an owner in Texas who violated the Fair Housing Act by refusing to rent a house slated to be a group home for persons with severe mental disabilities.

HUD is prioritizing enforcement guidance to help house people with SMI. In January 2020, FHEO issued guidance on assessing a person's request to have an animal as a reasonable accommodation under the Fair Housing Act. The guidance is significant because it pertains to the daily interactions people with disabilities are entitled to or protected from in a housing environment, (e.g., housing providers are not entitled to have detailed information about people's mental illness when making accommodations).
The Bureau of Justice Assistance (BJA) within the Department of Justice (DOJ) serves under the Attorney General, who is the designated ISMICC member. DOJ, and specifically the BJA, has long supported behavioral health and justice partnerships through programming, policy, and grant opportunities. Additionally, since the beginning of ISMICC, DOJ has increased programming and policy.

In support of Recommendations 4.4 and 4.5, BJA funds activities through the Justice and Mental Health Collaboration Program (JMHCP). Special court dockets and mental health boards have been a legislative priority, as well as other competitive grant programs for states, tribes, and local governments. The goal is to partner with behavioral health to increase response to people with SMI and improve treatment and services along the continuum. In the past year, BJA established the Connect and Protect Law Enforcement Behavioral Health Response Program under the JMHCP to address the needs of law enforcement as first responders (Recommendation 4.3) and divert people who may be better served in the community. Further, three large cohorts will soon receive awards. The soon-to-be-released Crisis Response Training Program outlines a model approach for law enforcement and behavioral health and includes co-responders, (e.g., mobile crisis teams), case management, placing clinicians in 911 dispatch centers, and many other innovative best practices to increase and improve diversion, (Recommendation 4.1, 4.4).

BJA has strengthened its Stepping Up initiative, which provides best practice guidance for local jails to screen every person for SMI. This initiative has evolved over the last several years to include universal screening and assessment and to demonstrate how connections to care reduce recidivism in people with SMI in local jails (Recommendation 4.6). BJA is also investing significant resources to develop and explore Recommendation 4.8: Reduce barriers that impede immediate access to treatment and recovery services upon release from correctional facilities. A main focus for FY22 is to increase tools for community supervision.

Under the current acting director, Kristin Mahoney, BJA expanded the law enforcement mental health learning sites and developed new online tools to support the field. These tools include self-assessment tools for law enforcement responsiveness and a police mental health collaboration tool to help agencies design a response. BJA also offers free expert consultation through two national centers to law enforcement, jails, courts, probation, prisons, and community supervision programs.

Recently, in concert with the Council of State Governments Justice Center and the University of Cincinnati, BJA hosted a national event to learn more about the crisis response continuum. Topics during this national discussion included identifying treatment opportunities in community crisis services, knowing how to divert people who are appropriate for treatment in the community from an encounter with the justice system, understanding when law enforcement is and is not needed. More tools, programming, and products will be forthcoming as a result.
Department of Justice: Bureau of Prisons
Allison Leukefeld, Administrator of Psychology Services Branch, Bureau of Prisons

The Bureau of Prisons (BOP) focuses on several initiatives to reduce the use of restrictive housing in prisons. Policy requirements ensure inmates with SMI are reviewed before placement in restrictive housing, and strict exclusionary criteria for many forms of restrictive housing are in place. Additional efforts include building a large number of reintegration units for individuals who are seeking protective custody and would otherwise be placed in restrictive housing. In the last two years, 700 beds have been added to those units with an anticipated 300 more beds to be added in the next year or two. Four secure mental health programs are currently in place to divert individuals with SMI from mental housing, and additional programs are being developed. By adding intensive treatment programs, BOP enhanced services available to incarcerated individuals, helping them stabilize and reduce the need for restrictive housing. Lastly, BOP is striving to reduce wait times for competency restoration.

Department of Veterans Affairs
Sandy Resnick, Ph.D., Deputy Director, Northeast Evaluation Center, Office of Mental Health and Suicide Prevention, Dept. of Veteran Affairs

The Department of Veterans Affairs has a wide array of initiatives aligned with a broad range of ISMICC recommendations:

Recommendation 1.6 and 1.7: Use data to improve quality of care and outcomes and ensure that quality measurement efforts include mental health. The VA has an extremely strong quality metrics program focused on mental health and works in partnership with many stakeholders to ensure the metrics and the data are being used to advance quality of care.

Recommendation 2.5: Establish standardized assessments for monitoring of consumer progress. The VA’s initiative to implement measurement-based care as the standard of care across the entire VA mental health continuum of care has seen enormous progress over the last four years. The continuum of care begins with mental health services integrated into primary care and carries through to general mental health services, specialty care, residential and acute inpatient services. These services are supplemented by a robust peer support program, supported employment, vocational rehabilitation services, and other specialty care such as the Intensive Community Mental Health Recovery (ICMHR) program, psychosocial rehabilitation, and recovery centers.

Recommendation 3.7: Advance the National Adoption of effective suicide prevention strategies. The VA is focused on veteran suicide, as well as on suicide in general and suicide prevention.

Recommendation 3.8: Develop a priority research agenda for SMI treatment and recovery services. The VA’s Office of Research and Development funds a wide range of research across multiple priority areas, many of which are in support of treatment and recovery for people with SMI.
Recommendation 2.7: The use of telehealth and other technologies to increase access to care.
As a leader in telehealth services, the Veteran Health Administration set and achieved the goals of ensuring all outpatient mental health providers completed at least one video-to-home visit with veterans; increasing virtual care integration into routine clinical practice with at least 25% of visits being virtual; increasing veteran telehealth capability through VA-loaned devices to help with internet connectivity; instituting a national test call console to help veterans set up their devices. The VA supports increased national focus and funding for telehealth research and evaluation. As such, a national initiative was implemented to develop evidence-based therapies for suicide prevention via telehealth, and multiple educational tools promoting telehealth uptake by patient and provider.

Recommendation 3.3: Coordinate specialty care for first episode psychosis available nationwide.
In 2020, the VA launched the Early Psychosis Intervention Coordination (EPIC) program to develop systematic capacity to assess the treatment needs of VHA patients experiencing emergent psychotic disorders. The VA provides coordinated specialty care through coordination of available VA mental health treatment services. EPIC is supported in over 100 of the VA medical centers. An appointed EPIC team leader is given protected time to develop a team of providers and administrators. The team reviews care information from the VA data to identify veterans experiencing FEP and coordinate a personalized outreach and care coordination.

Recommendation 1.6: Using data to improve quality of care and outcomes
Through the SMI Re-Engage Program, the VA identifies veterans with schizophrenia or bipolar disorder who have not had care for 12 months or more and conducts proactive outreach to facilitate return to VHA health care. Evaluation reveals veterans contacted by the program are more likely to return to care, the VA is making extensive efforts to identify best practices and disseminate them to all of the clinicians participating in the program.

Recommendation 3.7: Advancing the national adoption of effective suicide prevention strategies.
The VA is collaborating with health systems in communities across the country to address its top clinical priority: suicide prevention. Seeking a systems transformation, the VA aims to improve identification and access to resources through a full public health model, including community-based and clinically based interventions, and to implement a national strategy with two main focuses. SP 2.0, which began in 2018, is a six-year strategic plan with national reach focusing on the implementation of clinical and community-based prevention, (e.g., the Mayor’s Challenge), intervention and postvention services. Following the national strategies of treatment, recovery, and support services, SP 2.0 outlines a strategy for implementing the VA DoD clinical practice guidelines for suicide. The plan supports evidence-based treatment through the dissemination of tele-mental health suicide prevention services across the system. In 2020, the SP NOW initiative launched, bundling multiple interventions across various domains aligned with the vision of the national strategy. Key elements include focus on lethal means safety, suicide prevention and medical populations. The two initiatives are now combined.
The Department of Education (ED) prioritizes early identification and intervention for children, youth and young adults to maximize the capacity of the behavioral health workforce while supporting family members and caregivers. A new resource released last week provides information and resources to enhance the promotion of mental health and social-emotional well-being from early childhood through higher education. ED also released guidance for states and districts to use funds available through the American Rescue Plan to integrate social-emotional and behavioral health services and supports.

The Federal Commission on School Safety, led by ED, released a federal report with guidance for developing the schoolsafety.gov website to help schools and districts create safe and supportive learning environments.

Over the years, ED funded a number of technical assistance (TA) centers. Through a collaboration with HHS’s Office of Childcare and Office of Head Start, the National Center for Pyramid Model Innovations focuses on children birth through age 5. The TA Center on Positive Behavioral Interventions and Supports (PBIS) seeks to enhance system capacity for implementing a multi-tiered approach for social emotional and behavioral support in schools. The PBIS Center released the Interconnected Systems Framework, a resource for embedding trauma-informed care approaches and mental health supports in schools. Additionally, the Center to Improve Social and Emotional Learning and the School Safety Net Center expands the knowledge and capacity of states and districts to integrate evidence-based social and emotional learning and school safety programs and practices.

Grants are also available to districts and state educational agencies in support of students and professionals. For example, the school climate transformation grants support the enhancement or expansion of systems of support and provides technical assistance for schools implementing an evidence-based, multi-tiered framework for improving behavioral outcomes and learning conditions. To support school personnel, ED funded the school-based mental health service grants to increase the number of qualified, licensed, certified, and well-trained or credentialed mental health service providers that provide school-based mental health services. Other funding includes:

- Mental Health Service Professional demonstration grants support innovative partnerships to train and deploy school-based mental health service providers.
- The Center for Parent Information and Resources includes trauma-informed practices.
- Parent Training and Information Centers and statewide family engagement centers support parents in understanding their roles and responsibilities under the Disability Education Act.
The Department of Labor's (DOL) Office of Disability Employment Policy (ODEP) was established in 2001 to develop and promote policies and practices that increase employment opportunities for people with disabilities, including persons with SMI. Through data collection and analysis, program evaluation, demonstration projects, and technical assistance, ODEP provides leadership and coordination within the DOL, as well as across federal, state, and local governments, as well as with employers and other stakeholders.

Substantial evidence shows employment can prevent some of the worst potential consequences of SMI, (e.g., poverty, hospitalization, incarceration, homelessness, depth of despair). Further, quality employment is a crucial social determinant of health affecting income, housing, social support, and community integration. Research also shows that employment helps increase self-efficacy, self-esteem, daily structure, and symptom control regarding SMI.

Notably, there is strong evidence that the Individual Placement and Support (IPS) model of supported employment helps people with SMI obtain jobs that align with their interests and skills and sustains competitive, integrated employment. However, IPS is extremely underutilized; 60 percent of adults with SMI report a desire to work while only two percent of those have access to IPS services. Policies, programs, expertise, and funding needed to provide IPS services are absent, or limited, in many localities. ODEP has a number of initiatives to advance policy and catalyze the adoption of IPS, including supported employment models to address

Focus Area 1: Strengthen Federal Coordination to Improve Care. In 2018, ODEP led the formation of an interagency supportive employment workgroup to coordinate implementation and research that continues to meet.

Focus Area 3: Treatment and Recovery: Close the Gap Between What Works and What is Offered. ODEP supports visionary opportunities to increase competitive employment initiatives. In 2019 and 2020, ODEP supported 25 states to align policy, practice, and funding to increase employment by expanding access to IPS. In 2021, ODEP launched the Advancing State Policy Integration for Recovery and Employment (ASPIRE) initiative, working with seven states to align policy funding and service strategies to increase the availability of IPS supported employment. ASPIRE also includes several federal agencies in a technical workgroup (Focus Area 1).

ODEP’s Center for Advancing Policy on Employment for Youth (CAPE Youth) was established to help states build capacity and improve employment outcomes for youth with disabilities, including mental health conditions. In August, CAPE Youth released a brief on improving mental health service delivery, including coordinated specialty care for youth with an FEP, using resources available through the Workforce Development System and American Rescue Plan.

Regarding mental health and employment in general, ODEP released a mental health toolkit in 2019 to help employers better understand mental health issues in the workplace and cultivate an
background that supports employee mental health. ODEP aims to increase awareness of employee mental health through efforts such as the Disability Employment Public Service Announcement, entitled “Mental Health at Work: What can I do?”

ODEP and the DOL will continue to use ISMICC recommendations as a guide to improve employment opportunities for people with SMI and welcomes continued input from ISMICC. In closing, Ms. Williams recognized Richard Davis, senior policy advisor and fierce advocate whose contributions support the initiatives shared.

Social Security Administration
Marion “Taffy” McCoy, Ph.D., Office of Research and Demonstration, Social Security Administration

The Social Security Administration (SSA) collaborates with other agencies and ISMICC to improve programs serving the nation, including the approximately 40 percent of adults and youth with SMI and SED. One particular interagency effort with the Bureau of Labor and Statistics is to update the dictionary of occupational titles to ensure disability determination specialists (DDS) have current information when deciding if someone has SMI ad whether they will be awarded benefits. SSA also expanded training for their 400 medical consultants (Recommendation 2.3) to provide continuum medical education on behavior disorders in children.

Regarding Focus Area 3: Treatment and Recovery, SSA launched a youth toolkit in FY 2021 for caregivers, families, and individuals experiencing SMI or SED to understand how to get or continue benefits. They also have many demonstrations evaluating the use of IPS for people with diagnosed SMI.

SSA is working with people who were denied mental health benefits in a long-term supported employment demonstration called the Beyond Benefits Study, (formerly known as Exits from Disability Study), that ends in 2022. The goal is to address some of the issues with continuing medical and disabilities reviews that occur every three to seven years, depending on the severity of the condition. They found that while 70 percent of the people terminate benefits because they are working and their medical situation has improved, they are not in self-sufficient jobs. By exploring those experiences, they can also use motivational interviewing to explore the availability of benefits. Motivational interviewing helps people overcome their ambivalence, fears, and reservations about working and coupled with an IPS access, may benefit people on a large scale.

SSA is also increasing its integrated services research. Working with the Administration of Children and Families within HHS on a joint-funded cooperative agreement, they are exploring ways to help families coordinate care that may be available to the same swath of the population. A new program soon to launch addresses reentry issues while better integration of Certified Community Behavioral Health Centers and IPS models of supported employment may be part of future efforts.
Ms. Foote thanked all speakers and called for a 15-minute recess.

ISMICC Members Feedback Session on the 2021 Draft Report to Congress
Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use

Dr. Delphin-Rittmon thanked everyone for reporting on their efforts citing the numerous areas of potential. She then opened the floor for comments.

Ron Bruno praised the work of the federal partners, and noted the different philosophies shared at the start of ISMICC have since come into alignment to pave the way forward. Mr. Pete Earley stated hearing how federal partners used the report to implement programs was extremely useful. Dr. Delphin-Rittmon thanked everyone for linking back to the focus areas, a tactic that will inform the work in the future. She then explained that members would have the opportunity to provide feedback on each chapter of the coming report.

Chapter 1 provides a summary of the federal advances in SMI and SED over the past four years in each of the five areas. When Dr. Delphin-Rittmon asked if other programs or policies should be included in Chapter 1, there were no comments.

Before moving on, Dr. Everett welcomed feedback on the visuals as well as the content. Ron Bruno affirmed the quality of the graphics and layout as well as the alignment of advances with recommendations. He suggests building out the callout box and the three areas that will be highlighted in the 2021 report by including an appendix that addresses every effort to each focus area and recommendation. Dr. Delphin-Rittmon concurred with the appendix concept.

Amanda Lipp agreed with Mr. Bruno, and suggested adding a visual cue, such as a check mark or a reference, to the appendix number. Dr. Everett welcomed the idea of an inventory in the appendix. David Covington affirmed the idea of tying direct impact to the recommendation. For example, Recommendation 2.1 asks for a national standard for crisis care and the National Guidelines for Behavioral Health Crisis Care: A Best Practices Toolkit was published in February 2021. Further, the callout in the report on 988 is a critical step toward fulfilling Recommendation 4.2: Develop an integrated crisis response system to divert people with SMI and SED from the justice system. However, another major milestone that should be included is the expansion of mobile crisis and crisis facility care.

Dr. Delphin-Rittmon called on Jennifer Higgins to begin the discussion of Chapter 2, focusing on national data relevant to adults with SMI, as well as children, adolescents, and youth with SED, their families, and caregivers. In addition to the mention of screenings at the PCP level, Ms. Higgins inquired about including a social determinants of health screening, such as the tool AHRQ uses for PCP level of care.

Yasmine Brown asked if research involving the confluence of racism and stigmatization against SMI would be included under access to care. Dr. Everett affirmed the importance of the inclusion, adding that Chapter 3 might be the place for it. Dr. Delphin-Rittmon stated that there could be an opportunity to include the work within SAMHSA’s Office of Behavioral Health.
Equity, which aims to enhance and increase access to care among those participating in SAMHSA’s discretionary grant programs. Additionally, the Office of Minority Health recently published a behavioral guide to the CLAS (culturally and linguistically appropriate services) Standards.

Johanna Kandel is pursuing the classification of eating disorders as an SMI, adding that the disorder affects every federal department. Those experiencing eating disorders are not able to function and, far from being a choice, eating disorders are a biological, psychological, and social illness. Ms. Kandel has drafted a letter to ISMICC on the subject, which Dr. Delphin-Rittmon agreed to review.

Dr. Covington noted that referencing the unlawful practice of psychiatric boarding, (i.e., the practice of people in crisis sitting for days in a hospital emergency department), in the report may set the foundation for the integrated crisis continuum. Secondly, including data on the engagement of law enforcement in crisis scenarios and the burden it places on the system may be an opportunity to explain that 988 without mobile teams and crisis facilities is going to exacerbate the challenges we already face.

Steven Leifman expressed concern over how long it will take for 988 to be a viable national resource since 911 took 20 years to become established. He urges consideration of a virtual crisis system so people can immediately speak to someone face to face, possibly de-escalating the situation and reducing the need for crisis response. Thinking more futuristic, rather than relying on a phone call, a virtual system could be a big help to rural areas and urban communities alike.

Dr. Meena Vythilingam, from the Office of the Assistant Secretary of Health (OASH), noted her approval of the graphics and suggested adding mention of ISMICC. Regarding Chapter 1, she suggested including the primary data analysis used to develop the Report to Congress on African American Youth Suicide Prevention, a collaborative effort of OASH, CDC, ASPE, NIMH, NICHD, ACF, SAMHSA, and several other agencies. Lastly, regarding telehealth, ISMICC may want to address patient and provider tele-mental health training.

Dr. Delphin-Rittmon moved the conversation to Chapter 3, which will outline specific recommendations for ISMICC actions until the committee sunsets in March 2023. Mr. Earley stated that the two senators most responsible for creating ISMICC and writing mental health law under the 21st Century Cures Act have failed to mention ISMICC in recent questionnaires on changing the law. He encouraged addressing the lack of awareness on their part, and at a federal level in general. Mr. Bruno concurred and strongly urged the continuation of ISMICC noting the recommendations and categories should evolve and go deeper. For example, crisis could become its own focus area. Dr. Delphin-Rittmon stated that his suggestion aligns with at least two SAMHSA priority areas: addressing children and youth behavioral health and crisis and suicide prevention.

Dr. Vythilingam inquired how many of the 45 recommendations would be fully addressed by March 2023. She noted that even though it may be a very daunting challenge, it is critical to focus on the impact of COVID-19 on SMI and SED, especially in children and youth. Further,
OASH is sponsoring workshops on new technological advances and approaches to address disparities and predict suicide at the individual level and the community level, including suicide rates in youth and American Indian and Alaskan Native suicide prevention specifically for children.

Dr. Katherine Warburton stated that the escalating criminalization crisis is driving major policy changes. She believes ISMICC should continue in light of future mental health reform. She noted Dr. Brian Hepburn’s chat comment about structuring the committee to keep pace with changing policy by implementing working groups. Dr. Delphin-Rittmon affirmed the idea of and need for workgroups.

Dr. Everett asked for input about the frequency of reports and more input about the structure of ISMICC. Dr Delphin-Rittmon added that they can also schedule Capitol Hill briefings when a report is submitted and be intentional about inviting members of Congress and their teams to engage lawmakers with the recommendations.

Regarding the inquiry about the number of fully addressed recommendations, Ms. Kemp reminded the Committee that the recommendations are big, broad, aspirational, and long-term. Dr. Delphin-Rittmon concurred, stating that a continuation would allow ISMICC to devote more time to reaching these goals.

Dr. Everett stated that adding other agencies and departments to ISMICC if it continues is also a possibility. Dr. Delphin-Rittmon affirmed the idea and welcomed input. She also concurred with Dr. Brian Hepburn’s chat that SAMHSA priorities and cross-cutting issues would give ISMICC a solid focus. Dr. Vythilingam echoed back to Ms. Kemp’s comment that the work is far reaching, which justifies continuation of ISMICC. As far as other groups that could be included, she mentioned the Behavioral Health Coordinating Council has a youth subcommittee whose work on suicide prevention, resilience, and access to care overlaps with some of the recommendations.

Ms. Kandel highlighted the effects of the pandemic on mental illness and its impact for years to come, including the work of ISMICC. Consideration must be taken to address the level of trauma it has caused, including the skyrocketing number of suicide attempts in the youth population and hospitalizations that have doubled for youth with eating disorders. Dr. Delphin-Rittmon strongly agreed, adding that numerous reports reveal the impact of the pandemic. For example, the National Survey on Drug Use and Health (NSDUH) released this past week included additional questions related to the impact of the pandemic with specific data related to young people. She noted that chat comments related to including more individuals with lived experience is also an important recommendation and that all input would be tracked.

Public Comment
Pamela Foote, Designated Federal Official, ISMICC

Ms. Foote stated there were no public comments.
Final Comments/Adjourn
Miriam E. Delphin-Rittmon, Ph.D., ISMICC Chair, Assistant Secretary for Mental Health and Substance Use

Before adjourning, Dr. Delphin-Rittmon called for final comments and assured members the feedback from this meeting would be incorporated. Seeing no comments, she asked for input from Ms. Kemp or Dr. Everett regarding next steps. Dr. Everett noted Judge Stroud had a comment.

Judge Stroud stated the COVID-19 pandemic brought with it a greater criminalization of misdemeanor offenses by young people, and young black African American males in particular, for “quality of life” crimes, (e.g., trespassing, urban camping, disorderly conduct), that leads to long-term criminalization. She urges ISMICC to recommend developing more mental health courts and misdemeanor mental health courts to decrease the chances of people graduating to felony offenses or federal offenses. Early intervention and diversion (Recommendation 4.4) is key. Further, veterans that commit misdemeanors need a place to land and get treatment for the first time or reconnect to services. Judge Stroud noted the cross-purpose of SAMHSA, CMS, SSA, and hopes for resources such as the GAINS Center to move this effort forward. Dr. Delphin-Rittmon appreciated the recommendation and noted the connection with crisis, youth, and equity work. She reiterated that feedback would be summarized and added to the document and said that several different areas could be focal areas for the ISMICC moving forward.

Dr. Delphin-Rittmon stated the seeming consensus is to continue the ISMICC, and that the session allowed for a number of potential goals to be identified. She then turned the meeting over to Ms. Kemp and Dr. Everett to talk about next steps.

Dr. Everett thanked everyone for their participation. She stated that if ISMICC is reauthorized, Congress can make changes to the structure and timeline, such as requiring the presence of people with lived experience, authorizing a time arc, authorizing more frequent reports, and other feedback presented during the session. Additionally, SAMHSA is seeking legal council on the concept of subcommittees. The next convening of ISMICC will be in the next several months, after the report is submitted. After thanking the members, she turned the meeting over to Ms. Kemp.

Ms. Kemp explained the report is due to Congress on December 13th. All comments and considerations will be included in a draft final report for Dr. Delphin-Rittmon, and Dr. Everett to review before it goes through the federal clearance process. Ms. Kemp discussed the timeline for federal clearing of the updated report that will contain feedback from the listening session. Mr. Earley stated that the updated report should be sent to all of the ISMICC members for a review prior to federal clearance so the committee could see what is being submitted. Dr. Delphin-Rittmon assured the ISMICC that they would have the opportunity to review the document prior to federal clearance submission of the final report to Congress. Hearing no further comment, Dr. Delphin-Rittmon expressed gratitude and appreciation for the meeting and the discussion. She added that the December meeting will be an opportunity to shape the upcoming agenda and then turned the meeting over to Ms. Foote.
Ms. Foote adjourned the meeting at 3:55 p.m.