Interdepartmental Serious Mental Illness Coordinating Committee

2024 Report to Congress

Building on Progress: Federal Action for a System That Works for All People Living with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and Their Families and Caregivers

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EXECUTIVE SUMMARY

The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) was established in 2017 to address the critical needs of individuals living with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), along with their families and caregivers. Its foundational report, *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers*, set the stage for a coordinated federal response to SMI and SED. In 2022, ISMICC released *Advances Through Collaboration: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers,* a supplemental report highlighting federal achievements in improving care and support for people with SMI and SED since 2017. The ISMICC was reauthorized in 2023 for another five years, underscoring ongoing federal commitment to this cause.

The ISMICC is responsible for submitting comprehensive reports to Congress and relevant federal agencies on its activities and accomplishments. These reports, including this 2024 report, provide:

- A summary of research advances in SMI and SED.
- An evaluation of federal programs related to SMI and SED.
- Recommendations for the coordination of federal activities related to SMI and SED.

To operationalize the recommendations from its 2017 report, the ISMICC established five Working Groups, comprised of both Federal and Non-federal Members, who meet regularly to transform strategic recommendations into tangible actions. The five Working Groups are:

- **Data and Evaluation Working Group** to Promote Data-Driven Services and Supports for People with SMI and SED
- **Access and Engagement Working Group** to Make It Easier to Get Good Care
- **Treatment and Recovery Working Group** to Close the Gap Between What Works and What Is Offered
- **Criminal Justice Working Group** to Increase Opportunities for Diversion and Improve Care for People with SMI and SED Involved in the Justice System
- **Finance Working Group** to Develop Finance Strategies to Increase Availability and Affordability of Quality Care

The ISMICC's work represents a critical step forward in creating a more integrated and effective system for addressing the needs of individuals with SMI and SED, demonstrating a comprehensive federal approach to mental health that emphasizes collaboration, evidence-based practices, and policy coordination.

INTRODUCTION

The convening of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) for the first time in 2017 signaled that mental health of individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) was considered a public health priority. Mental illness was noted to be a leading cause of disability and productivity loss in the workplace and schools—driven in large part by disorders that can commonly be associated with SMI and SED such as major depressive disorder, schizophrenia, and bipolar disorder. Suicide was the 10th leading cause of death among people of any age and the 2nd leading cause of death among people aged 10 to 44.[1] Suicide rates were the highest among older men, with men 75 and older having the highest rate of any group in the country.[2] At least one-third of people with SMI were not receiving mental health services, and there was recognition of the racial and ethnic disparities in terms of who was diagnosed and who was treated.[3]

The ISMICC developed its 2017 report *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers* to coordinate a comprehensive federal response to these challenges and spent the next two years moving their recommendations into action.

In 2020, the world was disrupted by a global pandemic. The social isolation, economic uncertainty, and chronic stress about the risk of infection heralded a spike in depression and anxiety.[4] The COVID-19 pandemic also created an unprecedented strain on the mental health workforce, limiting access to emergency and crisis services and severely disrupting regular mental health care at a time in which it was most critically needed.[5] Crucially, the pandemic exacerbated long-standing racial, ethnic, socioeconomic, and geographic and other disparities in access to quality mental health services.[6]

Despite the enormous loss of life and dire outcomes on mental health across the nation, the COVID-19 pandemic also accelerated momentum in federal efforts to promote mental well-being, increase access to mental health services, and bridge disparities. For instance, the pandemic:

- Created a broader awareness of mental health.
- Spurred the urgency for effective interventions.
- Accelerated the utilization of innovative service delivery models such as telehealth.
- Spotlighted longstanding systemic challenges to health equity, such as structural racism.
- Demonstrated how federal agencies and non-federal organizations could work synergistically, swiftly, and effectively toward a common goal.

Although the public health emergency of the COVID-19 pandemic has since ended, the effects of COVID-19 persist and the mental health crisis remains a challenge[7] However, there is hope. SMI and SED are treatable, and people can recover. Increased federal funding in mental health research and collaborative efforts to improve data collection have advanced the understanding of mental illness and recovery. Federal efforts have strengthened the capacity of states to respond to their communities, improve their data systems, and expand mental health services and supportive programs. For example, federal efforts have helped increase access to high-quality mental health care, such as initiatives to expand and standardize peer recovery support, the rapid expansion of Certified Community Behavioral Health Clinics (CCBHCs), and the revision of the CCBHC certification criteria to update the already rigorous standards governing the CCBHCs.

The path from federal initiative to state implementation to community impact has been forged. In 2022, the ISMICC released a supplemental report on federal accomplishments since 2017—*Advances Through Collaboration: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers*. In 2023, the ISMICC was reauthorized for another five years and now has a clear direction toward increasing its momentum to promote a system of care that provides individualized, holistic services to adults with SMI and children and youth with SED. With this clarity and renewed focus, the ISMICC will forge ahead with a new footprint—one that is solidified in its commitment to recovery, utilizes its five Working Groups to move evidence into action, and centers its focus on communities and people. This report unveils the ISMICC's new emblem that demonstrates its commitment to person-centered recovery (see ***Figure 1***), provides an update on the initiatives and scientific advances that are moving federal action in this direction, delivers an update on the status of the ISMICC's 2017 recommendations, and outlines its way forward.

Please note that all data, program updates, and federal activities outlined in this report are up to date as of December 2023.

Figure 1. The ISMICC's New Emblem

The ISMICC Emblem

The ISMICC's official emblem encapsulates both its core values and operational structure. At the heart of the logo are five interconnected rings that represent each of the ISMICC's five Working Groups. While each ring can stand alone to characterize the specialized focus of each Working Group, their interconnectedness highlights their synergy. The outer purple ring symbolizes recovery as the ISMICC's overarching mission.

Depicted within the five interconnected rings are three figures representing persons with outstretched arms, underscoring the ISMICC's person-centered, community-oriented focus. Surrounding these figures is a smaller purple ring in honor of the courageous choice made daily by people with SMI and SED in their journey towards recovery.

The Role of the ISMICC

Authorization

The ISMICC was established by Congress in December 2016 through the 21st Century Cures Act (Public Law 114-255). In December 2022, the 2023 Consolidated Appropriations Act (Public Law 117-328) reauthorized the ISMICC and codified it into statute as Section 501C of the Public Health Service Act. It is governed by the Federal Advisory Committee Act (5 U.S.C.). The ISMICC's objective is to enhance coordination across relevant federal agencies to improve access and delivery of services for adults with SMI and children and youth with SED. Section 501C of the Public Health Service Act requires the ISMICC to submit a report to Congress and other relevant departments and agencies on:

1. A summary of research advances in SMI and SED research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of SMI and SED, and advances in access to services and supports for adults with SMI or children and youth with SED.
2. An evaluation of the effect that federal programs related to SMI have on public health outcomes.
3. Recommendations for actions that agencies can take to better coordinate the administration of mental health services for adults with SMI or children and youth with SED.

This report provides an overview of promising advances in research and service delivery while highlighting Federal exemplar programs and inter-agency collaboration that embody these advances. Within the report, there is also an inventory of federal activities that support the needs of individuals with SMI and SED and information regarding the evaluation and/or data collection of one significant federal initiative from each ISMICC partner agency. Finally, there is a section dedicated to each Working Group that encompasses the current comprehensive list of ISMICC recommendations and pertinent details regarding progress towards their fulfilment.

History

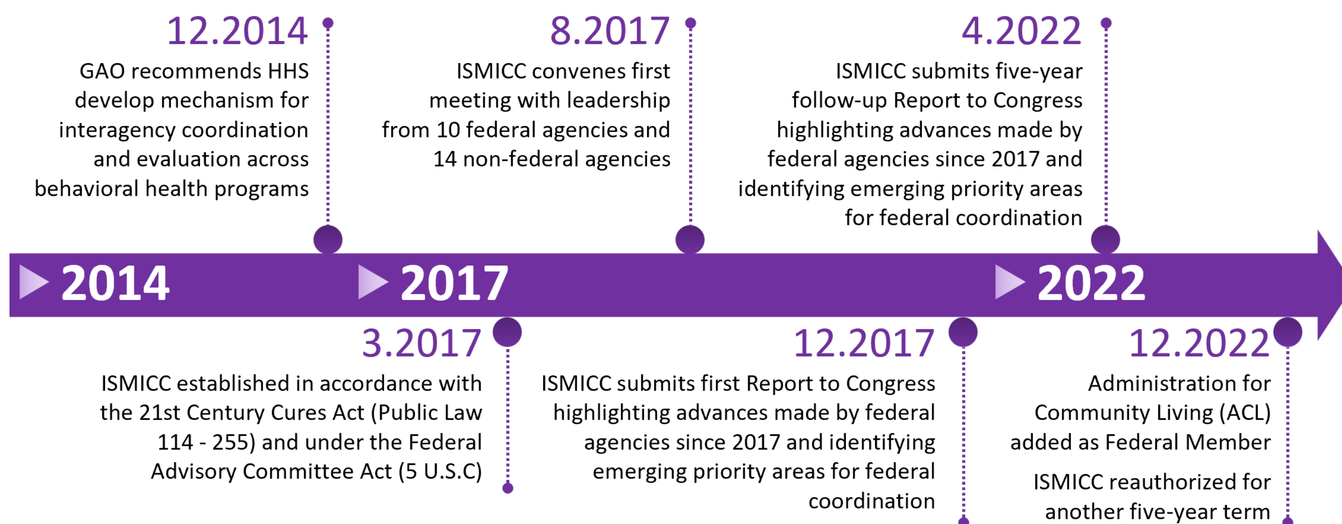
In **December 2014**, the U.S. Government Accountability Office (GAO) found that programs for SMI lacked coordination and consistency and recommended that the Department of Health and Human Services (HHS) develop a mechanism for interagency coordination across these federal programs. The ISMICC was established by Congress to respond to this call to action. The ISMICC convened its first meeting on August 31, 2017. This meeting included leadership from 10 federal agencies that have a footprint in providing services related to SMI and SED and 14 non-federal public stakeholders.

In **December 2017,** the ISMICC submitted its first Report to Congress, *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers*. The report provided 45 recommendations across five focus areas that emphasized the importance of collaboration, coordination, and planning across federal agencies with the advisory support of the non-

federal members to ensure that adults with SMI and children and youth with SED had access to the highest quality of care.

In **April 2022**, the ISMICC submitted its five-year follow-up Report to Congress, *Advances Through Collaboration: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers*. This report highlighted the advances made by federal agencies since its first report and identified emerging priority areas that would benefit from continued federal coordination and collaboration. In **December 2022**, the ISMICC was reauthorized by Congress for another five-year term and codified into statute. The ISMICC's first meeting of 2024 was on March 27.

Figure 2. The ISMICC's Timeline



The ISMICC's Operations

The HHS Secretary has designated the Assistant Secretary for Mental Health and Substance Use to serve as the ISMICC Chair. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides management and operating support to the ISMICC. As a Federal Advisory Committee, the ISMICC is supported by a Designated Federal Official (DFO)—a SAMHSA staff member—to oversee the formal administrative processes associated with the Federal Advisory Committee Act. Other SAMHSA staff coordinate and oversee the ISMICC operational planning meetings and Working Group meetings. ***Figure 3*** depicts how each of these entities interact within the ISMICC. The full ISMICC meets twice a year to review federal activities and research advances, obtain updates from its Working Groups, and develop recommendations.

Members

The ISMICC is strengthened by its interface of Federal and Non-federal Members. The ISMICC's Federal Members include representatives or their designees from:

- The Secretary of Health and Human Services
- The Assistant Secretary for Mental Health and Substance Use
- The Attorney General
- The Secretary of Veterans Affairs
- The Secretary of Defense
- The Secretary of Housing and Urban Development
- The Secretary of Education
- The Secretary of Labor
- The Administrator of the Centers for Medicare & Medicaid Services
- The Administrator of the Administration for Community Living
- The Commissioner of Social Security

The ISMICC's Non-federal Members are national experts who provide the necessary context to inform effective services, offer feedback on recommendations and priority areas, and advocate for the implementation of federal programs and activities. The ISMICC's charter ensures that the Non-federal Members include a range of representation, including members with lived experience with SMI and SED or caring for someone with SMI and SED, researchers, advocates, clinicians, social workers, peer support specialists, criminal justice professionals, and professionals who work with people experiencing homelessness. Non-federal Members serve three-year terms and may be reappointed for subsequent terms.

The ISMICC's Working Groups

The ISMICC has been granted the statutory authority to organize itself within Working Groups and has created five Working Groups to support each of the five focus areas in their 2017 report of recommendations. The Working Groups consist of Federal and Non-federal Members who meet regularly outside of regular ISMICC meetings. Working Groups focus on translating recommendations into action by activities such as prioritizing efforts, developing short- and long-term objectives, coordinating programs and policies, identifying existing activities that could be updated or optimally utilized to serve the target populations, and evaluating the feasibility and impact of specific federal initiatives and programs. Working Groups report their findings and offer action-oriented recommendations to the ISMICC. Working Groups then discuss and vote on these recommendations to

move forward or not. Appointed federal staff act as Stewards for each of the Working Groups to support their operations and report progress.

The ISMICC's five Working Groups are listed below and referenced in ***Figure 3***. A more detailed description of each can be found under each Working Group's section.

Data and Evaluation Working Group

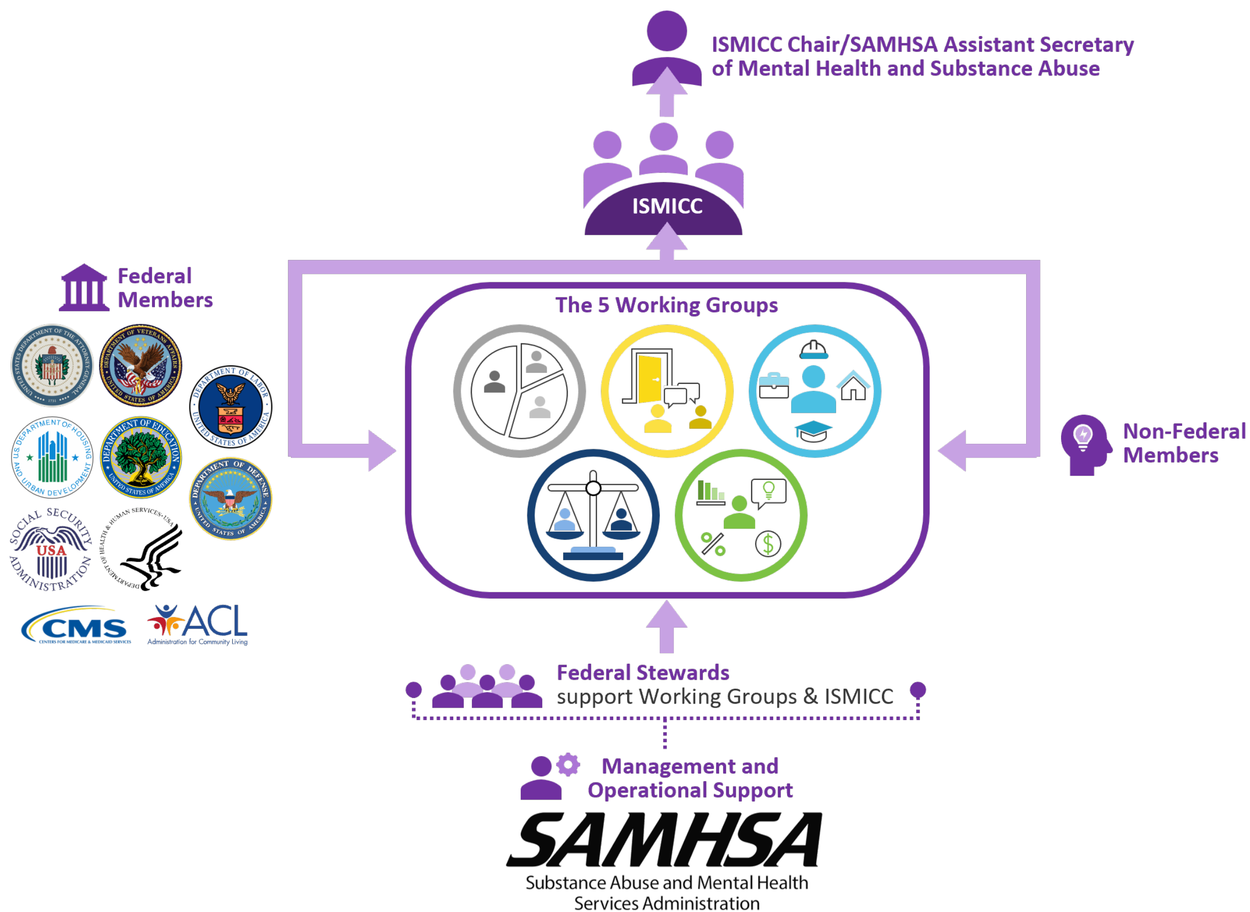
Access and Engagement Working Group

Treatment and Recovery Working Group

Criminal Justice Working Group

Finance Working Group

Figure 3. The ISMICC's Operational Structure



Public Comment

The ISMICC is both accountable to and empowered by the public it serves. ISMICC meetings are open to the public and announced in the Federal Register. Those who wish to submit public comments are encouraged to do so, either in writing prior to the meeting or in person at a designated time within the meeting agenda. Public commenters are an important voice in the ISMICC's mission. They breathe life into the ISMICC's work by sharing real-world experiences of people living with SMI and SED, caring or advocating for people with SMI and SED, and providing services to people with SMI and SED and their families. To reflect the ISMICC's commitment to these voices, each public comment is thoughtfully reviewed, organized, and distributed to the appropriate ISMICC Working Group after each meeting.

Public comments are organized using multiple criteria, including topic, the commenter's position, challenge areas, and feedback type, to determine the ISMICC Working Group best suited to address the feedback. Public comments come from various stakeholders and address a range of topics. The October 2023 ISMICC meeting, for example, had 44% of comments submitted by people with lived experience of SMI and SED or their loved ones and 56% by providers, members of advocacy organizations, and nonprofit representatives. Comment topics ranged from social determinants of health, treatment and

services, the need to improve the relationship between those receiving and providing care, support for expanding the definition of peer specialists to include parents and caregivers, and the use of the least restrictive forms of treatment.

Figure 4. Examples of Public Comments

"*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.*"
--Public Commenter (December 2021)

"*My 39-year-old son has been afflicted with mental illness since the age of five. He is an intelligent, hardworking, active churchgoing, civic-minded member of society. Over the past four years, he has become homeless, living out of his car, cycling through misdemeanors, nonviolent arrests, and numerous hospitalizations.*"
--Public Commenter (December 2021)

UNDERSTANDING SMI AND SED

What is SMI and SED?

Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) are clinical terms that can serve important functions in the healthcare system, policymaking, and research. In 1993, SAMHSA established standardized definitions[*] for SMI and SED to: 1) identify and estimate the two populations at the state-level, 2) support state-level mental health services planning, and 3) determine incidence and prevalence for Community Mental Health Services Block Grants. Based on these definitions:

> An adult with SMI is a person over the age of 18 who currently or at any time in the past year has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.
>
> A child or youth with SED is a person between birth to age 18 who currently or at any time in the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM and that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

[*] See: https://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf

It is important to remember that behind the clinical term is a person with complex, often unmet, needs.

- For instance, a young man with a family and a promising career might see his future derailed by bipolar disorder—when his sometimes-impulsive behavior leads him not to a hospital for care, but to prison for a legal infraction.
- Similarly, a middle-aged woman who has spent decades building an accomplished life may begin to experience terrifying hallucinations and paranoia. Her first episode of psychosis is misdiagnosed and untreated for several months, causing her employment, family life, and physical health to deteriorate.
- The stakes are equally high for a child with SED. Consider a teenager who experiences bullying, withdraws from friends, misses numerous school days, and is diagnosed with major depression. Their plummeting grades, feeling ostracized by peers, and perceived stigma of mental illness become too much to bear alone. They begin to self-harm and contemplate suicide as their only way out.

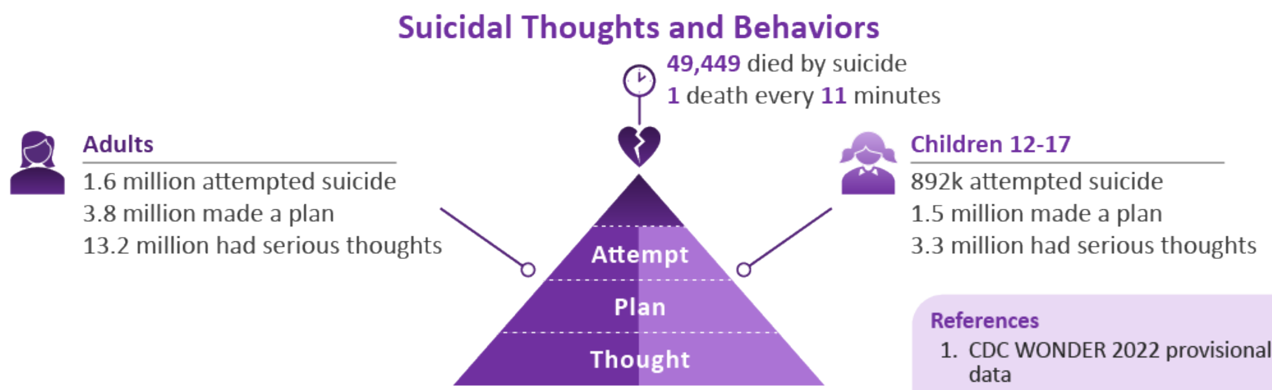
While these scenarios paint a sobering view of the challenges faced by people with SMI and SED, there is also hope. SMI and SED can be treated, and there are several advances in clinical practices and service delivery that are redefining what recovery looks like. From innovative, comprehensive treatments to accessible continuums of care—there is a compassionate, effective, and person-centered path to mental wellness.

Suicidal Thoughts and Behaviors

Suicidal ideation, suicide attempts, and suicide deaths are among the most serious outcomes associated with SMI and SED and remain a leading cause of death in the U.S. In 2022, 49,532 people died by suicide, making it the 11th leading cause of death in the U.S. Of these, 1,540 children aged 12 to 17 died by suicide, making it the 3rd leading cause of death in this age group.[8] [†]

[†] CDC WONDER data for 2022 were provisional at the time of publication and provide an early estimate of deaths before release of final data. Data can be found at https://wonder.cdc.gov/mcd-icd10-provisional.htm.

Figure 5. Suicidal Thoughts and Behaviors among Adults and Children



Determining Prevalence of SMI and SED

Despite its explicit definitions, determining the prevalence of SMI and SED is not so straightforward. **All mental illnesses can cause functional impairment that disrupts a person's life**. The "seriousness" of that disruption is subjective. SAMHSA utilizes an SMI/SED estimation methodology that facilitates the efforts of federal agencies to prioritize funding, programs, and policies to help a subset of people significantly affected by mental illness. However, this methodology is not universally accepted across all partners—including advocates, researchers, and the public. As a result, different methods are used to determine the prevalence of SMI and SED, and the data are likely undercounted. Further, prevalence data do not account for those who do not seek treatment because of persistent stigma, a lack of access to mental healthcare, or misdiagnosis. Consideration should be given to these limitations when reviewing prevalence data.

The Scope of SMI and SED

According to SAMHSA's National Survey on Drug Use and Health (NSDUH), 15.4 million adults, or 6% of the noninstitutionalized civilian adult population in the U.S., had SMI in the past year—with the highest prevalence among adults aged 18 to 25 years.[9] Although most adults with SMI received mental health care in the past year, more than half of adults with SMI who did not receive mental health treatment in the past year perceived an unmet care need. Notably, those aged 18 to 25 were most likely to have SMI in the past year, but adults in this age group who had SMI were also the least likely to receive care. Additionally, there were racial and ethnic disparities across those who had SMI and those who received mental health care. These disparities can be seen in ***Figure 7***—which, for instance, demonstrates a wide disparity among American Indian/Alaska Native people. About 7.4 million adults with SMI in the past year also had a substance use disorder (SUD) in the past year, and of the approximately 5.3 million of those who received treatment, most received only mental health services. According to the Uniform

Reporting System (URS) 2022 data, an estimated 4.6 million, or between 5 and 13% of children, were diagnosed with SED. In 2022, nearly 15% of youth had a major depressive episode with severe impairment in the past year, and only about half (53.4%) of these youth received treatment for depression in the past year.

Figure 6. The Scope of SMI and SED in the U.S. in 2022

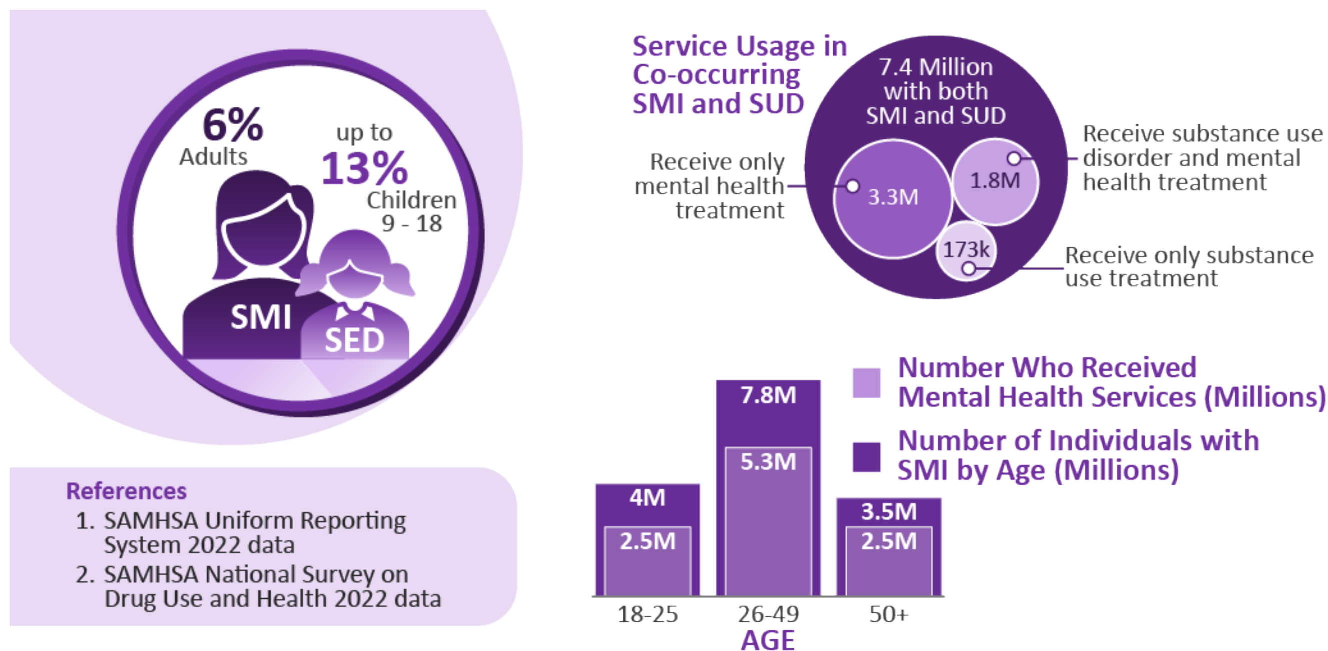
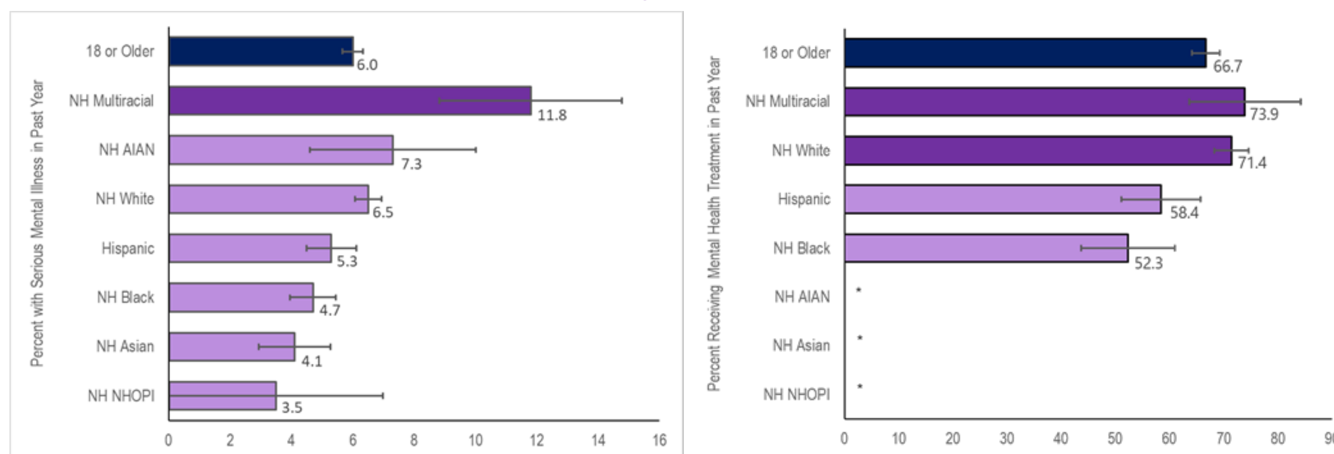


Figure 7. Percent of People with SMI compared to Receipt of Mental Health Treatment across Race/Ethnicity in the U.S. in 2022



AIAN = American Indian or Alaska Native; Black = Black or African American; Hispanic = Hispanic or Latino; NH = Not Hispanic or Latino; NHOPI = Native Hawaiian or Other Pacific Islander. Note: Error bars were calculated as 99 percent confidence intervals. Wider error bars indicate less precise estimates. Large apparent differences between groups may not be statistically significant.

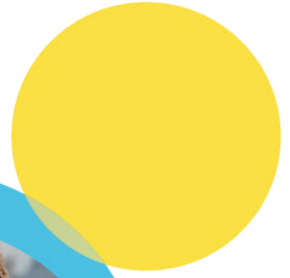
Impact of the COVID-19 Pandemic on SMI and SED

While most people agree that the pandemic negatively affected the mental health of many people, the effects of the pandemic were multifaceted and had disparate effects across different communities. For example, among people surveyed during the pandemic, Black, Hispanic, and Asian respondents reported that their mental health worsened more than White respondents.[10] It was also challenging to capture mental health data during the pandemic. Not only were mental health services limited, but research and other data collection efforts were halted as many businesses, universities, and government agencies shut down for several months.

However, some enlightening trends were captured. Researchers found that the prevalence of elevated depression and anxiety in children across the globe doubled in the first year of the pandemic. By 2021, an estimated 3.7 million youth in the U.S. had experienced at least one major depressive episode with severe impairment in the past year.[11]

Although there are no data that indicate that the prevalence of SMI and SED changed during the pandemic, these rates do not capture the full picture. Early in the pandemic, in-person mental health service usage declined by about 40% as buildings were closed and health services were limited.[7] At the same time, children's mental health-related emergency department visits began to increase, and children were more likely to be admitted and require a longer admission than before the pandemic.[12,13] There were also reports of an increased number of young adults, young women in particular, admitted to an intensive outpatient program for depression and anxiety.[14]

In short, despite a decline in mental health services overall and stricter limits on in-person care during the pandemic, there was an increase in admissions to hospitals and intensive inpatient care—suggesting that the severity of mental health needs had increased. Those who sought help did so because they were in dire need.



SUMMARY OF ADVANCES

Advances in Clinical Practices

SMI and SED are complex and nuanced, arising from multiple contributing factors such as genetic predisposition; biochemistry; and environmental, social, and psychological stressors—as well as co-occurring with substance use and other medical conditions.[15,16,17] The symptoms associated with SMI and SED can vary widely and evolve over time, further complicating accurate diagnosis and effective treatment. Furthermore, persistent stigma around mental illness can create additional barriers to both diagnosis and adherence to treatment plans.[18]

Addressing these challenges requires a robust foundation of evidence, high-quality data, and implementation strategies to bridge science to practice. Federal funding for research, efforts to improve data collection and sharing, and a focus on community-based approaches have been instrumental in driving advances in clinical practices—from understanding the scope and underlying factors of mental illness to advances in holistic, coordinated treatment and recovery services.

Understanding Mental Illness

Mental illness is inherently complex, and many factors are involved with its onset and progression. Developmental factors such as **childhood trauma** or **genetic predisposition** can interact with **environmental triggers** that influence the onset of symptoms.[19,20,21] There are subtle, prodromal[‡] factors, such as changes in sleep or social patterns, which can serve as early warning signs.[22,23] Some people with mental illness can experience periodic or cyclical crises, while others may experience a more chronic, debilitating course of illness.

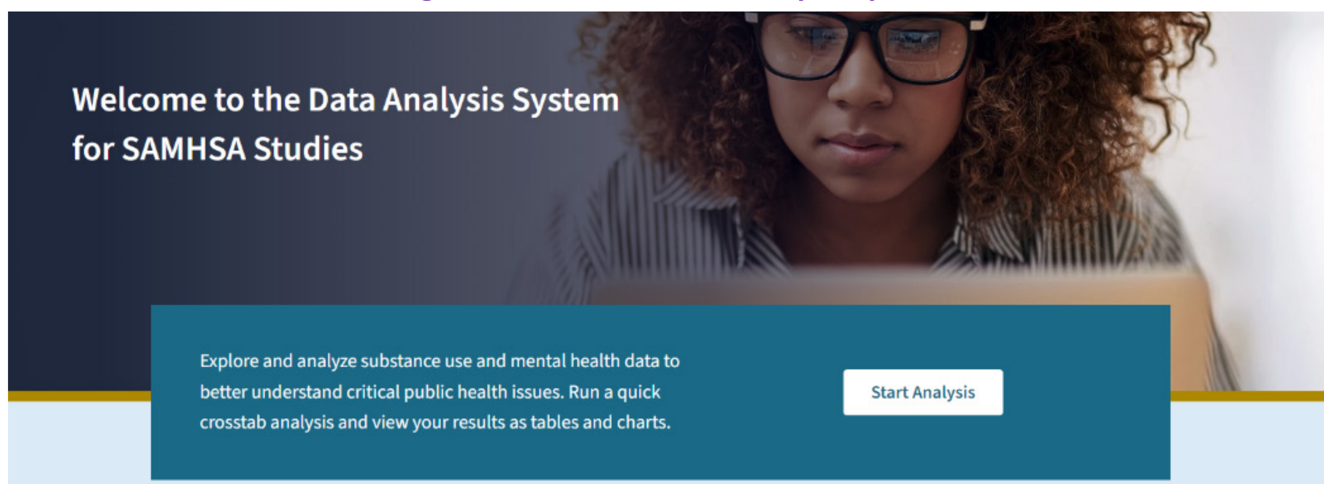
[‡]Prodromal refers to the early stage of illness in which subtle changes in feelings, thoughts, and behaviors occur before the onset of symptoms.

To better understand these complexities, researchers have begun integrating different types of data for more holistic insight into the risk, onset, and progression of mental illness. Machine learning and artificial intelligence can analyze large datasets, such as electronic health records or social media activity, to identify patterns that predict mental health outcomes. Wearable devices can offer real-time data on physiological markers, such as heart rate and sleep patterns. Genomic studies can help identify genetic markers associated with a higher risk of certain conditions. This technology is paving the way for more accurate diagnostics and targeted prevention strategies in the future.

Data Tools

SAMHSA's Data Analysis System (***Figure 8***) was updated in October 2023 and allows users to access and analyze variables from multiple data sources, including from the Mental Health Client-Level Data (MH-CLD), the National Survey on Drug Use and Health (NSDUH), and Treatment Episode Data Sets on Admissions (TEDS-A) and discharges (TEDS-D). The National Substance Use and Mental Health Services Survey (N-SUMHSS) replaced the National Survey of Substance Abuse Treatment Services (N-SSATS) and the National Mental Health Services Survey (N-MHSS) in 2021 by combining questions for substance use and mental health facilities. The N-SSATS and N-MHSS were combined to reduce burden on the facilities, optimize government resources to collect data, and enhance the quality of data collected. The Data Analysis System is online and available to anyone.

Figure 8. SAMHSA's Data Analysis System



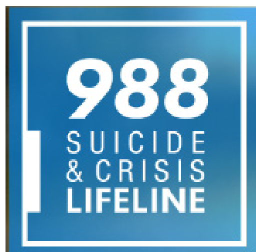
Treating Mental Illness

An effective mental health intervention is one that accounts for the multifaceted nature of mental illness and a person's unique life circumstances. Cultural and societal nuances, individual preferences, and pervasive stigma can further influence the uptake and effectiveness of an intervention.[24] Because mental

illness can manifest very differently from person to person, there is an imperative to move beyond a one-size-fits-all approach. A **tailored, person-centered approach** is needed to increase the effectiveness of treatment and improve outcomes.[25]

This necessitates a diverse array of evidence-based intervention approaches that can be adapted and implemented across a continuum of care—from crisis management to longer-term specialized treatment. Targeted and timely interventions ensure that each person receives the appropriate level of care when they need it most. The need for on-demand access to care is particularly important in crisis situations when the immediate availability of specialized care can save lives and divert individuals from unnecessary criminal justice involvement and into the treatment they need.[26,27]

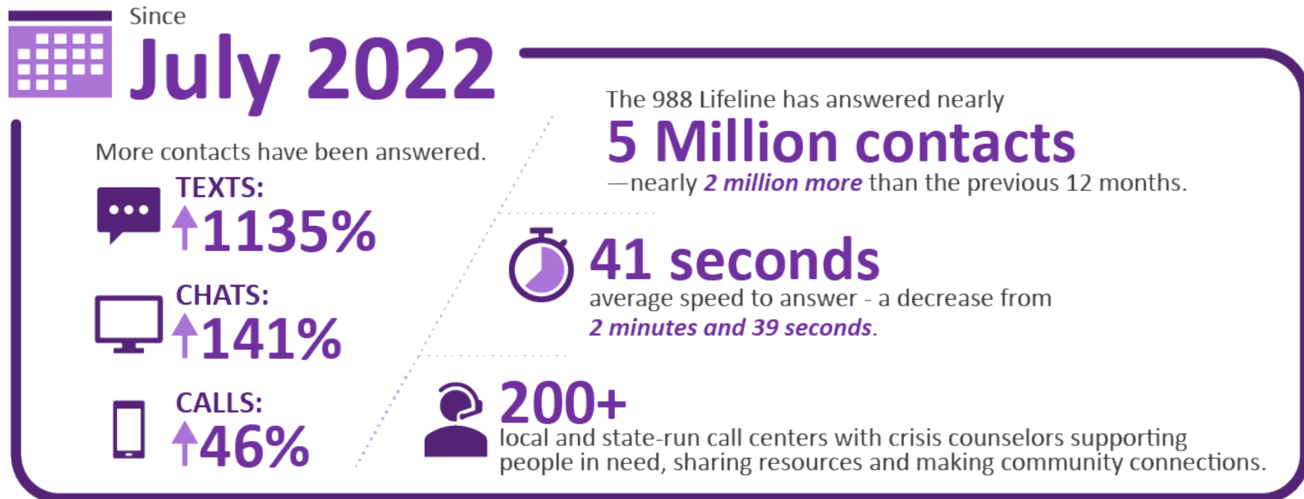
One of the ways SAMHSA is helping to bridge the gap between people and access to treatment is through FindTreatment.gov. FindTreatment.gov is the most comprehensive resource for people seeking treatment for mental and substance use disorders in the U.S. and its territories. FindTreatment.gov provides the ability to search for substance use and mental health facilities, health care centers, buprenorphine practitioners, and opioid treatment providers. SAMHSA also has designated representatives in each State Mental Health Agency and Single State Agency for substance use who are responsible for updating the status and location information for substance use and mental health facilities in their jurisdictions. Additionally, SAMHSA Launched EncuentraApoyo.gov, the Spanish language version of FindSupport.gov. This is a user-friendly website designed to help people identify available resources, explore information about various treatment options, and learn how to reach out to get the support they need for issues related to mental health, drugs, or alcohol. EncuentraApoyo.gov is not a direct translation of the English website. The content has been culturally adapted to the Hispanic audience and includes materials reflecting the Latino experience in the U.S.



Suicide prevention is a key component of crisis services. Within the ISMICC, suicide prevention is a collaborative effort between Federal Members (who contribute expertise and resources) and Non-federal Members (who promote the implementation of evidence-based practices at the local level). One significant advance in suicide prevention has been the **988 Suicide & Crisis Lifeline**. Launched in July 2022 as a transition from the National Suicide Prevention Lifeline, 988 provides a vital resource for people in a behavioral health crisis, offering the option to call, text, or chat with one of the more than 200 24/7 crisis contact centers nationwide. In order to improve language access, the 988 Suicide & Crisis Lifeline has been expanded with Spanish text and chat services to allow Spanish speakers in crisis to reach trained and culturally competent crisis counselors. Additionally, the Lifeline has adopted specialized call, chat, and text supports for LGBTQI+ youth and young adults under the age of 25, as well as American Sign Language and videophone services for people who are deaf or hard of hearing and for whom videophone and chat is a preferred method of communication. Not only

has there been an increase in the number of calls, texts, and chats since the transition, but the speed at which someone can reach a crisis counselor after contacting 988 has also increased (***Figure 9***).

Figure 9. 988 Lifeline Performance Metrics (July 2022 through June 2023)



The Federal Communications Commission (FCC), the Department of Veterans Affairs (VA), the Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), the Office of the Surgeon General (OSG), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the Department of Transportation (DoT) have also been critical in 988's launch, evaluation, and related suicide prevention efforts.

Not only does SAMHSA support the coordination of online access to the 988 Lifeline, but SAMHSA also supports the transformation of the crisis continuum nationwide. Building upon its national guidelines, SAMHSA has identified three main key components to a national crisis system— "**Someone to Contact"** through the 988 Lifeline, "**Someone to Respond"** through mobile crisis teams, and "**A Safe Place for Help"** through crisis receiving and stabilization supports.

SAMHSA is committed to both advancing and actively engaging in the collaborative revision of the National Strategy for Suicide Prevention (NSSP). SAMHSA's NSSP grant program aims to prevent suicide and suicide attempts among adults by supporting efforts to implement suicide prevention and intervention programs, as outlined through the 2021 Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention. The program supports a broad public health approach to suicide prevention and aims to raise awareness of the resources available to prevent suicide; promote help seeking behavior; establish referral processes and improve outcomes for individuals at risk for suicide; and enhance collaboration with key community stakeholders such as county health departments, workplaces, justice settings, senior-serving organizations, and community firearm stakeholders.

In June 2022, SAMHSA's Center for Mental Health Services (CMHS) established the Black Youth Suicide Prevention Initiative (BYSPI) to develop and implement strategies to address the Black youth suicide crisis. BYSPI aims to reduce the rates of suicidal ideation, behaviors, attempts, and suicide deaths among Black youth and young adults between the ages of 5 and 24.

The **Mental Health Services Block Grant Transformation Transfer Initiative (TTI)** program provides $250,000 to community-based programs to identify, adopt, and strengthen innovative initiatives. Enhancing equitable access to suicide prevention and crisis care for underserved communities is one of the active TTI topics and some of the states that participated in the Policy Academy are using these funds to support implementation of the plans that were developed.

In 2023, SAMHSA funded two new resource guides for improving equity in suicide prevention. Hope: A Guide for Faith Leaders to Help Prevent Youth Suicide was published by SAMHSA-funded National Action Alliance for Suicide Prevention, SAMHSA-funded Suicide Prevention Resource Center, and the HHS Center for Faith-based and Neighborhood Partnerships (Partnership Center) and was designed to provide faith leaders with guidance for identifying and helping youth who may be at risk for suicide. The Suicide Prevention Resource Center also published Mental Health Promotion and Suicide Prevention for LGBTQIA2S+ Youth: A Resource Guide for Professionals, Families and Communities, a series of guides to help professionals, families, and communities support the mental well-being of LGBTQIA2S+ youth.

One critical advance in clinical intervention has been the recent expansion of **mobile crisis teams** (i.e., "Someone to Respond"), which provide mental health and substance use services wherever people in need are. Mobile crisis teams have many compositions but, according to the SAMHSA National Guidelines for Behavioral Health Crisis Care, should include a team of a licensed mental health professional and other community mental health service providers who are trained to assess and de-escalate a crisis situation. These team members provide both adults and children with immediate clinical assessments, emergency behavioral health supports, and connection to the most appropriate community resources. The mobile crisis team expansion is an example of a program that spanning multiple different initiatives, across multiple different federal agencies.

In 2023, SAMHSA held its first Local Behavioral Health Crisis System Policy Academy focused on the development of a crisis continuum for rural and remote communities. The goals of the Policy Academy were for teams to develop person-centered action plans that focused on increasing access to crisis care, identifying and closing gaps within crisis systems, building system capacity, increasing interagency communication and collaboration, and incorporating evidence-based and best practices. The plans focused on identifying and addressing relevant policy, systems, and environmental changes to

strengthen the local crisis continuum. Six teams participated, which included counties, regional collaboratives, and a territory. A similar second Policy Academy was also hosted in July 2024 which also included a tribal team. The 988 and Behavioral Health Crisis Coordinating Office also held a state-level policy academy in April of 2024 that was focused on system design as well.

The Community Mental Health Services Block Grant program is a formula grant distributed annually to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and six Pacific jurisdictions to support State Mental Health Authorities in the development and expansion of a comprehensive, community-based, mental health service system for people with SMI and SED. The Mental Health Services Block Grant program includes two required set-asides: a 5% crisis-set aside and a 10% early intervention set-aside. The 5% crisis care set-aside supports evidenced-based programs that address the crisis care needs, which may include individuals with SMI and SED who are experiencing mental health crises. States are able to use the Mental Health Services Block Grant and its set-aside for mobile crisis services.

The **Community Crisis Response Partnership** program supports states, localities, territories, tribes, and tribal organizations in establishing new or enhancing existing mobile crisis response teams that divert the response for mental health and substance use disorder crises from law enforcement to behavioral health professionals. The **Certified Community Behavioral Health Clinic (CCBHC)** model also includes mobile crisis care as a required service. Both programs can also divert individuals in crisis away from emergency departments as well.

The CCBHC program is a rapidly expanding cross-governmental initiative between SAMHSA, the Centers for Medicare & Medicaid Services (CMS), and the Assistant Secretary for Planning and Evaluation (ASPE). CMS is long engaged in promoting access to crisis response services in a number of ways, including by providing technical assistance to State Medicaid agencies to help them access 85% federal Medicaid matching payments for mobile crisis services that meet requirements established in Section 9813 of the American Rescue Plan Act (P.L. 117-2).

CMS previously provided $15 million in planning grants to 20 states to support implementation of community-based mobile crisis intervention services that would meet the statutory requirement for enhanced federal Medicaid match. Foundational to these efforts has been a State Health Official Letter issued by CMS specifying the requirements for mobile crisis intervention services to be eligible for the temporary increased federal matching funds and also describing a number of additional ways states may support crisis services for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. As of June 2024, CMS has approved 18 states and the District of Columbia for the enhanced federal Medicaid match for mobile crisis services. CMS also has modified the Medicaid prospective payment system (PPS) policy for the CCBHC demonstration to support and stress the importance of CCBHCs providing crisis

response services in their communities. In addition, as required by Section 5124 of the Consolidated Appropriations Act, 2023 (P.L. 117-328), CMS is collaborating with SAMHSA to develop new guidance and a technical assistance center focused on improving awareness among states of how Medicaid and CHIP can support delivery of crisis response services.

While crisis services provide time-critical interventions in emergency situations, there are other moments in which intervention can significantly impact the trajectory of a person's mental health and well-being. Whether it occurs in childhood or later in life, a **first episode of psychosis or mania** is a critical period in which to intervene. Prodromal signs such as confused thinking can be important early indicators of a psychotic disorder, but early intervention and specialized care can improve outcomes.

Coordinated Specialty Care (CSC) is a holistic, comprehensive treatment approach designed to be implemented soon after first episode psychosis. CSC encompasses five core activities: cognitive or behavioral psychotherapy, medication management, family education and support, service coordination, case management, and supported employment and education. In 2014, Congress directed SAMHSA to set aside funds from its Mental Health Services Block Grant program to cover CSC services. In 2023, SAMHSA released a guide to financing Coordinated Specialty Care for First Episode Psychosis.

Coordinated care is important not only as an early intervention for first episode psychosis but also for the more than **7 million people in the U.S. who have co-occurring SMI and SUD**.[2] Only two-thirds of people with co-occurring SMI and SUD receive services—a vast majority of whom only receive mental health services.[11] SAMHSA promotes integrated, personalized treatment approaches, ensuring that there is "no wrong door" for a person needing treatment for both mental health and substance use.

Treatment-Resistant Depression

In 2019, the Food & Drug Administration (FDA) approved esketamine for adults with treatment-resistant depression. Studies found that esketamine was safe and effective in most patients who had not responded to standard treatments for depression and could be administered in an outpatient setting.[28] Any drug that meets the definition of a covered outpatient drug and for which the manufacturer has signed a rebate agreement must be covered for medically necessary indications through Medicaid.

Living with and Recovering from Mental Illness

Recovery from mental illness is a journey that often extends beyond traditional treatment. It encompasses not only relief from symptoms but also a holistic approach for restoring one's sense of self, empowerment, engagement with the community, and independence across life's day-to-day activities. Recovery is dependent on multiple factors, including one's personal history, support systems, resilience, and societal and cultural attitudes. It requires a comprehensive, sustainable approach and an integration of healthcare and community resources, and SAMHSA has instated the Office of Recovery in the Office of the Assistant Secretary to elevate the need for a recovery lens in the care for individuals with behavioral health needs. **The goal of recovery is to thrive, not just survive**.

One significant challenge in supporting recovery from SMI and SED is the **growing shortage of mental health professionals**—a shortage that disproportionately impacts rural areas and that was exacerbated by an increased demand for mental health services during the COVID-19 pandemic.[29] Additionally, there is a lack of diversity in the mental health workforce, making it more difficult for Black, American Indian/Alaska Native, Hispanic, and LGTBQI+ people to receive sensitive, culturally- and linguistically-appropriate care.[30,31]

The **Minority Fellowship Program (MFP)** is SAMHSA's oldest workforce grant program and is jointly funded by CMHS, the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). It aims to reduce health disparities and improve behavioral health outcomes for underserved racial and ethnic populations by offering scholarships, or fellowships, to people pursuing degrees in various fields of behavioral health including psychiatry, psychology, social work, marriage and family therapy, nursing, mental health counseling, substance use and addictions counseling, and addiction medicine. Each year, about 200 fellows are awarded educational scholarships, which are provided through eight national behavioral health organizations. Since 1973, there have been over 5,000 fellows. In June 2023, SAMHSA celebrated the 50th Anniversary of the MFP.

Peer Recovery Support Specialists are an important and effective component of a holistic mental health workforce.[32] Peer supporters are those who are successfully navigating their own recovery or supporting the recovery of a family member and who help other people in their community reach their recovery goals. To ensure that peer support workers have the core competencies needed to provide high-quality services, SAMHSA has developed several resources[§] to train potential peer support workers and

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[§] SAMHSA resources for Peer Support Workers can be found at https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

integrate them into behavioral healthcare service delivery systems, including SAMHSA's National Model Standards for Peer Support Certification. CMS issued updated guidance on Medicaid and CHIP coverage of peer support services.

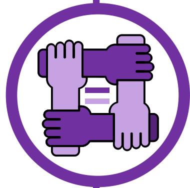
Psychosocial interventions are another holistic, person-centered approach that promotes independence and self-management through skills training, integrated medical and mental health care, peer support networks, and case management. Older adults with SMI can particularly benefit from psychosocial interventions, as they can be more likely to have co-occurring medical conditions, are isolated, have inadequate access to preventive care, and experience fragmented care coordination.[33] SAMHSA's guide for older adults with SMI provides healthcare providers with guidance and resources for supporting this vulnerable population with evidence-based psychosocial approaches.

Federal agencies recognize the profound impact of social determinants of health and are actively addressing the structural inequities often faced by people with SMI and SED, as well as minoritized populations. In October 2022, SAMHSA's Office of Behavioral Health Equity launched its updated version of the Disparity Impact Strategy (DIS 2.0), which requires that all SAMHSA funded discretionary grant recipients submit a statement identifying a disparity vulnerable, underserved ethnic/racial minority population. The grantee must describe how they will outreach and engage this population and improve access, services, and outcomes. All grantees submit data on their service population and outcomes as part of their federal performance measurement requirements. In recent years, several federal agencies have launched initiatives to support areas that can be particularly challenging to people with SMI and SED. These initiatives aim to reduce disparities and promote independence and well-being. Some of these initiatives have been highlighted in the callout box below.

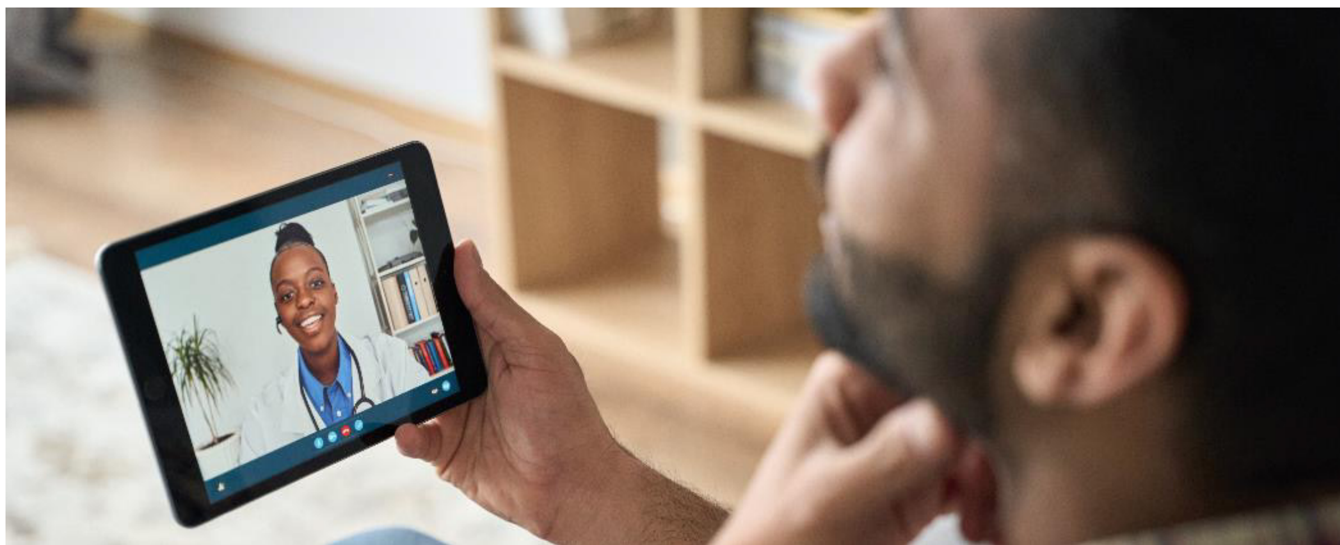
Social Determinants of Health

Education, employment, and housing are among the most impactful social determinants of health on mental wellbeing and access to high quality care. Federal agencies work synergistically to develop programs and initiatives that support people with SMI and SED in their entry into the workforce and into safe, stable housing. Some of these initiatives include:

- **Supported education** helps children, transitioning youth, and adults with resources such as academic counseling, skills training, and inclusive environments. The Department of Education's (ED) new Career Z Challenge supports innovative education approaches to help today's students become members of tomorrow's workforce.
- The DOL provides several supported **employment programs** to help transitioning youth and adults with SMI find and maintain meaningful employment. Their Employment First State Leadership Mentoring Program offers a framework for the system changes needed to integrate people with SMI and other disabilities into the workforce. DOL also offers apprenticeship programs to support transition-aged youth preparing to move from a school to a supportive work environment. In 2023, SAMHSA funded 13 Supported Employment programs through the Transforming Lives through Supported Employment Grant program (7 in 2019 and 6 in 2023). SAMHSA plans to hold a 2024 Policy Academy focused on Supported Employment in CCBHCs. SAMHSA also funds supported employment through other programs such as the CCBHC program and the Mental Health Block Grant.



- **Stable housing** is the cornerstone of well-being for people with SMI and SED, who often need affordable options and varying levels of support. Structural racism can add another challenge that impedes access to safe and affordable housing. Through their Section 811 Supportive Housing for Persons with Disabilities program, HUD promotes affordable housing through subsidies to housing developers and rental assistance to state housing agencies. HUD's Section 8 Housing Choice Voucher program, including Mainstream and Non-Elderly Disabled vouchers that are targeted specifically to people with disabilities, provides people with a choice of housing options that meet specific criteria for health and safety. SAMHSA's Treatment for Individuals Experiencing Homelessness (TIEH) expands access to mental health and substance use services to people experiencing homelessness, including people with SMI and SED. The goal of TIEH is to increase access to evidence-based treatment, services, and peer support to promote recovery and connection to permanent housing. In addition to strengthening behavioral health treatment, TIEH grants require linkage to homelessness Continuum of Care coordinated entry systems.
- Access to safe housing, healthy food, transportation, and other basic needs can have a significant impact on a person's mental health. CMS has recently clarified through multiple guidance documents and initiatives how states can access a variety of Medicaid authorities, e.g., state plan authorities, sec. 1915 home and community-based services (HCBS) waivers and state plan programs, managed care in-lieu-of services and settings (ILOSs), and section 1115 demonstrations, as well as CHIP Health Service Initiatives (HSIs).



Advances in Service Delivery

SMI and SED encompass a wide range of variability—from different types of mental health and co-occurring disorders to evolving treatment and support needs over a person's lifespan. Further, there can be **barriers to essential services**, such as persistent stigma, limited geographical access, financial challenges, and fragmented service systems.[34] The delivery of mental health services must therefore be flexible, adaptable, equitable, and responsive to individual needs.

Federal initiatives to expand access to services, promote equitable service delivery, and tailor service delivery to individuals and communities help people with SMI and SED overcome barriers and receive the treatment and support they need. Research has shown that integrating mental health services within other health systems, leveraging technology to expand access to services, and meeting people where they are can help reduce the stigma of seeking mental health care, overcome socioeconomic barriers, and ensure that people receive high-quality care.[35,36] Despite inducing multiple negative socio-economic effects, the COVID-19 pandemic accelerated several federal initiatives to advance service delivery.

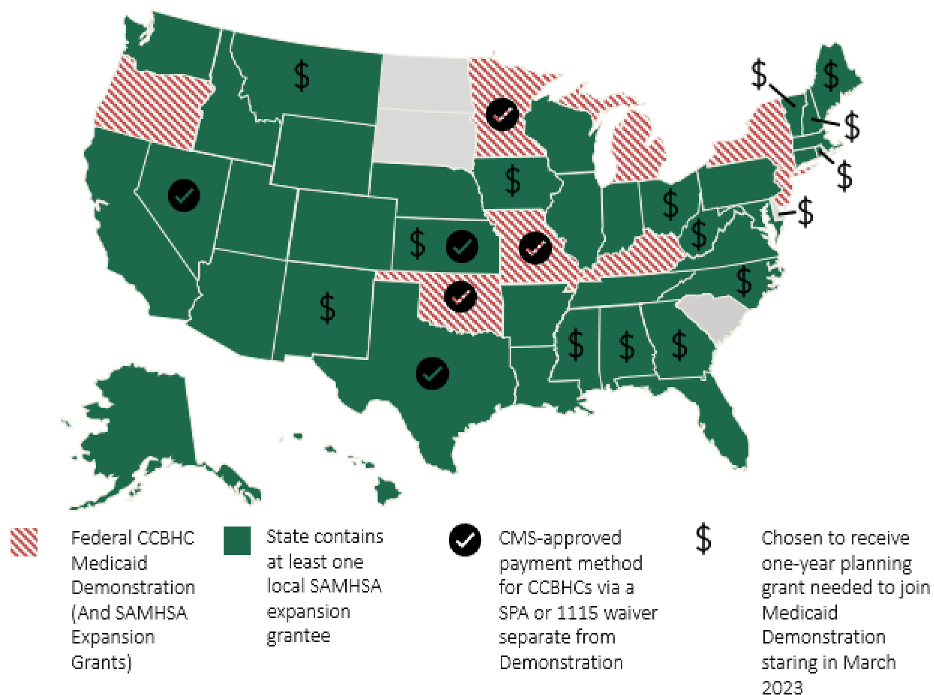
For example, the pandemic accelerated the adoption of **telehealth** technologies, which allow a person to receive services anywhere they can connect to a telephone, mobile phone, or computer with internet access—reducing the need to travel and minimizing disruption to work or other daily activities. People can receive one-on-one virtual therapy, participate in virtual group therapy, participate in online medication management visits, and integrate telehealth with in-person services. Telehealth can also help decrease wait times, reduce costs often associated with mental health services such as travel or childcare costs, and overcome stigma-fueled reluctance to seek mental health support.[37,38] Federal agencies are continuing to advance telehealth services through initiatives that expand coverage for telehealth for

mental health services, including increasing the accessibility of telehealth services under Medicaid and Medicare and providing evidence-based guidance such as SAMHSA's Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders resource guide.

The **Certified Community Behavioral Health Clinic (CCBHC)** program is an initiative designed to increase access to comprehensive, quality mental health and substance use services. CCBHCs are required to deliver a broad range of mental health and substance use services, including 24/7 support for people in crisis to anyone—regardless of ability to pay or place of residence. CCBHCs offer nine core services including a broad range of mental health, SUD services, primary care screening, care coordination, monitoring, and recovery supports, and must offer developmentally appropriate care across the lifespan. CCBHCs are required to assess clinical care needs, immediately respond to crises, and provide routine services within 10 business days—significantly reducing the long wait times that are common for mental health care and reducing the need for more intensive services such as emergency room admission or hospitalization.

CCBHCs are also required to provide services during times that meet community needs, including evenings and weekends. Currently, there are more than 500 CCBHCs operating across the country, either participating in the Section 223 CCBHC Medicaid Demonstration program that established the CCBHC model, receiving support though SAMHSA's CCBHC expansion grants, or as part of an independent state CCBHC program outside of the CCBHC demonstration program. SAMHSA supports this growing network of CCBHCs through two technical assistance centers. One center, the Certified Community Behavioral Health Clinic (CCBHC) State Technical Assistance Center (CCBHC S-TAC), is focused on supporting individual clinics in the execution of the comprehensive service model. The other center focuses on supporting states during the planning stage to engage in the demonstration program or assisting states who are already a part of the demonstration with systems-based approaches to provide high-quality CCBHC services throughout the state.

Figure 10. Map of CCBHCs Across the United States as of February 2024

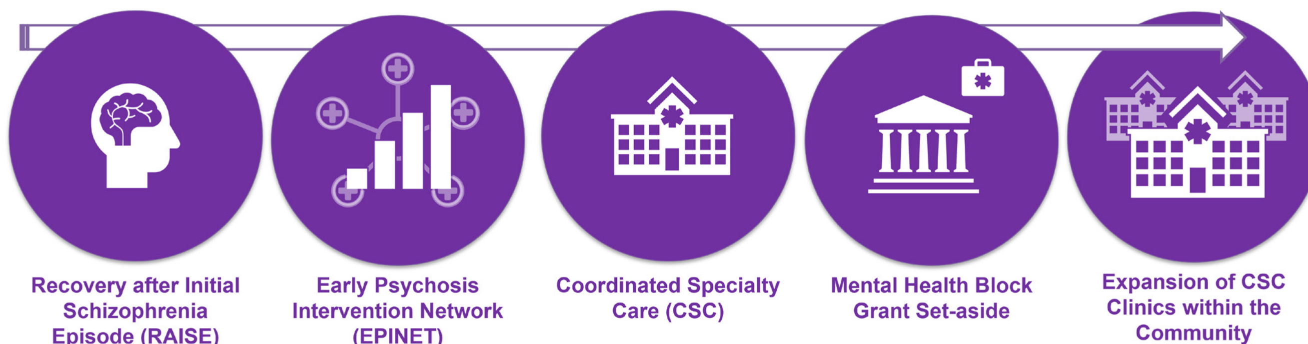


People with SMI and SED often have co-occurring, chronic physical health challenges that can create barriers to recovery and well-being. Too often, mental health and physical health are treated in isolation from each other, leading to fragmented treatment and poor outcomes. **Integrating mental health and substance use services into primary care settings** can overcome these challenges. Indeed, research indicates that primary care settings support nearly one-third of services for SMI.[39] Primary care settings are an opportunity to support otherwise unmet mental health needs, but it is important that primary care providers have access to resources for integrating mental health into their practice. SAMHSA's **Promoting the Integration of Primary and Behavioral Health Care (PIPBHC)** program is available to states working in collaboration with qualified community programs, health centers, rural health clinics, Federally Qualified Health Centers, or primary care practices serving adult and/or pediatric patients. The grants support the improvement of integrated care by promoting full integration and collaboration in clinical practices between physical and behavioral health care. Adults with SMI and youth with SED who also have co-occurring health problems are potential special populations of focus for this grant program.

SAMHSA funds the **Center of Excellence for Integrated Health Solutions**, which provides innovative tools and resources for organizations interested in integrating primary and behavioral health care. Integrated care recently emerged as a federal priority. SAMHSA, CMS, and other federal agencies aim to advance the implementation of integrated care through technical assistance, guidance, and funding opportunities to states and organizations seeking to de-silo these services.

Another holistic approach to mental health services is **Coordinated Specialty Care (CSC)**, which integrates different treatment modalities tailored to an individual's specific needs. Data from the multi-center National Institute of Mental Health (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) research initiative served as a prototypical proof of concept that a particular array of services known as CSC for individuals in the prodromal stage of psychotic disorders, a set of common conditions associated with SMI and SED, was more effective than treatment as usual. The initiative demonstrated not only an improvement in engagement, but also an improvement in recovery-related outcomes.[40] RAISE emphasized shared decision-making between the patient, families, and the care team to develop a program of therapy, medication management, supported employment and education, and care management to address daily living skills. NIMH's Early Psychosis Intervention Network (EPINET) now funds scientific hubs connected to CSC programs, as well as a national data coordinating center to further study this work.

Figure 11. Expansion of Evidence-Based Coordinated Specialty Care through Federal Funding



However, financing a comprehensive care delivery framework, such as CSC, can be a challenge. Based on the foundational research demonstrating the effectiveness of these programs, Congress mandated that states and territories support these services through a 10% early intervention set-aside investment of SAMHSA's Community Mental Health Services Block Grant. This funding catalyzed a rapid expansion of these CSC programs across the country. This expansion was enumerated in SAMHSA's Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies. According to that report, there were about 59 CSC teams nationally in 2014—the first year of the Community Mental Health Services Block Grant First Episode Psychosis funding. As of 2022, there were an estimated 381 programs.[41] This growth has been made possible by "braiding" or coordinating funds from a variety of sources, including the Community Mental Health Services Block Grant program, Medicaid, state funding, local funding, and funding captured through commercial insurance policies. SAMHSA's Coordinated Specialty Care for First Episode Psychosis provides guidance on the different financing options to help sustain this important service approach.

Community programs for outreach and intervention with **Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P)** is another service delivery model that aims to identify, intervene, and lessen the impact of psychotic disorders. SAMHSA has funded several CHR-P initiatives aimed at delivering evidence-based services to high-risk youth and young adults. SAMHSA also funds the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (also known as the Children's Mental Health Initiative or CMHI). The CHMI program supports states, territories, local government, and federally recognized tribes and tribal organizations in the implementation, expansion, and integration of the systems of care approach by creating sustainable infrastructure and services. The overall goal of the program is to improve the mental health outcomes for children and youth with SED and their families. Grantees are provided technical assistance on the implementation of evidence-based practices through the National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC). Similarly, the **Circles of Care program** provides Tribes and Tribal organizations with tools and resources to plan and design a family-driven, community-based, and culturally and linguistically competent system of care for children.

Coordinated care and early intervention are also key to managing SED in children and transition-age youth for several conditions. The effect of the COVID-19 pandemic[42] and the alarming rise of suicide rates among children and youth underscore the urgency of advancing innovative service delivery models that are responsive to the unique needs of this at-risk population.

In addition to the advances in service delivery, SAMHSA promotes the **Zero Suicide** model which is available to support evidence-based suicide prevention healthcare delivery. Zero Suicide is a comprehensive, multi-setting approach designed to improve suicide care within both physical health and behavioral health systems. Its aspirational goal is to prevent suicides by utilizing system-wide approaches to identify and intervene with individuals who are at risk for suicide. The SAMHSA Zero Suicide grant program supports the implementation of the Zero Suicide intervention and prevention model for adults throughout a health system or systems.

School-Based Health Services

Providing mental health services in schools is a mechanism to overcome access barriers so that *all* students—regardless of background, race or ethnicity, location, gender-identity or sexual orientation—have access to the supports they need for mental well-being and academic success. Several ISMICC Federal Member agencies have programs that are designed to expand access to school-based services for our nation's youth.

SAMHSA's Project AWARE (Advancing Wellness and Resiliency in Education) is one of several grant programs that supports youth in schools. Project AWARE supports a sustainable infrastructure for school-based mental health services. Grantees work to build collaborative partnerships with the State Education Agency, Local Education Agency, Tribal Education Agency, State Mental Health Agency, community-based providers, school personnel, community organizations, families, and school-aged youth to implement a spectrum of services, including mental health-related promotion, awareness, prevention, intervention, and resilience activities, to ensure that students have access and are connected to appropriate and effective behavioral health services.

Sustainability is achieved by building school mental health infrastructure, changing policies, establishing key partnerships, and expanding mental health referral pathways both in the school and communities. The Department of Education's (ED) Mental Health Services Professional Demonstration Grant provides funding to support training for mental health services providers to work in schools and local educational agencies. Similarly, their School-Based Mental Health Services Program provides funding to educational agencies to increase the number of credentialed mental health service providers. In May 2023, CMS released their Delivering Services in School Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, a school-based health guide that complements the infrastructure building work that is done through the AWARE grants through the provision of guidance for how to bill Medicaid and CHIP in school-based settings. In addition, CMS announced on June 25, 2024, that eight grant awards for $2.5 million each over three years would fund the implementation, enhancement, and expansion of Medicaid and CHIP school-based services.

THE ISMICC 2024 RECOMMENDATIONS

The ISMICC's Working Groups

The ISMICC's five working groups consist of Federal and Non-federal Members who meet regularly to discuss ways to translate the ISMICC recommendations outlined in the 2017 Report to Congress into action. The Working Groups were organized around the five Focus Areas listed below. ISMICC members are significantly assisted in their work by the involvement of subject matter experts from each of the participating federal departments. Federal Members lend their knowledge of innovations, programs, and policies to identify federal levers of change to advance ISMICC recommendations.

It should be noted that within Focus Area 1, four recommendations address the operation of ISMICC (1.1, 1.2, 1.3, and 1.4), guide all the ISMICC's recommendations, and are therefore delegated to SAMHSA as the agency providing management support to the ISMICC. The remainder of the recommendations in Focus Area 1 are centered on data and evaluation, which prompted the creation of a Working Group focused on data and evaluation.

Focus Area 1: Data and Evaluation Working Group to promote data-driven services and supports for people with SMI and SED

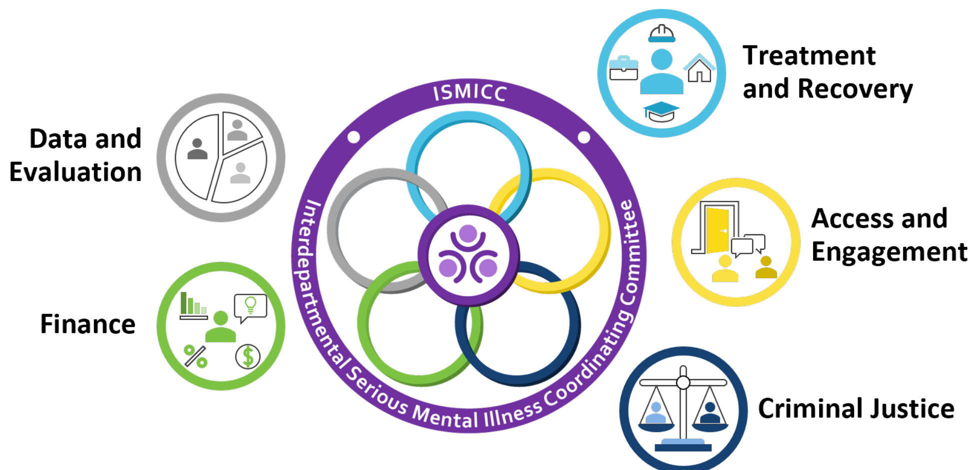
Focus Area 2: Access and Engagement Working Group to make it easier to get good care

Focus Area 3: Treatment and Recovery Working Group to close the gap between what works and what is offered

Focus Area 4: Criminal Justice Working Group to increase opportunities for diversion and improve care for people with SMI and SED involved in the justice system

Focus Area 5: Finance Working Group to develop finance strategies to increase availability and affordability of care

Figure 12. The ISMICC's Working Groups



There are multiple recommendations, and the Working Groups—under the direction of the full ISMICC—identify priority recommendations on which to focus their attention and efforts. The following sections outline ISMICC's updated 2024 Recommendations and highlight notable federal accomplishments towards implementing the recommendations. Numerated below, **N** indicates that a recommendation is new. **R** indicates that a recommendation has been revised since 2017. The first section provides an overview of the first four overarching recommendations from Focus Area 1 that fall under SAMHSA's support. The remaining five sections outline each Working Group's activities and accomplishments.

The ISMICC Overarching Recommendations

Focus Area 1a: Strengthen Federal Coordination to Improve Care

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

Since 2017, SAMHSA has worked diligently to support the coordination of federal activities for people with SMI and SED. SAMHSA's Assistant Secretary for Mental Health and Substance Use serves as the designated ISMICC Chair and undertook the role of its ongoing coordination. SAMHSA staff also serve as management and operational support for the ISMICC, convene the ISMICC meetings, coordinate and lead Working Group meetings, assemble inventories, respond to legislative inquiries and constituency questions, and prepare reports to Congress.

The ISMICC adopted recommendations made by Non-federal Members in its 2017 report to Congress, used the recommendations as a blueprint for coordinating activities to improve the lives of people with SMI and SED and their families, and updated the recommendations over time. The ISMICC conducts an inventory of federal activities, the most recent inventory of which is included under the Evaluation of Federal Activities for SMI and SED section of this report on page ***48***. The ISMICC's five Working Groups are dedicated to promoting federal coordination to harmonize and improve policies that impact people with SMI and SED and meet frequently throughout the year to coordinate activities, policies, and programs, as well as advance the ISMICC's recommendations into practical solutions.

Data and Evaluation Working Group

Focus Area 1b: Promote Data-Driven Services and Supports for People with SMI and SED

1.5 Evaluate the federal approach to serving people with SMI and SED.
1.6 Use data to improve quality of care and outcomes.
1.7 Identify and work to build on previous efforts to develop a quality measure that measures the use of measurement-based care in community-based behavioral health settings. **N**
1.8 Improve national linkage of data to improve services.

People with SMI and SED often have serious, complex needs. Many individuals present with comorbid health conditions such as heart disease, diabetes, or substance use disorders that require integrated treatment plans and monitoring of treatment interactions. They live in different regions with varying levels of access to mental health services, different socioeconomic backgrounds, and diverse cultural needs.

Tailoring treatment to a person's needs, expanding health services in areas with limited health services, and targeting policies to optimize mental health outcomes requires knowledge about individual outcomes; population-level insights; and the effectiveness of services, programs, and policies.

However, there tend to be **silos** across mental health care, medical services, SUD services, and other services (e.g., support for cognitive disabilities). There may also be silos in payment for services across different health care payers. As a result, the data needed to understand the needs of people with SMI and SED are too often impossible to capture in a meaningful way.

The ISMICC's **Data and Evaluation Working Group** focuses on understanding the need for, availability of, and access to evidence-based services. Efforts to standardize screening and assessment tools, coordinate data collection and linkages, and monitor the implementation and outcomes of mental health services are critical for identifying need gaps, developing treatment approaches, and improving outcomes over time.

Over the last five years, Federal Members from the Administration for Community Living (ACL), the National Institute of Mental Health (NIMH), the Office of the Assistant Secretary for Health (OASH), and the Veterans Health Administration (VHA), as well as Non-federal Members, have shared their knowledge in this area, bringing multiple perspectives and valuable insights about both challenges and successes.

Promoting Data-Driven, Person-Centered Care

The Data and Evaluation Implementation Working Group has focused on implementation of **measurement-based care** for behavioral health services in community settings as a priority effort. Measurement-based care is an evidence-based clinical approach to care that uses standardized, validated, repeated measures to track and inform treatment quality and outcomes. The Working Group identified this goal to ensure that individuals with SMI and SED who are receiving care are indeed improving and moving towards their recovery goals. Measurement-based care has not been widely adopted in behavioral health settings—therefore, the Data and Evaluation Working Group is prioritizing the identification of gaps and opportunities for its widespread adoption in behavioral health service delivery.

In June 2023, the Data and Evaluation Working Group played a critical role in a SAMHSA-sponsored in-person convening on measurement-based care that brought together subject matter experts from different disciplines. In addition to Working Group members and representatives of other federal agencies, the convening included (but was not limited to) representatives from behavioral health provider organizations and advocacy organizations that represent providers, payers of behavioral health services, and accrediting entities. The two-day event explored examples of successful measurement-based care implementation, challenges, and opportunities for next steps.

Members of the Data and Evaluation Working Group also co-authored a brief report on measurement-based care. This report was informed by the expertise of Working Group members, as well as other subject matter experts who shared their expertise in group meetings. These subject matter experts included representation from individuals implementing measurement-based care in Federally Qualified Health Centers, the Veterans Health Administration (VHA), the NIMH EPINET Research Network, The Joint Commission, and the Yale Measurement-Based Care Collaborative (including an expert in use of measurement-based care in the delivery of mental health services for children and adolescents). This report serves as a foundation for next steps for its implementation in mental health service delivery.

In October 2023, the Data and Evaluation Working Group shifted some of its focus to quality measures for **measurement-based care**. There are hundreds of quality measures related to behavioral health that are collected across different federal agencies. Therefore, the Data and Evaluation Working Group has begun to collect and review materials from earlier efforts related to quality measures to identify those relevant to people with SMI and SED and their families and to inform the ISMICC's guidance on the widespread use of measurement-based care. The new Recommendation 1.7 demonstrates this expanded effort.

In addition to its work specific to measurement-based care, the Data and Evaluation Working Group continues to monitor and support ongoing efforts to improve data linkages and reduce silos across the nation. Since 2017, there have been substantial advances to linking federal data but much more work is needed.

Access and Engagement Working Group

Focus Area 2: Make It Easier to Get Good Care

2.1 Define and implement a national standard for crisis care.
2.2 Continue to take steps to grow and transform the behavioral health crisis services continuum through partnerships at the federal, state, and local levels. **R**
2.3 Educate providers, service agencies, people with SMI and SED and their families, and caregivers about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, including 42 CFR Part 2, in the context of psychiatric care.
2.4 Reassess civil commitment standards and processes.
2.5 Establish standardized assessments for level of care and monitoring of consumer progress.
2.6 Prioritize early identification and intervention for children, youth, and young adults.
2.7 Use telehealth and other technologies to increase access to care.
2.8 Maximize the capacity of the behavioral health workforce.
2.9 Support family members and caregivers.
2.10 Expect SMI and SED screening to occur in all primary care settings.

In 2018, the **Access and Engagement Working Group** convened an expert panel focused on crisis care. In response to this convening and other ISMICC discussions, SAMHSA published the National Guidelines for Behavioral Health Crisis Care. This document details best practices to support systems of crisis care throughout the nation. SAMHSA also funds initiatives that support **crisis response services**. For example, SAMHSA-administered CCBHC Expansion grants help CCBHCs meet CCBHC Certification Criteria (updated in March 2023), facilitating the ability for more individuals to receive high-quality mental health and substance use services. SAMHSA also funds Cooperative Agreements for Innovative Community Crisis Response Partnerships, which create new or enhance existing mobile crisis response teams in high-need communities to divert adults, children, and youth experiencing a mental health crisis from a law enforcement response. In September 2022, SAMHSA awarded 12 of these grants, which provided each awardee with up to $750,000 each year for up to four years. SAMHSA also provides substantial funding for the 988 Suicide & Crisis Lifeline operations and follow-up services through additional grant programs.

The Access and Engagement Working Group has also focused on expanding CCBHCs to improve access to mental health and SUD services, engaging ASPE and CMS as integral partners to their work, as mentioned in the Treating Mental Illness section. In addition to supporting crisis care initiatives, the Access and Engagement Working Group prioritizes telehealth and workforce expansion to increase access to behavioral health services. Although the COVID-19 pandemic accelerated the use of telehealth and other technologies to increase access to health care, CCBHC criteria have further expanded and

clarified language around the use of telehealth technologies such as video conferencing, remote patient monitoring, and asynchronous interventions. This provides options for people with SMI and SED to obtain services based on their preferences, needs, and location. Initial CCBHC evaluations can also be conducted by phone or video to quickly coordinate appropriate care. The criteria also includes requirements for outreach to underserved populations, an equity-driven community health needs assessment, training on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards, and an equity analysis of program outcomes, including the disaggregation of data collected as a part of quality improvement processes in order to assess for disparate outcomes among minorities within the clinic.

The pandemic also highlighted shortages in the health care workforce, especially among behavioral health providers. In addition to the aforementioned National Model Standards for Peer Support Certification, CMS recently finalized policies to reimburse peer support specialists, as well as other types of providers, such as community health workers and Marriage and Family Therapists, for their services. These new policies will help close the access gap, decrease unmet behavioral health care needs, and address social support needs such as housing, food, or transportation. Peer support is also a required component of the CCBHC model.

"Anyone, anytime, anywhere "

Research has shown that the predecessor of the 988 Suicide & Crisis Lifeline has been shown to be an effective service itself, with most people not requiring any additional services after the contact while improving symptomatology such as decreasing suicidal thoughts.[43] The rapid transition of the use of the 988 Suicide & Crisis Lifeline and associated growth of services in the behavioral health crisis continuum has been another significant advance in access and engagement. The ISMICC and its members have been pivotal in supporting SAMHSA with the actualization of Recommendations 2.1 and 2.2 by informing the Agency's publication of National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. This sentinel document has been the foundation of the ongoing standardization of crisis care throughout the nation. The 988 Initiative continues to grow and expand access to suicide prevention and crisis services, meeting the needs of adults, adolescents, and children at any time and from anywhere across the U.S. Federal and non-Federal Members of the ISMICC and their representative organizations continue to be engaged in the support of the transition including the provision of training and technical assistance. Notably, SAMHSA has funded and provided technical assistance to 38 tribal organizations through the 988 Tribal Response Program and has conducted targeted 988 outreach and awareness efforts with African American young adults, especially in Historically Black Colleges and Universities (HBCUs).

Treatment and Recovery Working Group

Focus Area 3: Close the Gap Between What Works and What is Offered

3.1 Provide a comprehensive continuum of care for people with SMI and SED.
3.2 Make screening and early intervention among children, youth, transition-age youth, and young adults a national expectation.
3.3 Make coordinated specialty care for first-episode psychosis available nationwide.
3.4 Make trauma-informed, whole person health care the expectation in all our systems of care for people with SMI and SED.
3.5 Implement effective systems of care for children, youth, and transition-aged youth throughout the nation.
3.6 Make housing more readily available for people with SMI and SED.
3.7 Advance the national adoption of effective suicide prevention strategies.
3.8 Develop research agenda for SED/SMI prevention, diagnosis, treatment, and recovery services.
3.9 Make integrated services readily available to people with co-occurring mental illnesses and substance use disorders, including medication-assisted treatment (MAT) for opioid use disorders.
3.10 Develop national and state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI and SED.

The **Treatment and Recovery Working Group** focuses their efforts on promoting the adoption of evidence-based mental health interventions that have been underused, such as **Supported Employment** and **Supportive Housing**. The ISMICC's Federal and Non-federal Members share information about the federal initiatives within their departments and agencies to better coordinate programs and policies that promote the use of evidence-based practices, particularly those that are underutilized among transition-aged youth. Among these evidence-based practices, the Treatment and Recovery Working Group has prioritized Supported Employment because of its touchpoints across multiple federal agencies. Supported Employment helps people with SMI identify, acquire, and sustain part- or full-time jobs of their choosing within their community. This approach sees employment not as a result of recovery, but as an integral support towards recovery. Research shows that Supported Employment increases self-esteem, promotes independent living, improves mental health symptoms, reduces stigma, and decreases the number of hospitalizations. Despite this evidence, Supported Employment continues to be underutilized.

In June 2023, SAMHSA collaborated with federal and non-federal partners to conduct a Policy Academy on Supported Employment for Transition Age Youth (SE-TAY). State teams from Alaska, Illinois, Mississippi, Ohio, Oklahoma, South Carolina, and Utah worked directly with subject matter experts to develop an action plan for implementing or enhancing their current efforts toward SE-TAY. The primary

goal of this Policy Academy was for select teams to develop a state-wide strategic plan to advance policies and practices to enhance their capacity to meet the competitive employment needs of transition-age youth with mental illness.

Many federal partners contributed with planning and support of the Policy Academy, including ACL's National Institute on Disability Independent Living Rehabilitation Research, Department of Labor (DOL), Social Security Administration (SSA), Administration for Children and Families (ACF), Veterans Administration (VA), ED Rehabilitation Services Administration, Department of Justice (DOJ), CMS, OASH, and SAMHSA Regional Directors (SAMHSA RDs). Non-federal partners also participated in this event, including a Non-federal ISMICC member and leader of the the National Association of State Mental Health Program Directors to encourage collaboration with state leaders and adoption of the work. The Policy Academy cohort will continue in 2024 with a one-year learning collaborative. SAMHSA, the Department of Housing and Urban Development (HUD), and VA have also raised awareness about the values of Supported Employment. Supported Employment is now included in CCBHC criteria, SAMHSA Mental Health Services Block Grant, and ongoing support through DOL's Office of Disability Employment Policy and the VA.

Supportive Housing is an evidence-based practice that combines affordable housing with coordinated supportive services to help people with SMI maintain stable housing and receive appropriate treatment. Evidence shows that people with SMI who receive Supportive Housing services are more likely to gain and maintain stable housing while also having improved mental and physical health, reduced use of inpatient care, and a lesser likelihood of criminal justice involvement. Like Supported Employment, Supportive Housing has been underutilized.[44] The Treatment and Recovery Working Group has been instrumental in identifying opportunities for federal collaboration to increase the uptake of Supportive Housing—leveraging an existing collaboration between SAMHSA and HUD to increase awareness about the challenges that people with SMI face without secure, safe housing and hosting a joint webinar under the leadership of HUD on World Mental Health Day in 2023. The Working Group is also helping SAMHSA update their Permanent Supportive Housing Evidence-Based Practices toolkit.

Promoting Evidence-Based Practices

Federal block grant set-asides and program requirements promote the uptake of evidence-based practices across the nation. Universal screening, early intervention, trauma-informed practices, medication-assisted treatment, and crisis services are examples of evidence-based practices that have been bolstered by federal support. For example, SAMHSA's Community Mental Health Services Block Grants and other discretionary grant programs require screening and early intervention in programs that serve children, youth, transition-aged youth, and young adults and their families. Congress has also set aside 10% of Mental Health Block Grant funding to expand treatment for Early Serious Mental Illness, including CSC services for individuals experiencing First Episode Psychosis. To further increase the utilization of high fidelity evidence-based practices, SAMHSA has awarded a technical assistance center focused on supporting communities in providing care for Early Serious Mental Illness.

Criminal Justice Working Group

Focus Area 4: Increase Opportunities for Diversion and Improve Care for People with SMI and SED Involved in the Criminal and Juvenile Justice Systems

A disproportionate number of people involved in the criminal and juvenile justice systems are those with SMI, SED or COD—particularly among people of color.[45] This population currently faces serious risks when involved in these systems, including but not limited to, incarceration/detention replacing behavioral health services, long periods of waiting in the competency to stand trial phase, isolating and overly-restrictive forensic housing, and insufficient support and services while incarcerated and upon reentry. The following recommendations support the use of diversion at all points of the Sequential Intercept Model (SIM) in order to provide quality treatment and recovery supports. Recommendation 4.1 addresses the need to prioritize diversion at all intercepts in the SIM in favor of trauma-informed, accessible, culturally and linguistically competent and developmentally appropriate mental health treatment and recovery services for both adults and youth. 4.2 addresses the need for federal agencies to continually analyze currently applicable and new federal legislation to identify opportunities and collaborate to address these issues at all points in the SIM. 4.3 through 4.8 address specific intercepts in the SIM, prioritizing diversion and access to quality care throughout.

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

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

4.3 Enhance diversion and crisis mental health services to divert people with SMI, SED, and COD from the justice system before arrest and at all stages of the SIM and build the capacity of first responders to interact with this population in a de-escalating and trauma-informed manner.

4.4 Establish and incentivize best practices for competency to stand trial (CST) that prioritize diversion from arrest or jail/juvenile detention for people with SMI, SED or COD accused of committing low-level and non-violent offenses and that use community-based evaluation and restoration services when CST efforts are necessary.

4.5 Develop and sustain problem solving court dockets in federal civilian, state, and local courts for people with SMI, SED, or COD.

4.6 Encourage the use of universal screening for mental illnesses, substance use disorders, and other behavioral health needs of every person booked into jail, juvenile detention facilities and diversionary community services and provide assessment, treatment and referrals when warranted.

4.7 Except in cases where confinement in the general population poses a significant danger to self or others, strictly limit the use of unnecessary solitary confinement, seclusion, restraint, or other forms

of restrictive housing for people with SMI, SED or COD in federal, state, and local jails, prisons and juvenile detention facilities.

4.8 Reduce barriers that impede immediate access to treatment and recovery services upon release from adult and juvenile correctional facilities.

The **Criminal Justice Working Group** recognizes that people with SMI and SED make up a disproportionate number of people involved in the criminal and juvenile justice systems and face serious risks when involved in these systems—such as incarceration or detention replacing behavioral health services, long wait periods in the competency to stand trial phase, isolation, overly-restrictive forensic housing, and insufficient support and services while incarcerated and upon reentry. The recommendations in this Focus Area support the use of diversion at all points of the Sequential Intercept Model (SIM)** across all stages of justice involvement, including providing quality treatment and recovery supports and addressing the need to prioritize diversion in favor of trauma-informed, accessible, culturally and linguistically competent and developmentally appropriate mental health treatment and recovery services. The Criminal Justice Working Group implements these recommendations to support ongoing federal analyses of current and new federal legislation, promotes federal collaboration, and prioritizes diversion and access to quality care.

The Criminal Justice Working Group is greatly concerned about people with SMI and SED whose competency to stand trial and restoration to competency has been questioned. During the long wait times for a chance to restore competency status, this already vulnerable population is living in a high-stress environment, often without much-needed medication or treatment. The Criminal Justice Working Group has focused on increasing awareness of this challenge and promoting best practices to reform the system. Federal Members inform the Working Group on the federal initiatives related to competency to stand trial within their departments and agencies, which helps better coordinate programs and policies.

For instance, SAMHSA informed the Criminal Justice Working Group informs the the technical assistance the GAINS Center for Behavioral Health and Justice Transformation provides to states and communities on competency to stand trial and competency restoration.The GAINS Center's technical assistance includes Learning Collaboratives (garnering participation from 14 states), Policy Academies, consultation, and an environmental scan and literature review. The GAINS Center released Foundation Work for Exploring Incompetence to Stand Trial Evaluations and Competence Restoration for People with SMI/SED, a report for policymakers and criminal justice and behavioral health professionals that provides an overview of the status of competence to stand trial, incompetence to stand trial, and

** https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

competence restoration for adults and youth in the criminal justice and juvenile justice systems. The GAINS Center is also working on model legislation to help states develop language and statutory examples of alternatives to holding competency to stand trial evaluations only in inpatient psychiatric hospitals.

The Criminal Justice Working Group's discussions regarding the topic of diversion also informed the development of the FY 2023 Notice of Funding Opportunity for SAMHSA's Behavioral Health Partnerships for Early Diversion of Adults and Youth grant program to establish new or expand existing programs that divert adults and youth with mental illness from the criminal or juvenile justice system. The program aims to help these individuals receive community-based mental health and substance use disorder supports and services prior to an arrest or booking. These Early Diversion grants were awarded in September 2023, and the Criminal Justice Working Group will continue to track the program's progress over the next five years.

Development of a Resource Inventory

The trajectory of a person with SMI towards criminal involvement is multifaceted—crossing social, economic, housing, and health related factors. Interagency collaboration is therefore critical to fully address this complex pathway. To increase awareness and facilitate resource sharing across federal agencies, the Criminal Justice Working Group developed a Resource Inventory, which allows the Working Group and the greater ISMICC to identify alignment across current resource gaps in federal activities and strengths that could be harnessed to develop new or improve existing activities.

One example of a federal activity included in the Resource Inventory is the free training and resources provided to communities through the Center for Justice and Mental Health Partnerships within the DOJ Bureau of Justice Assistance. The Center for Justice and Mental Health Partnerships also supports competency restoration and provides training and technical assistance to jurisdictions. The ISMICC members are encouraged to provide regular updates to the Resource Inventory.

Finance Working Group

Focus Area 5: Develop Finance Strategies to Increase Availability and Affordability of Care

5.1 Implement population health payment models in federal health benefit programs.
5.2 Adequately fund the full range of services needed by people with SMI and SED.
5.3 Fully enforce parity to ensure that people with SMI and SED receive the mental health and substance use services they are entitled to, and that benefits are offered on terms comparable to those for physical illnesses.
5.4 Identify and eliminate programs, practices, and policies that make it hard to implement all of the mental health services required to care for individuals living with serious mental illness. **R**
5.5 Pay for psychiatric and other behavioral health services at rates equivalent to other health care services.
5.6 Provide reimbursement for outreach and engagement services related to mental health care.
5.7 Fund adequate home- and community-based services for children and youth with SED and adults with SMI.
5.8 Expand the Certified Community Behavioral Health Clinic (CCBHC) program nationwide.
5.9 Develop sustainable financing for 988 systems and crisis services.

The **Finance Working Group** has focused its efforts on expanding access to CCBHCs by supporting HHS efforts to expand and improve the CCBHC model, which ensures that people with SMI and SED continue to receive comprehensive mental health and substance use services, regardless of their ability to pay. The Section 223 CCBHC Medicaid Demonstration program provides CCBHCs with cost-based prospective payment for a comprehensive package of services, enabling CCBHCs to provide services that people need, rather than only services that can be billed. Under Section 11001 of the Bipartisan Safer Communities Act, (P.L. 117-159), additional states are able to join the CCBHC Medicaid Demonstration programs. Under the demonstration, states also receive an "enhanced" Federal Medical Assistance Percentage (FMAP) for providing CCBHC services under the PPS. SAMHSA hopes to build on the expansions in the CCBHC model.

The CCBHC initiative is led through an HHS partnership that includes CMS, ASPE, and SAMHSA. Together these agencies manage the Section 223 CCBHC Medicaid Demonstration, work with states implementing CCBHC programs outside of this demonstration, manage CCBHC expansion grants, and work to evaluate the CCBHC initiative. Beginning with 67 clinics in 8 states in 2017, there are now more than 500 CCBHCs in 46 states, the District of Columbia, and Puerto Rico as a result of these efforts. Congress also recently established in the Consolidated Appropriations Act, 2024 (Pub. L 118-42) new optional Medicaid state plan authority for states to cover CCBHC services outside of the demonstration. The ISMICC's Non-

federal Members also inform guidance for CCBHCs, offering perspectives from states currently in the CCBHC Medicaid Demonstration program and professional advocacy groups that ensure that people in the U.S. have access to affordable, high-quality mental health and substance use services.

The Finance Working Group updated Recommendation 5.4 to narrow a blanket recommendation to eliminate the Institutions for Mental Disease (IMD) exclusion in the previous set of recommendations and instead focus on evaluating and implementing more narrow exceptions to the IMD exclusion to remove barriers to crisis stabilization and short-term inpatient stays that may be necessary for supporting stability in community settings.

The Working Group also added Recommendation 5.9, which focuses on building consistent and sustainable financing for systems that can respond to people experiencing mental health or substance use related crises. This Recommendation's focus is to develop sustainable financing systems that support nationwide, 24/7 access to crisis services linked with the 988 Suicide & Crisis Lifeline. When deliberating the Recommendation, the ISMICC emphasized that crisis services should ensure that they are available to anyone who needs them regardless of insurance status. These financing mechanisms should work across payers and support collaboration across systems including the 988 Lifeline, physical health and behavioral health care, law enforcement, and other first responders. Crisis financing systems should also create incentives that support connection to ongoing care when needed and for intervening early to avoid crises when possible. Crisis financing systems should not result in administrative or financial burden for the person or family in crisis and prevent issues such as surprise billing. As previously noted, SAMHSA is working with CMS on implementing Section 5124 of the Consolidated Appropriations Act, 2023 (P.L. 117-328), to provide a guidance document related to the financing of crisis services and the creation of a technical assistance center specific to the financing of crisis services.

Mental Health Parity

Parity ensures that health plans and health insurance issuers do not create special roadblocks or impediments in the way of receiving covered benefits for mental health conditions and substance use disorders that do not apply to benefits for physical health conditions. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that health plans and health insurance issuers that offer mental health and substance use disorder benefits provide those benefits with no more restrictions than are placed on medical and surgical benefits, including co-pays, deductibles, and treatment limitations. MHPAEA also prohibits separate treatment limitations that apply only to mental health and substance use disorder benefits.

Implementing and enforcing MHPAEA requires coordination across federal departments such as DOL, HHS, and the Department of the Treasury in order to help families and caregivers better understand and act on their rights under MHPAEA. The ISMICC receives regular multi-agency updates on the implementation of MHPAEA including active rulemaking activities. In June 2024, CMS released updated guidance on "Medicaid and CHIP Managed Care Monitoring and Oversight Tools, including States' Responsibility to Comply with Medicaid Managed Care and Separate CHIP Mental Health and Substance Use Disorder Parity Requirements" indicating plans to develop additional tools and resources to improve compliance with parity.

INVENTORY OF FEDERAL ACTIVITIES AND EVALUATIONS THAT SUPPORT INDIVIDUALS WITH SMI AND SED

The following section provides an inventory of programs and initiatives that participating Federal Departments and Agencies can and have used to support the needs of individuals with SMI and SED. Information in this section may include activities happening in 2024 and proposed plans activities. Programmatic inventory data is current as of December 2023. Some of the programs and initiatives have undergone evaluation—either formally, by grantees, contractors or through peer review. **Previously evaluated programs, and programs and initiatives with ongoing evaluations, are indicated with an** *****.

Note: For the Department of Justice Office of Justice (OJP) programs, some asterisks also indicate funding provided through research grants to study programs and initiatives that may or may not be funded by OJP but align with and inform further OJP initiatives. Each participating Federal Department or Agency has identified one key program that has been formally evaluated. If no formal evaluation has been performed due to funding limitations, the Department or Agency has identified an initiative and associated data to feature.

Administration for Community Living (HHS)

One example of the ACL's programs supporting individuals from all populations, including those with SMI and SED, is the No Wrong Door (NWD) System. This program is a network of state agencies and community-based organizations promoting access to long-term services and supports (LTSS) through coordinated points of entry. NWD assists individuals navigating health and social care services through outreach, streamlined assessments, person-centered plans, information, and referral to state and community-based resources, and a governance structure that ensures these functions are available and coordinated across the state.

The NWD System Management Tool is designed to collect and analyze data elements necessary to assess the progress of the NWD System model, track performance measures, and identify gaps and best practices. The purpose is to understand and document the extent to which the NWD System is streamlining and coordinating access to LTSS through its four core functions of State Governance and Administration, Public Outreach and Coordination with Key Referral Sources, Person-Centered Counseling, and Streamlined Eligibility for Public Programs.

Data collected between April 2020 and September 2022 across fifty-five state and territory Aging and Disability Resource Centers/COVID grantees reflect the broad impact of the NWD System with 14,649,810 unduplicated contacts receiving information, referrals, and other assistance; 2,587,448 individuals receiving Person-Centered Counseling (PCC); 3,374,588 individuals receiving assistance with applications (1,436,793 Medicaid LTSS applications; 38,690 VA program applications; 1,937,795 Other Federal & State Program application assistance); and 66,808 individuals transitioned home or to a community setting from hospitals (24,066) or nursing facilities (42,742).

National Institute on Disability, Independent Living, and Rehabilitation Research

Being Needed: Building Social Connections that Matter to Reduce Social Isolation and Loneliness*

Enhancing Supported Employment Services for Individuals with Psychiatric Disabilities to Address Workplace Prejudice and Discrimination*

Learning & Working During the Transition to Adulthood Rehabilitation Research and Training Center*

National Spinal Cord Injury Statistical Center (NSCISC) Collaborative Research Project Grant*

Peer Navigators for the Health and Wellness of People with Psychiatric Disabilities*

Rehabilitation Research and Training Center (RRTC) on Aging Among Adults with Serious Mental Illnesses*

Rehabilitation Research and Training Center (RRTC) for Community Living and Participation for TAY with Serious Mental Health Conditions from Disadvantaged, Vulnerable, and Marginalized Backgrounds*

Rehabilitation Research and Training Center on Community Living and Participation of People with Serious Mental Illness*

Rehabilitation Research and Training Center for Improving Employment Outcomes for Individuals with Psychiatric Disabilities*

Rehabilitation Research and Training Center (RRTC) for Improving Health and Functioning of People with Serious Mental Illness*

Traumatic Brain Injury Model System (TBIMS) National Data and Statistical Center Collaborative Research Project Grant*

Yale Post-Doctoral Research Training Program to Advance Competitive Integrated Employment for People with Psychiatric Disabilities*

Administration on Aging

Evidence-based disease prevention and health promotion programs funded through Older American's Act Title III-D and discretionary grants

- PEARLS (Program to Encourage Active, Rewarding Lives for Seniors)
- Healthy IDEAS (Identifying Depression Empowering Activities for Seniors)
- WRAP (Wellness Recovery Action Plan)
- BRITE (Brief Intervention and Treatment for Elders)

Evidence-based Suicide Intervention Training funded through Innovations in Nutrition Replication Grants

Annual Older Adult Mental Health Awareness Day (OAMHAD) Symposium

Administration on Disabilities

No Wrong Door: system of access to long-term services and supports

The Link Center- Bridging I/DD and Mental Health Systems*

UCEDD National Training Initiative to Support People with Intellectual and Developmental Disabilities with Co-Occurring Mental or Behavioral Health Disabilities*

Centers for Medicare & Medicaid Services (HHS)

CCBHCs are clinics that receive funding to expand the scope of mental health and substance use services in their community and serve anyone who walks through the door, regardless of their diagnosis or insurance status. Currently, there are over 500 CCBHCs operating across the country, as CCBHC expansion (CCBHC-E) grantees (through a program administered by SAMHSA) as clinics participating in their states' Medicaid CCBHC demonstration, or as a part of independent state CCBHC programs separate from the Medicaid CCBHC Demonstration. In 2024, CCBHCs were also added as an optional benefit in Medicaid under Section 209 of the Consolidated Appropriations Act, 2024 amended. An estimated 2.1 million people are currently served across all active CCBHCs. CCBHCs are also improving access by reducing wait times, enabling people being served to receive care more quickly. Almost nine in 10 CCBHCs (87%) report seeing patients for routine needs within 10 days of the initial call or referral, 71% provide access within one week or less, and one-third (32%) offer same-day access to services. This is in contrast to the national average of 48 days between a client's first outreach/referral until their first appointment– as cited in an MTM Services analysis of 10,000 care access protocol flowcharts collected from 1,000 community mental health centers engaged in initiatives to measure and reduce wait times for care in 47 U.S. states.

CMS Innovation Center

Center for Medicare & Medicaid Innovation in Behavioral Health Model

Center for Medicaid and CHIP Services

Certified Community Behavioral Health Clinic Demonstration

Ensuring Compliance with the Mental Health Parity and Addiction Equity Act

Guidance and Technical Assistance on Medicaid & CHIP Support for Crisis Response

Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated Community-Based Mobile Crisis Planning Grants and Enhanced Federal Medicaid Matching Payments

Promoting School-Based Services including MH and SUD Prevention and Treatment

Review of State Compliance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirement

Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance Strategies to Address the Opioid Epidemic

Working with States to Provide Medicaid Coverage of Services Addressing Health Related Social Needs

Center for Medicare Expansion of eligible credentialed behavioral health providers

Department of Education

Through the Office of Special Education Programs' (OSEP) Personnel Development to Improve Services and Results for Children with Disabilities Program (PDP) (Assistance Listing Number 84.325), discretionary grants are funded to support the preparation of personnel, including special education, early intervention, and related services providers, who serve and support children with disabilities. In FY 2023, over 6,000 scholars were trained through OSEP's Personnel Development Program (PDP). These scholars were enrolled in over 358 active grants across 150 institutes of higher education (IHEs). Some of the grantees will prepare qualified professionals who will serve on school-wide mental health teams, support student behavioral health, and provide evidence-based interventions in schools.

Mental Health Service Professional Demonstration Grant Program (MHSP)

Model Demonstration Projects to Enhance Social, Emotional, and Mental Health Services and Supports for Middle or High School Youth with and at Risk for Disabilities

National Technical Assistance Center on Positive Behavioral Interventions and Supports.

Preparation of Related Services Personnel Serving Children with Disabilities who have High-Intensity Needs

Preparation of Special Education, Early Intervention, and Related Services Leadership Personnel

School-Based Mental Health Service Grant Program (SBMH)

Department of Housing and Urban Development

The Department of Housing and Urban Development's (HUD) Continuum of Care Program is the federal backbone of funding for community homelessness response systems across the country, funding long-term and transitional housing and supportive services programs, as well as system-wide planning and data collection activities. In March 2023, the Office of Community Planning and Development awarded approximately $2.8 billion in FY 2022 Continuum of Care grants. The funding includes approximately $1.8 billion in grants to support rental assistance and/or supportive services in over 3,500 Permanent Supportive Housing Projects, which serve people experiencing homelessness who have disabilities, including mental disabilities. Separately, HUD and HHS are providing a competitive opportunity for states to participate in a new federal technical assistance initiative known as the "Housing and Services Partnership Accelerator" ("Accelerator"). In February 2024, HUD announced $3.16 billion in funding to fund 7,000 housing and services projects for people experiencing homelessness – the largest expansion of annual federal funding provided through HUD's Continuum of Care program in history. The Accelerator will help participating states unlock critical resources to reduce homelessness by addressing health-related social needs, such as housing-related services.

Office of Community Planning and Development

Continuum of Care Program: Funding Permanent Supportive Housing

Office of Fair Housing and Equal Opportunity

Fair Housing Enforcement

Office of Housing

Housing for Persons with Disabilities (Section 811)

Office of Public and Indian Housing

HUD-Veterans Affairs Supportive Housing (HUD-VASH)

Mainstream Vouchers

Department of Justice

The Justice and Mental Health Collaboration Program (JMHCP) seeks to increase public safety by facilitating collaboration among the criminal justice, mental health, and substance use treatment systems to increase access to mental health and other treatment services for individuals with mental health or co-occurring mental health and substance use conditions. The program promotes public safety through the coordination of resources for individuals who come in contact with the justice system and who are accessing services across multiple systems, including hospital emergency departments, jails, and mental health crisis services.

Since its inception in 2006, the Justice and Mental Health Collaboration Program has funded 744 site-based awards to 49 states, the District of Columbia and 2 territories, and multiple tribal nations. Over $250 million has been awarded funding projects supporting 911 and 988 crisis response, crisis stabilization units, co-response models, Crisis Intervention Team (CIT) training, pretrial diversion, mental health courts, court-based diversion, jail-based diversion, jail and prison reentry programs and community supervision for individuals with mental health and co-occurring disorders. Launched in 2021 under JMHCP, the Connect & Protect: Law Enforcement Behavioral Health Response Program has funded over 90 grantees.

In addition to site-based grant awards, JMHCP also supports 15 Law Enforcement-Mental Health Learning Sites and, in Fiscal Year 2023, began supporting 10 Criminal Justice-Mental Health Learning Sites. Both efforts offer opportunities for peer-to-peer learning and mentoring to share innovative practices across communities and improve outcomes for individuals with mental health and/or substance use conditions that are involved with the justice system. Through these learning sites, JMHCP has supported hundreds of technical assistance requests, hosted several in-person site visits, conducted presentations as part of conferences and webinars, and conducted virtual meetings with jurisdictions looking for guidance on their police-mental health collaborations. Jurisdictions seeking additional support can also request free training and technical assistance on a variety of topics such as 911 call processing, 988 for crisis calls, building a comprehensive crisis system, systems-wide behavioral health diversion interventions, co-occurring disorders in jails, and specialized caseload. Between 2019 and 2023, JMHCP provided training and technical assistance to grantees through 8,166 phone calls and emails, 59 webinars, and 82 in-person and virtual site visits.

Bureau of Prisons

Evaluation of Challenge Program

Evaluation of Criminal Thinking

Evaluation of Mental Health Step Down Programs

Illness Management and Recovery

Civil Rights Division

Enforcement of The Civil Rights of Institutionalized Persons Act (CRIPA), Title I (employment), Title II (services, programs, and activities of state and local governments), and Title III (places of public accommodation) of the Americans with Disabilities Act, and the Fair Housing Act. The Division's enforcement work includes the ADA's integration mandate and the Olmstead decision, campus mental health issues, disability discrimination in voting, education, housing, employment, criminal justice, emergency response systems, and numerous other areas.

Office of Justice Programs

Adapted Risk-Needs-Responsivity Reentry Model to Reduce Jail Recidivism in Underserved Area: A Randomized Controlled Trial of Pre-Release and Post-Release Reentry Components*

A Process, Adaptation, and Outcome Evaluation of San Gabriel Valley Crisis Assistance Response & Engagement (SGV CARE)*

A Randomized Controlled Trial of Co-response for Mental Health Calls for Service to the Police in Fort Collins, CO*

Aligning Health and Safety

Byrne State Crisis Intervention Program (Byrne SCIP)

Collaborative Crisis Response and Intervention Training (CRIT) Program

Collaborative Crisis Response and Intervention Training (CRIT) Training and Technical Assistance (TTA)

Connect and Protect: Law Enforcement Behavioral Health Response Program

Connect and Protect: Law Enforcement Behavioral Health Response Program (TTA)

Data on Maternal Health and Pregnancy: Outcomes from Prisons and Jails

Evaluation of Culture and Climate Effects in the Virginia Department of Corrections Cognitive Communities

Expanding Mental Health Diversion Opportunities: A Prospective Evaluation of the Los Angeles County Intake Booking Diversion Program*

Improving Adult and Youth Crisis Stabilization and Community Reentry Program

Initiative To Develop and Test Guidelines for Juvenile Drug Treatment Courts

Integrated Treatment Individuals with Co-occurring Disorders in the Criminal Justice System

Juvenile Drug Treatment Court Program

Justice and Mental Health Collaboration Program (JMHCP)

Justice and Mental Health Collaboration Program (JMHCP) Training and Technical Assistance (TTA)

- National TTA Centers: The Center for Justice and Mental Health Partnerships
- Law Enforcement – Mental Health Learning Sites
- Criminal Justice - Mental Health Learning Sites
- Propelling Change: A Prosecutor's Call to Action

Multisite Randomized Controlled Trial of Comprehensive Trauma Informed Reentry Services for Moderate to High-Risk Youth Releasing from State Prison*****

National Inmate Survey (NIS)

National Survey of Youth in Custody (NSYC)

National Prisoner Statistics (NPS) Program: Maternal Health Supplement

NIJ Multisite Impact and Cost-Efficiency Evaluation of Veterans Treatment Courts

Partners in Crisis: Improving Police Response to Individuals in Moments of Crisis by Providing Service Alternatives*****

Police-Mental Health Collaboration (PMHC) Toolkit

Prisons as Schools for Change: Evidence from Illinois*****

Stepping Up Initiative

Survey of Inmates in Local Jails (SILJ)

Survey of Prison Inmates (SPI)Training and Technical Assistance to Enhance Law Enforcement Services for Improved Agency Operations, Policies, and Responses to People with MHDs/MHSUDs: supporting state/local capacity building for jurisdictions and the field (TTA)

Youth Justice and Mental Health Collaboration Program

Department of Labor

To support and expand competitive integrated employment (CIE) for people with mental health conditions, the Office of Disability Policy (ODEP) launched the Advancing State Policy Integration for Recovery and Employment (ASPIRE) initiative. ASPIRE provides selected states with tailored and targeted technical assistance to integrate state policy, program, and funding infrastructures to expand evidence-based employment services for people with a disability resulting from mental health conditions. Particular emphasis is placed on expanding best practices such as the Individual Placement and Support (IPS) model of Supported Employment. Lessons from ASPIRE will help other states, federal agencies, and service providers adopt proven methods to increase gainful employment for this underserved population. Florida, Indiana, Iowa, Louisiana, Montana, New York, and Virginia were selected to participate in the second round of ASPIRE in December 2022, which continued through July 2024.

Office of Disability Employment Policy

Advancing State Policy Integration for Recovery and Employment (ASPIRE) Program

Employer Assistance and Resource Network on Disability Inclusion (EARN)

Job Accommodation Network (JAN)

State Exchange on Employment and Disability (SEED)

Department of Veterans Affairs

The Veteran's Health Administration's (VHA) Measurement Based Care in Mental Health Initiative defines measurement-based care (MBC) as an evidence-based clinical process that uses patient-reported outcome measures (PROMs) to empower Veterans and providers to collaborate on goal setting and treatment planning.[46] The initiative disseminates a three-part clinical model called "collect, share, act." Data suggest steady increases in uptake of MBC since the inception of the MBC Initiative in FY 2017, with 100% of VA Medical Centers now participating in MBC. Over 14,800,000 PROMs have been administered to Veterans since the initiative began. In a national Mental Health Provider Survey administered for FY 2022, 76% of mental health providers surveyed agreed that PROMs are valuable for patient care. At intake, 74% said that they use these measures most or every time, and after initial assessment 64% of providers report using these measures most or every time. The reported rates of use of PROMs have been steadily trending upward since the questions were added in 2016.

The Veteran Satisfaction Assessment (VSA) is a national survey of Veterans receiving mental health care in VHA. Data from the VSA in FY 2023 indicate that Veterans' perceptions of their care match the Mental Health Provider Survey. About 54% of Veterans surveyed stated that their mental health provider had administered a questionnaire or survey "about how I'm doing with my mental health." Of those who received such a questionnaire, 72% agreed with the statement that it was administered twice or more (collect) and 63% agreed that the results had been used to discuss their treatment goals and how to meet them (share and act). Studies of MBC within VA have been similarly positive. One facility studied the implementation of MBC in their integrated mental health primary care program and concluded that MBC enhanced communication and clinicians valued MBC.[46] Another implementation study of MBC in integrated mental health primary care concluded that the MBC in MH Initiative was effective in helping programs to increase MBC implementation, and that depression care improved when MBC was implemented.[47]

Veterans Health Administration: Office of Mental Health

Note: *Since the original drafting of this report, the Office of Mental Health and the Office of Suicide Prevention have become two distinct offices in VHA.*

Early Psychosis Intervention Coordination (EPIC) Program

Family Services

General Outpatient Mental Health Services and Behavioral Health Interdisciplinary Program (BHIP) teams*

Integrated Geriatric Mental Health Services

Acute Inpatient Mental Health Treatment Programs*

Intensive Community Mental Health Recovery Services (ICMHR) *

Mental Health Residential Rehabilitation Treatment Programs*

Mental Illness Research, Education and Clinical Centers

Primary Care - Mental Health Integration*

Psychosocial Rehabilitation and Recovery Centers (PRRC) *

PTSD Treatment

Specialized PTSD care, including PTSD Clinical Teams*

Substance Use Disorder Treatment*

Recovery Engagement and Coordination for Health --Veterans Enhanced Treatment (REACH VET)*

Re-Engaging Veterans with Serious Mental Illness*

Telemental Health Program

Vet Centers

Veterans Crisis Line*

VHA Vocational Rehabilitation Services*

Veterans Health Administration: Office of Suicide Prevention

Suicide Prevention*

Veterans Health Administration: Homeless Program Office

Continuum of specialized services for homeless Veterans*

Veterans Health Administration: Office of Quality and Patient Safety

Clinical Practice Guidelines

Office of the Assistant Secretary for Health (HHS)

Office of the Assistant Secretary for Planning and Evaluation

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA; P.L. 113-93) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test a new strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. Subsequent laws expanded the demonstration to add additional states and the ability for CCBHCs to become a part of a state's Medicaid plan outside of the demonstration. The Office of ASPE is conducting an evaluation of the CCBHC Demonstration program, in coordination with SAMHSA and CMS. The 2023 evaluation report assessed the implementation and outcomes of the CCBHC demonstration in the seven states that continued the demonstration as of September 2021 and the two new states that joined the demonstration in 2021.

Findings from the report draw on interviews with state officials in each demonstration state; a survey of all participating CCBHCs in 2023, and state- and CCBHC-reported quality measures available for analysis as of March 2023. Findings from the report include that in recent years of the demonstration, CCBHCs in the original demonstration states have worked to maintain and expand activities to increase access to care. For example, open-access or same day scheduling is a common way CCBHCs provide accessible

services. States and CCBHCs have also focused on integrating CCBHCs with 988 call centers and state crisis systems to increase access to care. They have also continued to invest in staff and tools to support care coordination. CCBHCs and states described various continuous quality improvement activities as a result of participation in the program, often using the collected quality measure data required by the demonstration. Note: Additional details regarding the evaluation and associated outcomes of the CCBHC demonstration program can be found under the CMS section.

Office of Disease Prevention and Health Promotion

Healthy People 2030 (fifth iteration of the Healthy People Initiative) Topic Area on Mental Health and Mental Disorders

Social Security Administration

Under the Consolidated Appropriations Act, 2021 (P.L. 116–260), that gave the Secretary of Health and Human Services the authority to establish special enrollment periods (SEPs) for Medicare enrollment in the case of individuals who meet exceptional conditions as the Secretary may provide, a new SEP for formerly incarcerated individuals was created. In the case of Medicare-eligible individuals who are released from the custody of penal authorities on or after January 1, 2023, if these individuals failed to enroll or reenroll in Medicare premium Part A or Part B during a valid enrollment period (i.e., the Initial Enrollment Period [IEP], General Enrollment Period [GEP], or Special Enrollment Period [SEP]) due to being in the custody of penal authorities, they are no longer required to wait until the next GEP to enroll. The SEP begins the day of the individual's release from the custody of penal authorities and ends the last day of the 12th month after the month in which the individual is released from the custody of penal authorities. Individuals enrolling in Medicare premium Part A or Medicare Part B through this SEP are not subject to a late enrollment penalty. Between 1/1/23 and 10/1/23, nearly 600 individuals applied for and received Medicare Part B under the SEP when released from the custody of penal authorities.

Carceral and Mental Health Institutions

Exceptional Conditions Special Enrollment Period (SEP) for Formerly Incarcerated

Substance Abuse and Mental Health Services Administration (HHS)

SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program was created to reduce or eliminate homelessness and imminent risk of homelessness for individuals with SMI or co-occurring mental and substance use disorders. Overall, 2020 Triennial PATH Evaluation Report outcome and process goals data demonstrated the PATH program has had considerable success serving its target populations. Specifically, the evaluation suggests that an average of 184,142 homeless persons were contacted each year (191,926 in 2016, 185,524 in 2017, and 147,952 in 2018); 48% of eligible homeless persons with SMI who were contacted were subsequently enrolled in services; and 65% of enrolled homeless persons received community mental health services.

Note: Evaluation information about the CCBHC program, which is a cross-agency effort, can be found in the CMS and ASPE sections above.

988 Lifeline Administrator Cooperative Agreement

988 Lifeline Crisis Center Follow Up Grant Program*

988 State and Territory Grant Program*

988 Suicide and Crisis Lifeline Operations

988 Suicide and Crisis Lifeline Access Improvement Project

988 Tribal Response Grant Program *

Assisted Outpatient Treatment (AOT) Grant Program*

Assertive Community Treatment (ACT) Grant Program

CCBHC Expansion Grants and CCBHC Improvement and Advancement Grant Program*

CCBHC Planning, Development, and Implementation Grants *

CCBHC Planning Grants and Demonstration*

CCBHC-E TA and State Technical Assistance Centers

Center for Integrated Health Solution

Circles of Care Grant Program

Clinical High Risk for Psychosis Grant Program

Clinical Support System for Serious Mental Illness Technical Assistance Center (SMI Adviser)

Center of Excellence for Behavioral Health in Nursing Facilities

Center of Excellence for Infant and Early Childhood Mental Health Consultation

Community Mental Health Centers (CMHC) Grant Program

Community Mental Health Services Block Grant (MHBG)

Consumer and Consumer Supporter Technical Assistance Centers (CONSTACs)

Cooperative Agreements to Implement Zero Suicide in Health Systems (Zero Suicide) *

Cooperative Agreements for Innovative Community Crisis Response Partnerships (CCRP)

Disaster Programs (Crisis Counseling Assistance and Training Program, Disaster Distress Helpline, SERG)

Disaster Training and Technical Assistance Center (DTAC)

E4 Center of Excellence for Behavioral Health Disparities in Aging

Early Diversion (ED) Grant Program

GAINS Center for Behavioral Health and Justice Transformation

Garrett Lee Smith State/Tribal Suicide Prevention Program (GLS State/Tribal) Grant Program*

Garrett Lee Smith Campus Grant Program (GLS Campus) *

Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance (Children's Mental Health Initiative)

Healthy Transitions Grant Program*

Historically Black Colleges and Universities Center of Excellence

Homeless and Housing Resource Center (HHRC) Technical Assistance Grant Program

Infant Early Childhood Mental Health Grant Program (IECMH) *

Mental Health Awareness Training Grant Program*

Mental Health Technology Transfer Center Network (MHTTC) *

MHBG State Program Improvement Technical Assistance (State Technical Assistance)

Minority AIDS Initiative - Service Integration (MAI-SI) Grant Program

SAMHSA Minority Fellowship Program

National Center of Excellence for Eating Disorders (NCEED)

National Center of Excellence for Tobacco-Free Recovery (National Center-TFR)

National Child Traumatic Stress Initiative (NCTSI) National Center for Child Traumatic Stress (NCCTS)

NCTSI Community Treatment and Service (CTS)*

NCTSI Treatment and Service Adaptation (TSA) Grant Program

National Crisis System Response Training and Technical Assistance Center

National Family Support Technical Assistance Center

National Harm Reduction Technical Assistance Center (partnership with CDC)

National Strategy for Suicide Prevention (NSSP) Grant Program*

National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC)

National Training and Technical Assistance Center for Early Serious Mental Illness (ESMI TTC)

Protection and Advocacy for Individuals with Mental Illness (PAIMI) Grant Program

Peer Recovery Center of Excellence

Project Advancing Wellness and Resiliency in Education*

Project LAUNCH (Linking Actions for the Unmet Needs in Children's Health) Grant Program

Projects for Assistance in Transition from Homelessness (PATH) Grant Program*

Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grant Program*

Resiliency in Communities after Stress and Trauma (ReCAST)

Refugee and Migrant Behavioral Health Technical Assistance Center

Service Members, Veterans, and their Families (SMVF) TA Center

SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance Center

State Program Improvement Technical Assistance (State TA) Contract

Statewide Consumer Network

Statewide Family Network

Suicide Prevention Resource Center (SPRC) Technical Assistance Center*

Supportive Employment (SE) Grant Program

Technical Assistance Coalition/Transformation Transfer Initiative (TAC/TTI)

Trauma-Informed Services in Schools*

Treatment for Individuals Experiencing Homelessness (TIEH) *

Tribal Behavioral Health Grant Program (Native Connections)

Tribal Training and Technical Assistance Center

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APPENDIX B: GLOSSARY OF TERMS

Abbreviation	Definition
ACL	Administration for Community Living
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHR-P	Clinical High-Risk State for Psychosis
CMS	Centers for Medicare & Medicaid
CMHI	Children's Mental Health Initiative
CMHS	Center for Mental Health Services
COD	Co-Occurring Disorders
COVID-19	Coronavirus Disease 2019
CSC	Coordinated Specialty Care
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CST	Competency to Stand Trial
D.C.	District of Columbia
DFO	Designated Federal Official
DOJ	Department of Justice
DOL	Department of Labor
DoT	Department of Transportation
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Department of Education
EPINET	Early Psychosis Intervention Network
FCC	Federal Communications Commission
FDA	Food & Drug Administration
FMAP	Federal Medial Assistance Percentage
GAINS	Gather, Assess, Integrate, Network, and Stimulate
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HUD	Department of Housing and Urban Development
HIS	Indian Health Services
IRS	Internal Revenue Service
IMD	Institutions for Mental Diseases
ISMICC	Interdepartmental Serious Mental Illness Coordinating Committee
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
MAT	Medication Assisted Treatment
MFP	Minority Fellowship Program
MH-CLD	Mental Health Client-Level Data

Abbreviation	Definition
MHPAEA	Mental Health Parity and Addiction Equity Act
NIMH	National Institute of Mental Health
N-MHSS	National Mental Health Services Survey
NQTL	Non-Quantitative Treatment Limitations
NSDUH	National Survey on Drug Use and Health
NSSP	National Strategy for Suicide Prevention
N-SSATS	National Survey of Substance Abuse Treatment Services
N-SUMHSS	National Substance Use and Mental Health Services Survey
NTTAC	National Training & Technical Assistance Center
OASH	Office of the Assistance Secretary for Health
PPS	Prospective Payment System
PATH	Projects for Assistance in Transition from Homelessness
Project AWARE	Advancing Wellness and Resiliency in Education
PIPBHC	Promoting the Integration of Primary and Behavioral Health Care
RAISE	Recovery After an Initial Schizophrenia Episode
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SE-TAY	Supported Employment for Transition Aged Youth
SIM	Sequential Intercept Model
SMI	Serious Mental Illness
SSA	Social Security Administration
S-TAC	State Technical Assistance Center
SUD	Substance Use Disorder
TIEH	Treatment for Individuals Experiencing Homelessness
URS	Uniform Reporting System
U.S.	United States
VA	Veterans Administration
VHA	Veterans Health Administration

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APPENDIX D: ACKNOWLEDGMENTS

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