



# Interdepartmental Serious Mental Illness Coordinating Council (ISMICC) Meeting

Thursday, August 31  
Afternoon Session  
1:00p.m. – 3:00 p.m.

Non-Federal Advances to Address  
Challenges in SMI and SED



# Non-Federal Advances to Address Challenges in SMI and SED

Thursday, August 31  
1:00p.m. – 3:00 p.m.

Lynda Gargan, Ph.D., Executive  
Director  
National Federation of Families for  
Children's Mental Health

# How Are The Children?

~Maasai Warrior Greeting~

The National Federation of Families for Children's Mental Health (NFFCMH):

- Established in 1989 by a group of parents and professionals determined to improve services and supports for children and youth experiencing behavioral health challenges
- The only national advocacy organization with the sole focus of children and youth experiencing behavioral health challenges and their families
- Over 120 chapters nationwide and in the territories

# How Are The Children?

~Maasai Warrior Greeting~

## Prevalence Data:

- Approximately 74.2 million children under the age of 18 reside in the U.S.
- 20% of our children (14.8 million) will experience a significant mental health challenge in their lifetime
- 10% of our children (7.4 million) are experiencing a significant mental health challenge today
- Suicide is the 2<sup>nd</sup> leading cause of death for young people age 15 – 24
- 90% of young people who complete a suicide are diagnosed with a mental illness

# How Are The Children?

~Maasai Warrior Greeting~

Our children are ill-defined: Depending upon the system, childhood ends at 18, at 21, or at 26

Our children are not “little adults”: We cannot extrapolate data and findings from studies with or services for adults and accurately apply these to children

Today’s children are far more traumatized than their predecessors and their social threats are immense

# How Are The Children?

~Maasai Warrior Greeting~

Personal Perspective: A Mother's Journey  
(Caution! This is one mother's story!)

- A framework for success – well-resourced, intact family; blue-ribbon schools; athletic all-star
- Early years – gender bias, one helicopter parent and one ostrich
- Middle school – He's such a great kid! Who's putting those holes in the wall?
- High school – Has anyone checked this kid's ACE scores? Is it ok to smile in a mug shot?

# How Are The Children?

~Maasai Warrior Greeting~

- ❖ College years – Fraternity president, student government vice-president and a 2.9 GPA!
- ❖ Seal Team dream – the military and medication
- ❖ And now – one of the youngest field reps for an international company, a gorgeous fiancée, and a very bright future

# How Are The Children?

~Maasai Warrior Greeting~

## Take-Aways and Lessons Learned:

- A great coach is often more effective than a great therapist
- We must listen to our children
- Mindfulness works for some kids, Cross Fit works for others
- Stigma is real and must be addressed
- To sustain our children, we must sustain our families
- We have created extraordinary Systems of Care with federal funding, we must expand these to fully embrace children and families in the private sector

# How Are The Children?

~Maasai Warrior Greeting~

To Support Our Children and Their Families We Must:

- ✓ Reject stigma and prejudice
- ✓ Identify children's behavioral health as a public health crisis and create enduring responses
- ✓ Quit expecting our teachers to do everything and create holistic, responsive systems for our children and families
- ✓ Cease reaching for the prescription pad as the first line of response

# How Are The Children?

~Maasai Warrior Greeting~

Creating Culturally Responsive Supports:

- Sentiments from an Appalachian American
- “Culture” takes on many forms
- Cultural translators are often essential to the success of traditional services and supports

# How Are The Children?

~Maasai Warrior Greeting~

Peer Support – an essential element in family-driven and youth-guided support:

A peer is an individual who possesses the lived experience of having parented a child who experiences mental/behavioral health challenges

Because families trust families, peers offer guidance and support that cannot be matched by professionals

Peers act as cultural translators, navigators, and advocates for families

# How Are The Children?

~Maasai Warrior Greeting~

**Let's Create a Responsive System That Answers "The Children Are Well"**

# How Are The Children?

~Maasai Warrior Greeting~

For more information, please visit our website at:  
[www.ffcmb.org](http://www.ffcmb.org)



# Non-Federal Advances to Address Challenges in SMI and SED

Thursday, August 31  
1:00p.m. – 3:00 p.m.

Lisa Dixon, M.D., M.P.H.  
Professor of Psychiatry  
Columbia University College of Physicians and Surgeons

# Key Advances in the Clinical Care of Individuals Experiencing SMI/SED

Assumptions:

Focus on Engagement

Continuum of Integrated Care

Evidence-Based Pharmacological Treatment

Person-Centered Approach

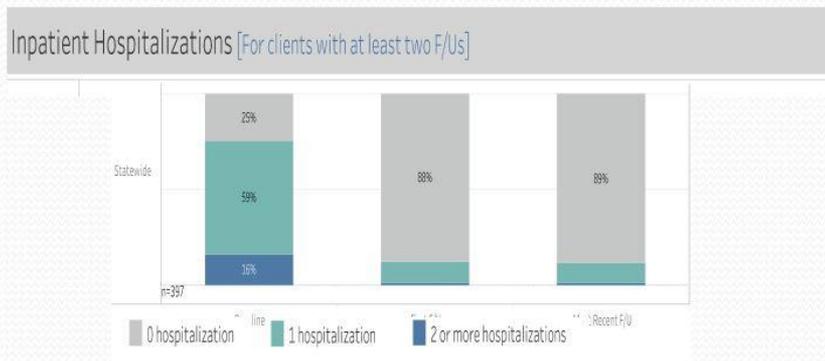
# Schizophrenia Facts

- Schizophrenia affects ~1% of the population, strikes in late adolescence and young adulthood, and is associated with disability and high costs
- Research has shown the advantages of two key strategies:
  - Shortening the *duration of untreated psychosis*: target three months or less
  - Providing team based multi-element intervention called *Coordinated Specialty Care*

# Coordinated Specialty Care for Individuals Experiencing Early Psychosis

- Coordinated Specialty Care is an evidenced-based approach to care with these elements:
  - Team based, person-centered intervention
  - Pharmacology and primary care coordination
  - Cognitive and behavioral psychotherapy
  - Supported employment and education
  - Family support and education
  - Care management
  - Suicide prevention
  - Peer support

# Data from OnTrackNY: Statewide Coordinated Specialty Care Program



## Inpatient Hospitalizations (For clients at least two F/Us)

### Statewide

#### Baseline

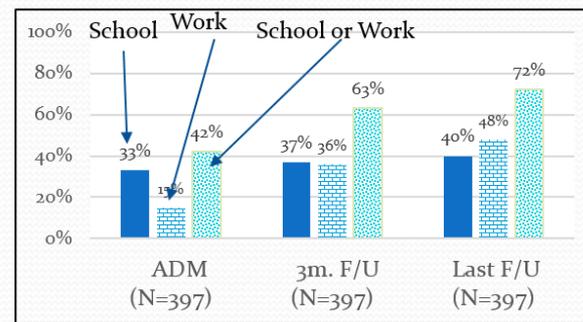
0 hospitalization 25%  
 1 hospitalization 59%  
 2 or more hospitalizations 16%

#### First F/U

0 hospitalization 88%  
 1 hospitalization 12%  
 2 or more hospitalizations 0%

#### Most Recent F/U

0 hospitalization 89%  
 1 hospitalization 11%  
 2 or more hospitalizations 0%



#### ADM (N=397)

School 33%  
 Work 15%  
 School or work 42%

#### 3m. F/U (N=397)

School 37%  
 Work 36%  
 School or work 63%

#### Last F/U (N=397)

School 40%  
 Work 48%  
 School or work 72%

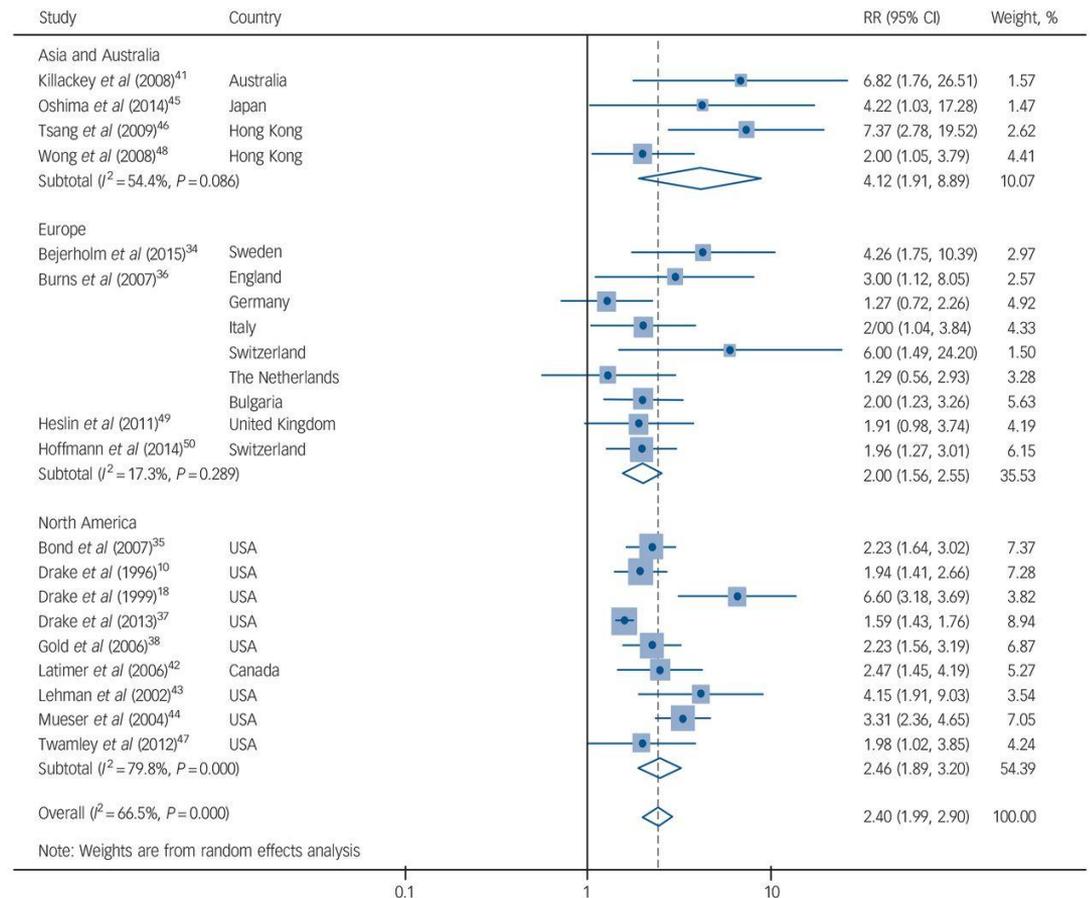
# Supported Employment: Why Focus on Work?

- Most clients want to work!
- Most clients see work as an essential part of recovery
- Being productive = Basic human need
- In most societies, typical adult role
- Working can be a way out of poverty
- Working may prevent entry into disability system

# Relative risk of competitive employment for Individual Placement and Support (IPS) compared with standard vocational rehabilitation

- Pooled risk ratio=2.40 (95% CI 1.99–2.90)
- Employment rates as high as 78% in IPS
- Effect present even when GDP growth < 2%

Matthew Modini et al. *BJP* 2016;209:14-22



# What are Peer Support Strategies and What are their Impacts?

- Peer support strategies include individuals with lived experience of mental illness in the provision of treatment and care.
- Research suggests that inclusion of peers has:
  - Reduced use of acute services (hospital readmissions and days)
  - Decreased substance use
  - Decreased depression
  - Increased engagement with care, relationship with providers, hopefulness and activation/self-care

Bellamy C, Schmutte T, Davidson L (2017) "An update on the growing evidence base for peer support", *Mental Health and Social Inclusion*, Vol. 21 Issue: 3, pp.161-167,

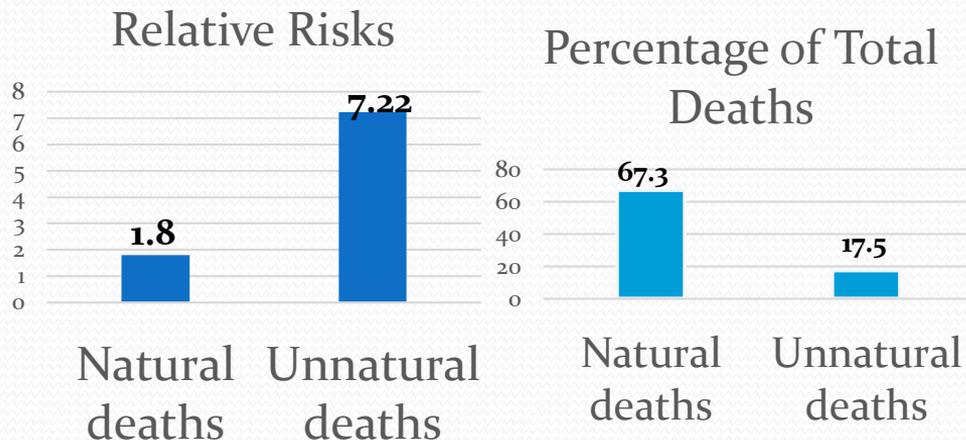
# Suicide and Serious Mental Illness

- Approximately 5-20% of those with SMI die by suicide
- Highest risk follows discharge from ED or inpatient hospital
- Effective strategies reduce risk during post-discharge period:
  - safety planning prior to discharge
  - follow-up outreach (phone; text; home visits)
  - suicide-specific psychotherapies (e.g. Cognitive Therapy for Suicide Prevention; Dialectical Behavior Therapy)
- Knowledge about detecting and treating suicidality (i.e., selective prevention) is not routinely employed in health care systems

# The Problem of Mortality and General Health

Mortality Risk:  
2.2 times  
the general  
population

10 years of  
potential  
life lost



## –Potential Evidence Based Solutions

- Strategic Care Integration: Bring primary care to individuals with SMI
  - Metformin for weight gain\*
  - Lifestyle modification for obesity
  - Bupropion for tobacco cessation
  - Varenicline for tobacco cessation

<sup>1</sup>J Clin Psychiatry. 2014 May;75(5):e424-40.

<sup>2</sup>Schizophr Bull. 2016 Jan;42(1):96-124

<sup>3</sup>. PLoS One. 2017 Jan 5;12(1):e0168549.



# Non-Federal Advances to Address Challenges in SMI and SED

Thursday, August 31  
1:00p.m. – 3:00 p.m.

Sergio Aguilar-Gaxiola, MD, PhD  
Professor of Clinical Internal Medicine  
Director, Center for Reducing Health Disparities  
UC Davis Health

# Objectives

- Disparities in mental health care (treatment gap)
- Barriers and key issues in mental health care
- Comorbidities
- State solutions to reducing mental health care disparities
- Social determinants of health

# Significance of Disparities

- In the context of growing demographic diversity in U.S.
- Significant burden of unmet mental health needs among diverse racially, ethnically, culturally and linguistically diverse populations
- Translates into ill health, premature death, diminished productivity and social potential, wasted resources
- A major U.S. problem

Source: Primm, 2009

# The Treatment Gap

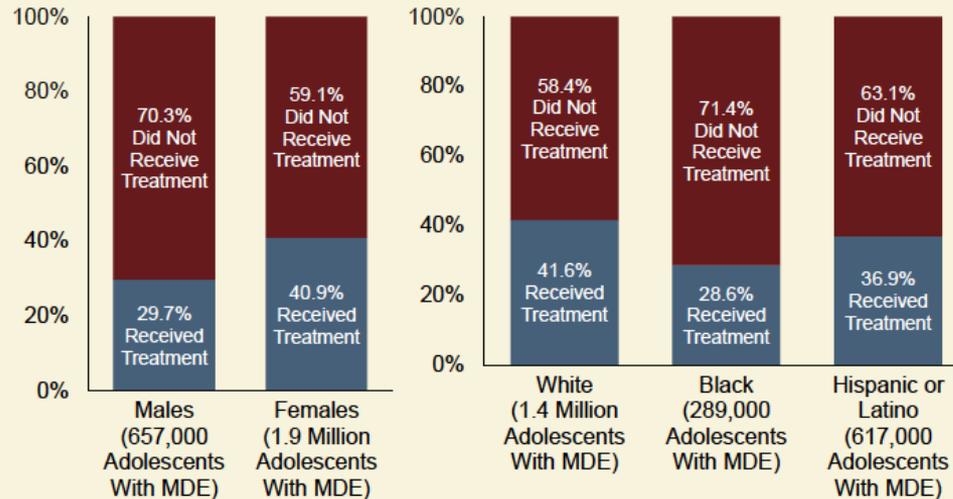
Between 50 to 90% of people with serious mental disorders have not received mental health care in the previous year.

# Treatment Gap in Adults

- Levels of **unmet need** (not receiving specialist or generalist care in past 12 months, with identified diagnosis in the same period)
  - Hispanics – 70%
  - African Americans – 72%
  - Asian Americans – 78%
  - Non-Hispanic Whites – 61%

Source: Alegria et al., 2006

## Past-Year Depression Treatment Among Adolescents Aged 12–17 With MDE, by Demographic Characteristics (2013)<sup>1,7</sup>



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.

5



# Why the Treatment Gap?

- Multiple barriers
  1. Individual level (e.g., stigma)
  2. Community level (e.g., lack of culturally and linguistically appropriate services)
  3. Systemic level (e.g., lack of social and economic resources and poor living conditions)
- Lack of engagement in behavioral healthcare

# Key Issues in Mental Health Care

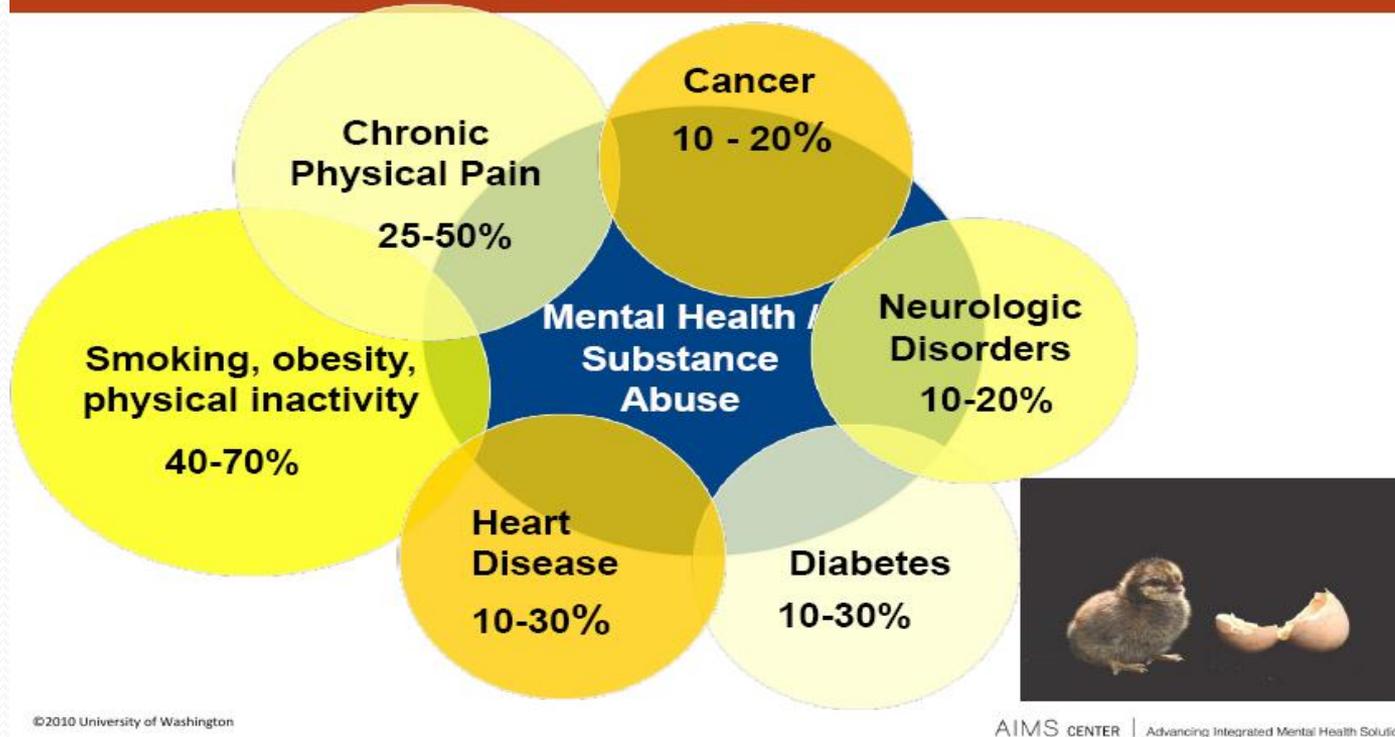
## ■ The 5 A's:

1. Accessibility
2. Affordability
3. Availability
4. Appropriateness
5. Advocacy

# SMI and SED Do Not Occur in a Vacuum

- Biological mechanisms
- Genetic factors
- Environmental risks
- Personal vulnerabilities
- Resilience factors
- **Co-occurrence of other disorders**

# Mental Disorders are Rarely the only Health Problem



Source: Unützer, 2010

# Solutions: Public Health Interventions

- Stigma reduction efforts
- Evidence-based treatment approaches and community-defined evidence
- Person-centered, culturally and linguistically competent, recovery-oriented, trauma-informed care
- Audiovisual tools and social marketing campaigns to combat stigma of mental illness

Source: Primm, 2009

# The Mental Health Services Act (MHSA)

- The Mental Health Services Act (MHSA) was passed by California voters on November 2004 and went into effect in January 2005.
- The MHSA provides increased funding for mental health programs across California.
- The MHSA is funded by a 1% tax surcharge on personal income over \$1 million per year.



# Diverse Audiences: African American



**Support Guide**  
Mental Health in the African American Community



BE THE VOICE OF HOPE

Other ways to create supportive communities:

- Develop neighborhood healing circles.
- Raise awareness through advocacy, leadership and collaboration.
- Keep places of worship open every day of the week. This creates safe places for people to gather and talk.
- Wear lime green, the national color for mental health awareness. Share why mental health matters to you.
- Share videos, blogs, or photos from eachmindmatters.org on Facebook or Twitter to get your friends talking.



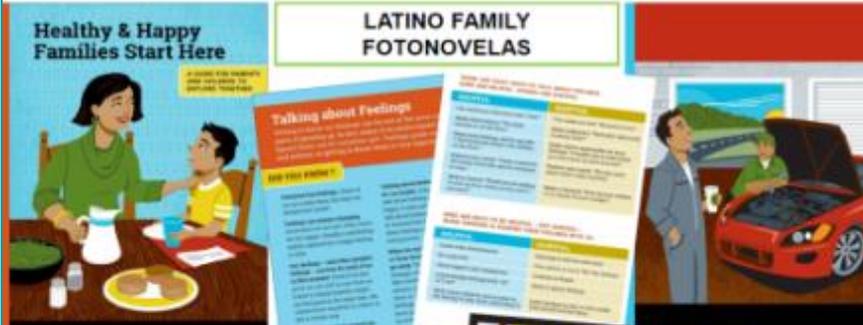
walkinourshoes.org



**Ten Commitments**

The Leaders of this House of Worship have made a commitment to our members and the broader community to become a Mental Health Friendly Community of Faith. We therefore have adopted the following Ten Commitments:

# Diverse Audiences: Latino



La historia de Cristina



La historia de Verónica



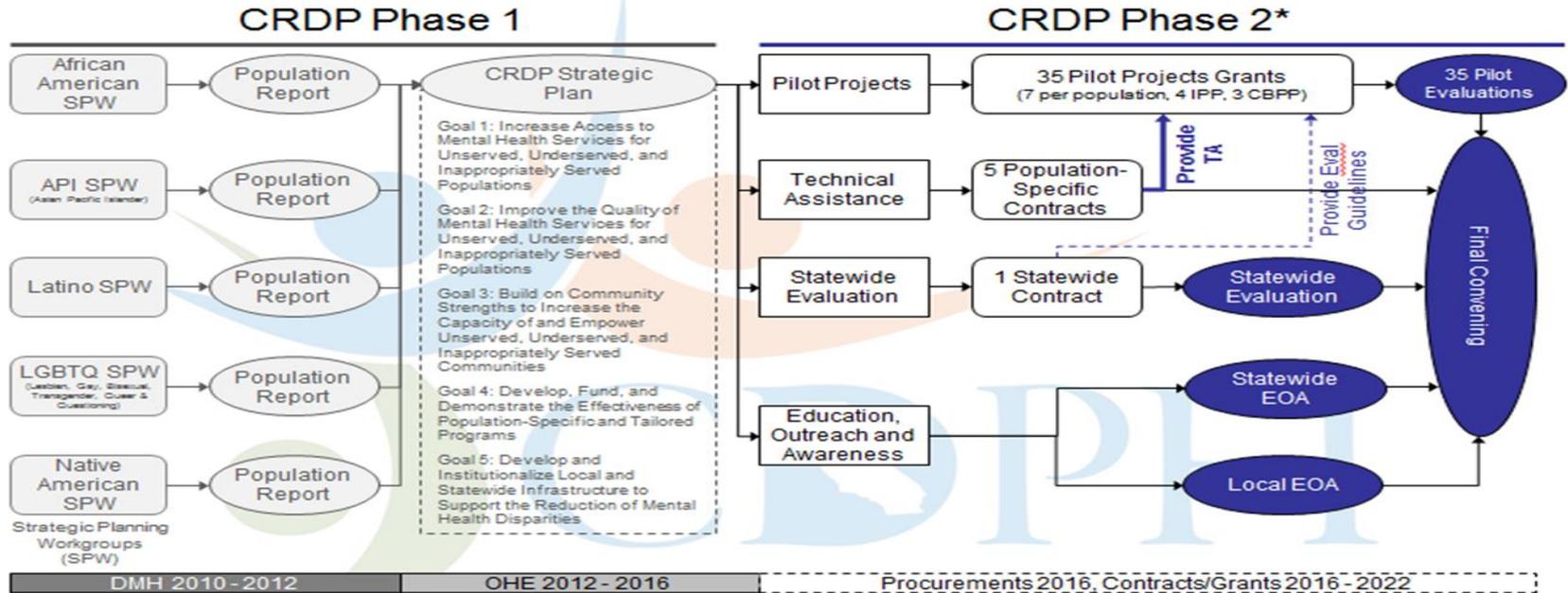
La historia de Pedro y José



La historia de Daniel



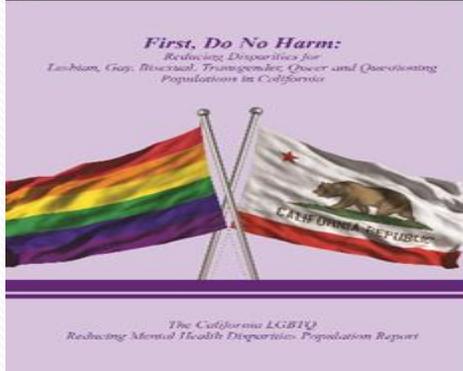
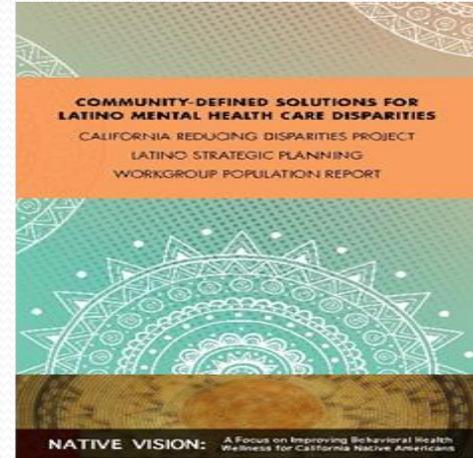
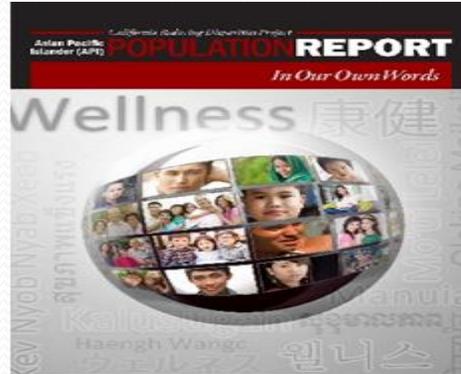
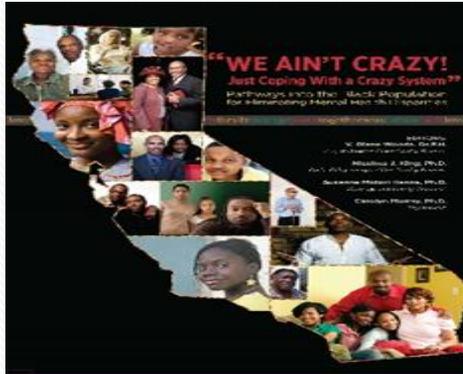
# California Reducing Disparities Project (CRDP)



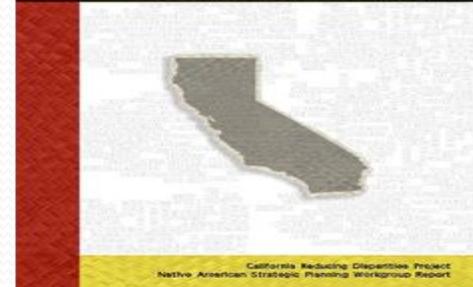
\* In process, specific details subject to change

[Accessible Text Version](#)

# CRDP Phase I Population Reports



## California Reducing Disparities Project (CRDP) Population Reports



# CRDP Phase II

- MHSa funded \$60m initiative to identify promising practices and systems change recommendations to address persistent disparities in historically underserved populations.
- Priority Populations:
  - African American; Asian and Pacific Islander; Latino; LGBTQ; and Native American communities
- In total, over 40 contractors and grantees are funded over six years to implement Phase II of the CRDP.



**Is it possible to improve  
mental health care by  
focusing primarily in  
access to care?**

# It is more than access to care...

## Drivers of Health



**Health access to health care is one component**

# Determinants of Mental Health: Focus on Policy, Systems, and Structural Change

“Addressing socioeconomic factors has the greatest potential to improve health...Achieving social and economic change might require fundamental societal transformation...Interventions that address social determinants of health have the greatest potential for public health benefit.”

**CDC Past Director Dr. Thomas Frieden**

Source: Frieden, A Framework for Public Health Action: The Health Impact Pyramid,” *American Journal of Public Health*, 2010

# Conclusions

- Only a minority of people with SMI and SED receive treatment.
- Unmet need for mental health treatment is pervasive.
- Alleviating these unmet needs requires expansion and optimal allocation of treatment resources.
- Seek solutions that involve diverse communities and grow and utilize community-defined evidence.
- There are some promising community-based solutions at the state and local levels to reducing mental health care disparities.

# Conclusions

- Engaging SMI and SED individuals and their families in the treatment process is key.
- Engagement is not a one-shot deal or a fixed entity. It is an iterative process in which clinicians and investigators engage the client and his/her family and continually evaluate their efforts.
- Incorporating the family in a culturally appropriate fashion within routine clinical settings would improve access to treatment, integration of care and ultimately, clinical outcomes for populations with SMI and SED.

# Relevant Questions

- How can we identify patients' non-medical health needs as part of their overall care?
- How can we connect patients to local services/resources that help people avoid getting sick in the first place or better manage illness, including mental health needs?
- How can we be a strong leader and champion to collaborate with other sectors to improve health where patients live, learn, work, and play?
- How can we connect community residents to jobs in the health care sector – one of the largest employers?



# Non-Federal Advances to Address Challenges in SMI and SED

Thursday, August 31  
1:00p.m. – 3:00 p.m.

Joseph Parks M.D.  
Medical Director For the National Council for Behavioral Health  
Distinguished Prof. Missouri Institute for Mental Health University of  
Missouri St. Louis

# Good News - Numerous Effective New Treatments

- First Episode Psychosis treatment programs
- Collaborative Care for behavioral health conditions in primary care
- Population Health Management in Health Homes, Certified Community Behavioral Health Centers, and PBHCI grantees
- Medication Assisted Treatment for Addictive Disorders
- Peer Support Services
- Dialectic Behavioral Therapy for some personality disorders
- Assertive Community Treatment teams for serious mental illness
- Telehealth

# The Bad News - People cannot access the effective new treatments

- Psychiatry Shortage
  - 40% of psychiatrists are in cash only practice
  - 70% of community mental health centers reported losing money on psychiatric services
  - Hospitals have to subsidize part of the professional cost of psychiatric care out of the hospital payment
- People Waiting in Emergency Rooms
  - Hospitals report losing money on inpatient psychiatric care
  - Community providers cannot get reimbursement for many of the effective new practices
- Substantial portion persons with SMI are still uninsured
- Quality of treatment is very uneven - some is quite good and some not

# Rates Are a Parity Issue

- Organizations limit provision of behavioral health care because they lose money or can make more money and other areas of healthcare
- Payment rates for behavioral healthcare must be sufficient to cover the actual cost of care
- Many components of the new effective care approaches are not directly reimbursable with the current payment methodologies and billing codes
- Some types of facilities and types of providers of the effective treatments are not reimbursable in general

# Enforce Parity Requirements

- Assess rate parity adequacy by comparison of the degree to which the managed care rates compare to the open market cash going rate - behavioral health vs general medical care
- Assess adequacy of the provider panel and access to care by secret shopper surveys

# Certified Community Behavioral Health Centers

- Should be expanded beyond the current eight state demonstration and extended beyond the current two-year demonstration period
- The payment rates are set to be adequate to cover the actual cost of care (just like managed care rates)
- Payment rates can include financial incentive for high-quality care
- Rates cover all components of new affective evidence-based treatments
- Required to provide treatment for addictions
- Required to provide or coordinate with and support medical treatment
- Required to offer a wide range of new effective evidence-based treatments
- Required to offer extended hours and 24/7 crisis services
- Required to publicly report treatment quality performance measures
- Required to serve all patients regardless of ability to pay

# Psychiatric Bed Crisis

- Use the data driven approach
  - Annually track total overnight beds used for mental illness of any type by all payers
- Assure Access to Adequate Community Treatments
  - Use standard definition of levels of care - LOCUS and CALOCUS
  - Require insurers to offer adequate payment to cover the cost of care for all levels of care
- Assure that rates cover the actual cost of providing hospital and residential substance abuse treatment
- Decrease portion of persons without BH insurance coverage to reduce uncompensated care costs
- Prevent inappropriately short inpatient length of stay by using LOCUS and CALOCUS

# Integration Works

- SMI adults and SED kids have high rates of chronic medical illness and substance use disorders
- SMI and SED recovery are much more likely when the substance use disorders and chronic medical illnesses are treated simultaneously
- Promote and Support Integrated Treatment
  - Expand and extend CCBHC opportunities
  - Continue primary and behavioral health care integration grant funding
  - Expand and extend grants to Federally Qualified Health Centers for behavioral health services
  - Require all states pay for mental health services received on the same day as primary care services at FQHCs
  - Require all Medicaid programs to cover the new collaborative care codes

# Actions to Relieve The Psychiatrist Shortage

- Revise the Conrad 30 waiver program so that waivers provided to psychiatrists do not count towards the states ceiling of 30 slots total
- Revise the direct GME calculation for psychiatry residents to use the same per resident payment as for OB/GYN or primary care
- Revise the redistribution requirements for unused Medicare direct GME training slots such that psychiatry training slots cannot be reduced and psychiatry along with primary care and surgery should account for at least 80% of all Medicare GME resident funding slots
- Remove regulatory barriers to tele-psychiatry
  - Eliminate requirement that both patients and clinicians be in a clinic
  - Do not limit tele-psychiatry only to rural areas
  - Expand loan forgiveness by increasing allowable NHSC encounter hours above 25% and lower the distance site HPSA score

# California Reducing Disparities Project (CRDP)

## CRDP Phase 1

This phase includes Strategic Planning Workgroups (SPWs) for several populations: African American, Asian Pacific Islander (API), Latino, LGBTQ, and Native American. From these SPWs, population reports contribute to the CRDP Strategic Plan.

Timeframe: DMH 2010–2012

## CRDP Strategic Plan

This plan includes the following goals:

- Goal 1: Increase access to mental health services for unserved, underserved, and inappropriately served populations.
- Goal 2: Improve the quality of mental health services for unserved, underserved, and inappropriately served populations.
- Goal 3: Build on community strengths to increase the capacity of and empower unserved, underserved, and inappropriately communities.
- Goal 4: Develop, fund, and demonstrate the effectiveness of population-specific and tailored programs
- Goal 5: Develop and institutionalize local and statewide infrastructure to support the reduction of mental health disparities.

Timeframe: OHE 2012–2016

## CRDP Phase 2

**Note:** Phase 2 is in process; specific details are subject to change.

From the CRPD Strategic Plan comes Pilot Projects; Technical Assistance; Statewide Evaluation; and Education, Outreach, and Awareness.

The Pilot Projects include 35 pilot projects grants (7 per population, 4 IPP, and 3 CBPP). The 35 pilot projects produce 35 pilot evaluations, which contribute to the Final Convening.

Technical Assistance includes 5 population-specific contracts. The contracts provide technical assistance to the pilot projects and also contribute to the Final Convening.

Statewide evaluations include one statewide contract and statewide evaluation, which also contribute to the Final Convening.

Education, Outreach, and Awareness includes statewide EOA and local EOA, which both contribute to the Final Convening.

Timeframe: Procurement 2016 contacts/grants 2016–2022