Interdepartmental Serious Mental Illness Coordinating Council (ISMICC) Meeting

Thursday, August 31
Morning Session
10:30 a.m. – 12:00 p.m.

Federal Advances to Address Challenges in SMI and SED
Federal Advances to Address Challenges in SMI and SED

Thursday, August 31
10:30 a.m. – 12:00 p.m.

Joshua A. Gordon, M.D., Ph.D.
Director, NIMH
NIMH Strategic Plan for SMI and SED Research

Disease Origins

Pre-Symptom

Prodrome

Disease

Recovery

Priorities

I. Identify Risk – Enhance Prediction

II. Identify biomarkers

III. Chart illness across development

IV. Develop personalized interventions

Development: Maturation/Sensitive Periods

8/31/2017 ISMICC Meeting
Risk Identification

Charting Genetic Risk – Supporting the Psychiatric Genomics Consortium

Biomarkers

Bipolar-Schizophrenia Network for Intermediate Phenotypes (BSNIP)

Chart Illness

North American Longitudinal Prodrome Study (NAPLS2)

Cannon, *Biological Psychiatry*, 2015
Early/Personalized Intervention
Recovery After an Initial Schizophrenia Episode (RAISE) initiative

Participants with shorter duration of untreated psychosis who received Coordinated Specialty Care had significantly greater improvement in quality of life and psychopathology over 2 years.

Kane, et al., Am. J. Psychiatry, 2016
Early/Personalized Intervention

- Reducing Treatment Delays in First Episode Psychosis (PAR16-264/-265)
- Research to Improve the Care of Persons at Clinical High Risk for Psychotic Disorders (RFA-MH-14-210/-211/-212)
- Advanced Laboratories for Accelerating the Reach and Impact of Treatments for Youth and Adults with Mental Illness (ALACRITY) Research Centers (PAR-16-354)
Personalized Interventions

Development and testing of novel neuromodulation and cognitive-based interventions

- Exploratory Clinical Trials of Novel Interventions for Mental Disorders (RFA-MH-16-406)
- Temporal Dynamics of Neurophysiological Patterns as Potential Targets for Treating Cognitive Deficits in Brain Disorders (PAR-14-153)
Personalized Intervention

Comparative effectiveness and mental health services research efforts

- Pragmatic Strategies for Assessing Psychotherapy Quality in Practice (RFA-MH-17-500)

- Effectiveness Trials for Post-Acute Interventions and Services to Optimize Longer-term Outcomes (PAR-17-272)

- Reducing Medical Comorbidities Among Youth (RFA-MH-16-600) and Adults with SMI (RFA-MH-14-060)
Suicide Prevention

• Applied Research Towards Zero Suicide Healthcare Systems (RFA-MH-16-800)

• Detecting and Preventing Suicide Behavior, Ideation and Self-Harm in Youth in Contact with the Juvenile Justice System (PAR-16-299)

• Addressing Suicide Research Gaps: Aggregating and Mining Existing Data Sets for Secondary Analyses (RFA-MH-18-400)

• Addressing Suicide Research Gaps: Understanding Mortality Outcomes (RFA-MH-18-410)
Federal Advances to Address Challenges in SMI and SED

Thursday, August 31
10:30 a.m. – 12:00 p.m.

Paolo del Vecchio, M.S.W., Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Receipt of EBPs by People with SMI/SED
(2016 Uniform Report System)

- Medications Management: 32.0%
- Illness Self Management: 19.0%
- Dual Diagnosis: 10.5%
- Family Psychoeducation: 1.9%
- Assertive Community: 2.1%
- Supported Employment: 2.1%
- Supported Housing: 3.1%

8/31/2017
ISMICC Meeting
Recommendation:
Coordinated, Collaborative & Comprehensive Care

“Practitioners recommend a combination of medication, psychotherapy, lifestyle choices, and community supports to treat persons with SMI.”

SAMHSA (2014). Literature Review Serious Mental Illness, National Registry of Evidence-based Programs and Practices
Coordinated Care Models: A “Three-legged Stool”
Medications/Medical Interventions

- Atypical antipsychotics
- SSRIs
- Lithium
- Benzodiazepines
- Electroconvulsive therapy
- Deep brain stimulation
- Ketamine, other repurposed agents
- Anti-Inflammatories
Psychotherapeutic Approaches

- Recovery Oriented Cognitive Therapy (CBT) for SMI
- Dialectical Behavior Therapy (DBT)
- Multi-systemic Therapy (MST)
- Cognitive Remediation Therapy (CRT)
- Motivational Interviewing
Recovery Supports

Reducing Homelessness, Incarceration, and Unemployment

- Housing First
- Jail Diversion
- Supported Employment
- Supported Education
- Self-Management
- Peer & Family Support
- Shared Decision Making
- Complementary/Integrative Approaches
Coordinated Care Approaches

- Coordinated Specialty Care for First-Episode Psychosis
- Primary and Behavioral Health Care Integration: health homes, co-location
- Certified Community Behavioral Health Clinics
- Assisted Outpatient Treatment (AOT)
- Trauma-Informed Care
- Assertive Community Treatment
Effective Coordinated Care Starts Early

- First-episode psychosis
- Clinically high-risk Populations/Prodrome
- Social-emotional development: *Good Behavior Game*
- School-based mental health
- Systems of Care
- Infant and Early Childhood Mental Health Consultation
The Acute Care Challenge

- Need for Coordinated Crisis Care Continuum
- Recent adverse trends but evidence that public health approach is effective.

ZERO Suicide in Health and Behavioral Health Care
A Path Ahead: Realizing the Promise of Coordinated Care

- Breakthrough Progress:
  - We are now preparing people for a life of recovery, not a life of disability
- How do we focus on starting early, increasing access, and assuring quality?
- How do we address financing and data needs?
- What about rights protection?
- Need for engagement & individualized/personalized care
- Partnerships and coordination are key!
For More Information

**SAMHSA**
Paolo del Vecchio, Director
Center for Mental Health Services/SAMHSA
5600 Fishers Lane • Rockville, MD • 20852
Phone: 1-877-SAMHSA-7 (1-877-726-4727)
TTY: 1-800-487-4889
Fax: 240-221-4292
http://www.samhsa.gov

**CMHS**
Phone: 240-276-1310
Fax: 240-276-1320
Federal Advances to Address Challenges in SMI and SED

Thursday, August 31
10:30 a.m. – 12:00 p.m.

John McCarthy, Ph.D., M.P.H.
Director, Serious Mental Illness Treatment Resource and Evaluation Center
Veterans Affairs Office of Mental Health and Suicide Prevention
The number of Veterans who utilized VHA services increased by 24% during this time.
Veterans Treated in VHA Outpatient Mental Health Settings, 2005 - 2016

The number treated in VA outpatient mental health settings increased by 85%.
VHA Users With Diagnoses of Mental Health Conditions, by Year, Percentage
Serious Mental Illness Treatment Resource and Evaluation Center

Program evaluation center, VA Office of Mental Health and Suicide Prevention

Monitoring and evaluation for VA patients with Serious Mental Illness (SMI)

- VHA National Psychosis Registry

<table>
<thead>
<tr>
<th>Disorder</th>
<th>N</th>
<th>Age</th>
<th>Male %</th>
<th>With Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder</td>
<td>110,013</td>
<td>53</td>
<td>82%</td>
<td>3,101</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>82,292</td>
<td>59</td>
<td>92%</td>
<td>1,140</td>
</tr>
<tr>
<td>Other psychoses</td>
<td>22,079</td>
<td>61</td>
<td>93%</td>
<td>553</td>
</tr>
</tbody>
</table>

- SMI Re-Engage Initiative

Ongoing VA health system suicide monitoring and analytics

8/31/2017

ISMICC Meeting
Annual Cohorts of VHA Patients with SMI, Fiscal Years 1999-2016

- Schizophrenia
- Bipolar Disorder
- Other

FY99 FY00 FY01 FY02 FY03 FY04 FY05 FY06 FY07 FY08 FY09 FY10 FY11 FY12 FY13 FY14 FY15 FY16

8/31/2017 ISMICC Meeting
Percent with VHA Inpatient Use, Psychiatric & Non-Psychiatric, 1999-2016
Average Outpatient Encounters, VHA Users with SMI, 2000-FY2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-MH</th>
<th>MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY00</td>
<td>21.3</td>
<td>22.5</td>
</tr>
<tr>
<td>FY01</td>
<td>22.5</td>
<td>23.5</td>
</tr>
<tr>
<td>FY02</td>
<td>23.5</td>
<td>24.5</td>
</tr>
<tr>
<td>FY03</td>
<td>24.5</td>
<td>25.5</td>
</tr>
<tr>
<td>FY04</td>
<td>25.5</td>
<td>26.5</td>
</tr>
<tr>
<td>FY05</td>
<td>26.5</td>
<td>27.5</td>
</tr>
<tr>
<td>FY06</td>
<td>27.5</td>
<td>28.5</td>
</tr>
<tr>
<td>FY07</td>
<td>28.5</td>
<td>29.5</td>
</tr>
<tr>
<td>FY08</td>
<td>29.5</td>
<td>30.5</td>
</tr>
<tr>
<td>FY09</td>
<td>30.5</td>
<td>31.5</td>
</tr>
<tr>
<td>FY10</td>
<td>31.5</td>
<td>32.5</td>
</tr>
<tr>
<td>FY11</td>
<td>32.5</td>
<td>33.5</td>
</tr>
<tr>
<td>FY12</td>
<td>33.5</td>
<td>34.5</td>
</tr>
<tr>
<td>FY13</td>
<td>34.5</td>
<td>35.5</td>
</tr>
<tr>
<td>FY14</td>
<td>35.5</td>
<td>36.5</td>
</tr>
<tr>
<td>FY15</td>
<td>36.5</td>
<td>37.5</td>
</tr>
<tr>
<td>FY16</td>
<td>37.5</td>
<td>38.5</td>
</tr>
</tbody>
</table>
Bipolar disorder and schizophrenia are substantial suicide risk factors, particularly among women receiving VHA care.

Table 3. Age-Adjusted Hazard Ratios of Suicide During FY 1999 to FY 2006 in All VHA Patients Treated in FY 1999 Who Were Alive at the Start of FY 2000

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any psychiatric diagnosis</td>
<td>2.50 (2.38-2.64)</td>
<td>5.18 (4.08-6.58)</td>
</tr>
<tr>
<td>Any substance abuse or dependence</td>
<td>2.27 (2.11-2.45)</td>
<td>6.62 (4.72-9.29)</td>
</tr>
<tr>
<td>Alcohol abuse or dependence</td>
<td>2.28 (2.12-2.45)</td>
<td>6.04 (4.14-8.82)</td>
</tr>
<tr>
<td>Drug abuse or dependence</td>
<td>2.09 (1.90-2.31)</td>
<td>5.33 (3.58-7.94)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>2.98 (2.73-3.25)</td>
<td>6.33 (4.69-8.54)</td>
</tr>
<tr>
<td>Depression</td>
<td>2.61 (2.47-2.75)</td>
<td>5.20 (4.01-6.75)</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>2.10 (1.94-2.28)</td>
<td>3.48 (2.52-4.81)</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>1.84 (1.70-1.98)</td>
<td>3.50 (2.51-4.86)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2.10 (1.93-2.28)</td>
<td>6.08 (4.35-8.48)</td>
</tr>
</tbody>
</table>

Ilgen et al., 2010, Arch Gen Psychiatry
Cumulative Probability of Suicide Following Hospital Discharge

Depressive disorder cohort $\chi^2 = 446.6; P < .001$
Bipolar disorder cohort $\chi^2 = 338.2; P < .001$
Schizophrenia cohort $\chi^2 = 273.7; P < .001$
Other mental disorders cohort $\chi^2 = 215.2; P < .001$
Substance use disorder cohort $\chi^2 = 160.0; P < .001$
Nonmental disorders cohort
Suicide Prevention: Everyone’s Business

Shared Responsibility through:

- Engagement of Staff and Leadership Across VA
- Strategic Community Partnerships
- Gatekeeper and Provider Training to Facilitate Risk Identification and Action
- Engagement in High Quality Mental Health Treatment that is Veteran Centered
- Robust Education about Safety related to Lethal Means
- Proactive Research and Data Science
Suicide Prevention Coordinators

More than 400 SPCs nation wide
Free, confidential support 24/7/365

Veterans Crisis Line
1-800-273-8255
PRESS 1

- Veterans
- Family members
- Friends
- Service members

Confidential chat at VeteransCrisisLine.net or text to 838255
Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment (REACH VET)

- Uses VA data and predictive analytics to identify Veterans at high risk for suicide
- Notifies VA providers of the risk assessment
- Asks providers to reevaluate and enhance the care as appropriate in collaboration with the Veteran

Started nationwide in fall 2016
Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET)

Early model demonstrated high risks in SMI patients.

**TABLE 1—Prediction Sample, Descriptive Characteristics, Overall, Among Suicide Decedents Within 12 Months: Veterans Health Administration, United States, 2008–2011**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Unique Patients, No. (%)</th>
<th>Suicide Decedents Within 12 Mo, No. (%)</th>
<th>Suicides/100 000, No.</th>
<th>In Top 5.00% of Predicted Probability, No. (%)</th>
<th>In Top 0.10% of Predicted Probability, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5 969 662</td>
<td>2138 (0.04)</td>
<td>35.8</td>
<td>298 483</td>
<td>5 969</td>
</tr>
<tr>
<td>Psychiatric diagnosis in past 24 mo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any***</td>
<td>2 245 554 (37.6)</td>
<td>1250 (58.5)</td>
<td>55.7</td>
<td>271 939 (91.1)</td>
<td>5 961 (99.9)</td>
</tr>
<tr>
<td>Depression***</td>
<td>1 216 754 (20.4)</td>
<td>876 (40.1)</td>
<td>72.0</td>
<td>221 475 (74.2)</td>
<td>5 471 (91.7)</td>
</tr>
<tr>
<td>Schizophrenia***</td>
<td>105 664 (1.8)</td>
<td>81 (3.8)</td>
<td>76.7</td>
<td>18 720 (6.3)</td>
<td>809 (13.6)</td>
</tr>
<tr>
<td>Bipolar disorder***</td>
<td>148 357 (2.5)</td>
<td>190 (8.9)</td>
<td>128.1</td>
<td>45 554 (15.3)</td>
<td>2 370 (39.7)</td>
</tr>
</tbody>
</table>

*McCarthy et al., 2015, Am J Pub Hlth*
SMI Re-Engage

- 3.4% of Veteran VHA patients with schizophrenia and bipolar disorder have a gap in VHA services that lasts more than one year
- Through SMI Re-Engage, Local Recovery Coordinators provide outreach to these Veterans to support return to VHA services
- SMI Re-Engage outreach contact increases return to care
- Since 2012, over 1700 Veterans with SMI have returned to VHA care
There are many other important services for Veterans with SMI, including:

- Psychosocial Rehabilitation and Recovery Care Program (PRRC)
- Intensive Community Mental Health Recovery Services (ICMHR)
- Substance Abuse Recovery and Rehabilitation Treatment Program
- Homeless Housing Programs and Support
  - Housing and Urban Development/VA Supportive Housing (HUD/VASH)
  - Grant and Per Diem Program (GPD)
  - Critical Time Intervention (CTI)

VA is working to enhance access to timely high quality health services, provide outreach to high-risk Veterans, and to enhance suicide prevention through community partnerships.
Federal Advances to Address Challenges in SMI and SED

Thursday, August 31
10:30 a.m. – 12:00 p.m.

Ruby Qazilbash
Associate Deputy Director
Bureau of Justice Assistance
Prevalence of SMI in the criminal justice system

General Population

- 4% Serious Mental Illness

Jail Population

- 17% Serious Mental Illness
- 72% Co-Occurring Substance Use Disorder

Source:


Steadman, HJ, Osher, FC, Robbins, PC, Case, B., and Samuels, S. Prevalence of Serious Mental Illness Among Jail Inmates, Psychiatric Services, 6 (60), 761-765, 2009.

Jails are where the volume is

Percent of population who met the threshold for serious psychological distress, 2009-2012

Jail inmates | Prisoners | Under Supervision
---|---|---
26% | 14% | 11%

Annual admissions to Jails vs. Prisons

Jail admissions | Prison admissions
---|---
10.9 million | 626,644

---


In Madison, WI, behavioral health calls for service take twice as long to resolve:
- All CFS = 1.5 hours
- BH CFS = 3 hours

MH-Related Calls to Law Enforcement Agencies in Deschutes County, OR

Source: Bend Police Department
Behind the Walls

About a third of people with a mental health indicator were currently receiving treatment while in jail or prison.

For inmates who indicated psychological distress...

People with mental illnesses tend to stay in jail longer than those without mental illnesses, but still stay for a relatively short period of time.

Source: https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

Source: CSG Justice Center, “Improving Outcomes for People with Mental Illnesses Involved with New York City’s Criminal Court and Correction Systems,” December 2012
Community-Based Programs Work, but Gaps Remain

Connections to community-based services (including case management) after release from jail associated with recidivism reduction

- People leaving jail who received community-based case management had lower probability of arrest, and longer period before rearrest

However, county analyses reveal gaps in such connections.

10,523 Bookings

969 People with serious mental illness

2,315 People with serious mental illness based on national estimates

609 Received treatment in the community

1,706 Did NOT receive treatment in the Community

926 LOW RISK

1,389 HIGH/ MOD RISK

Source: LA Ventura et al. Psychiatric Services 49 (10), 1330-1337. 10 1998

Source: CSG Justice Center, "Franklin County, Ohio: A County Justice and Behavioral Health Systems Improvement Project," May 2015
Policy Focus: Building Systems of Diversion with Connections to Community-Based Systems of Care

Law Enforcement
- Initial Contact with Law Enforcement
- Arrest

Jail-based
- Initial Detention
- Jail - Pretrial

Court-based
- First Court Appearance
- Dispositional Court
- Specialty Court

Pretrial
- Jail/Reentry
- Prison/Reentry
- Probation
- Parole

Community-Based Continuum of Treatment, Services, and Housing
- Outpatient Treatment
- Intensive Outpatient Treatment
- Integrated MH & SU Services
- Peer Support Services
- Supported Employment
- Crisis Services
- Psychopharmacology
- Supportive Housing
- Case Management

8/31/2017 ISMICC Meeting
### A Framework for Prioritizing Resources

#### Criminogenic Risk and Behavioral Health Needs Framework

**Subgrouping A**
- **Low Criminogenic Risk (low)**
  - Low Severity of Substance Abuse (low)
  - Substance Dependence (med/high)

**Medium to High Criminogenic Risk (med/high)**
- Low Severity of Substance Abuse (low)
- Substance Dependence (med/high)

**High Criminogenic Risk risk/ some significant BH treatment needs**
- Prioritize for intensive supervision (in lieu of incarceration or as condition of release) coordinated with appropriate treatment and supports

**Subgrouping B**
- **Low Criminogenic Risk (low)**
  - Low Severity of Substance Abuse (low)
  - Substance Dependence (med/high)

**Medium to High Criminogenic Risk (med/high)**
- Low Severity of Substance Abuse (low)
- Substance Dependence (med/high)

**High Criminogenic Risk risk/ some significant BH treatment needs**
- Prioritize for intensive supervision (in lieu of incarceration or as condition of release) coordinated with appropriate treatment and supports

---

8/31/2017

ISMICC Meeting
Justice and Mental Health Collaboration Program (JMHCP) Grants

Funding authorized through MIOTCRA (2004), 21st Century Cures Act (2016)

Grants awarded
2006-2016: 380 awardees
2017: 55 awardees

Funding levels
2006-2016: $92.4 million
2017: $12 million

Grant programs focus on:
1) County strategic planning to reduce the number of people with mental illnesses in jails
2) Improving law enforcement responses
3) Diversion and reentry programs

Representing 47 states and two U.S. territories
ISMICC Meeting
GOAL: There will be fewer people with mental illnesses in our jails tomorrow than there are today.
A Common Framework for County-Level Action

Six Questions County Leaders Need to Ask

1. Is your leadership committed?
2. Do you have timely screening and assessment?
3. Do you have baseline data?
4. Have you conducted a comprehensive process analysis and service inventory?
5. Have you prioritized policy, practice, and funding?
6. Do you track progress?

Released in January 2017

Strategies Should Focus on Four Key Measures

1. Reduce
   - The number of people with SMI booked into jail
2. Shorten
   - The average length of stay for people SMI in jails
3. Increase
   - The percentage of connection to care for people with SMI in jail
4. Lower
   - Rates of recidivism

8/31/2017 ISMICC Meeting
BJA’s LE-MH Initiatives

The PMHC Toolkit provides resources for law enforcement agencies to partner with mental health providers to effectively respond to calls for service, improve outcomes for people with mental illness, and advance the safety of all.

The six Law Enforcement-Mental Health Learning Sites collectively reflect the range of strategies a law enforcement agency might consider when developing a PMHC. As national learning sites they provide peer-to-peer learning and support to help other jurisdictions improve their responses to people with mental illnesses.

The National Training and Technical Assistance Center will provide on-demand TTA for agencies and jurisdictions seeking to enhance law enforcement responses to people with mental health needs and intellectual and developmental disabilities.