



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

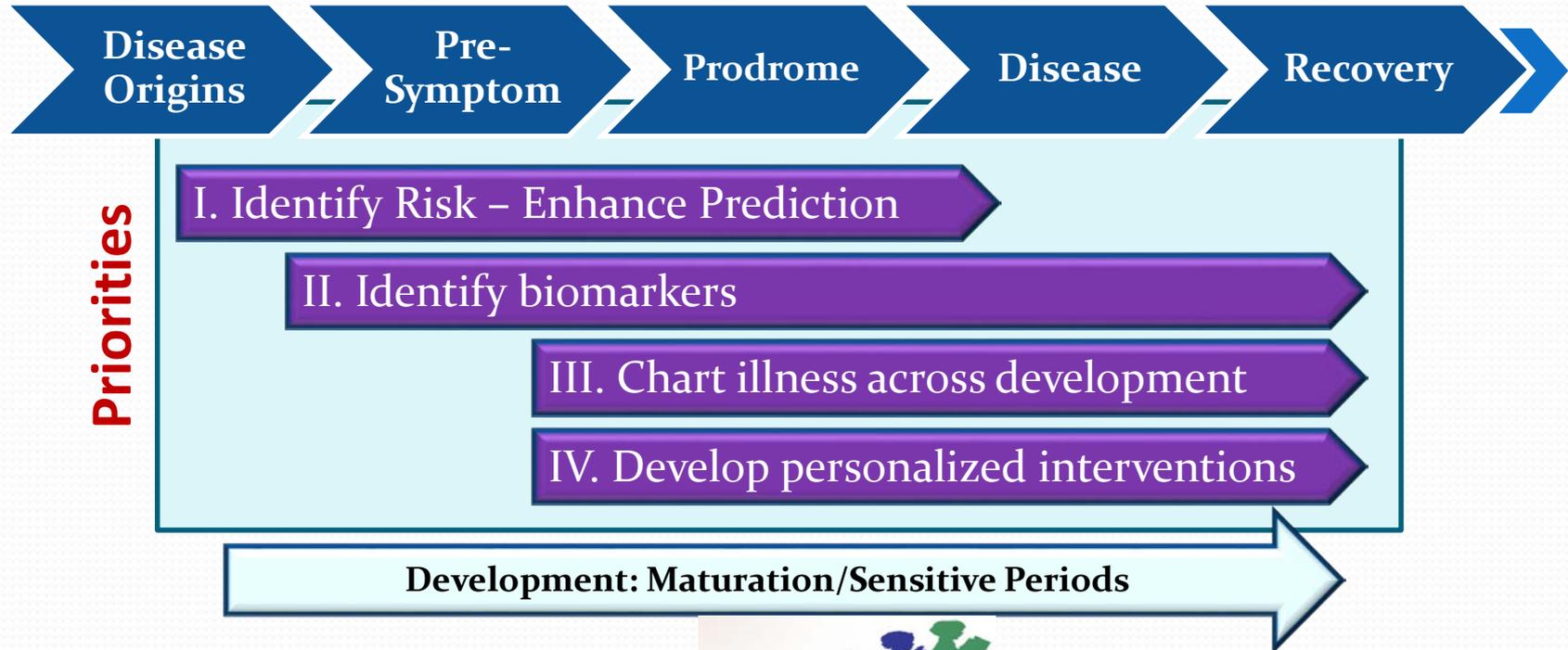


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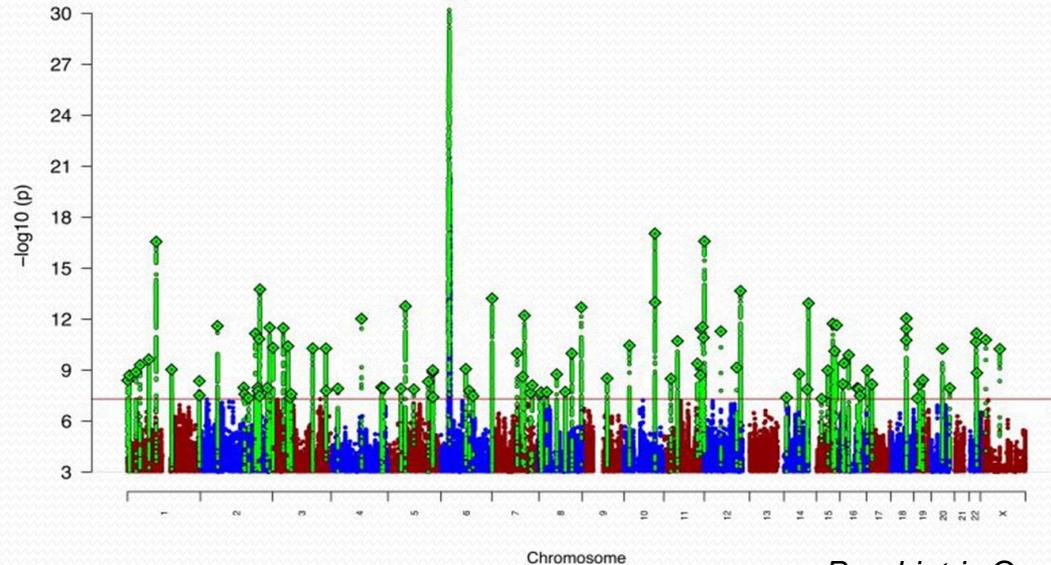
Joshua A. Gordon, M.D., Ph.D.
Director, NIMH

NIMH Strategic Plan for SMI and SED Research



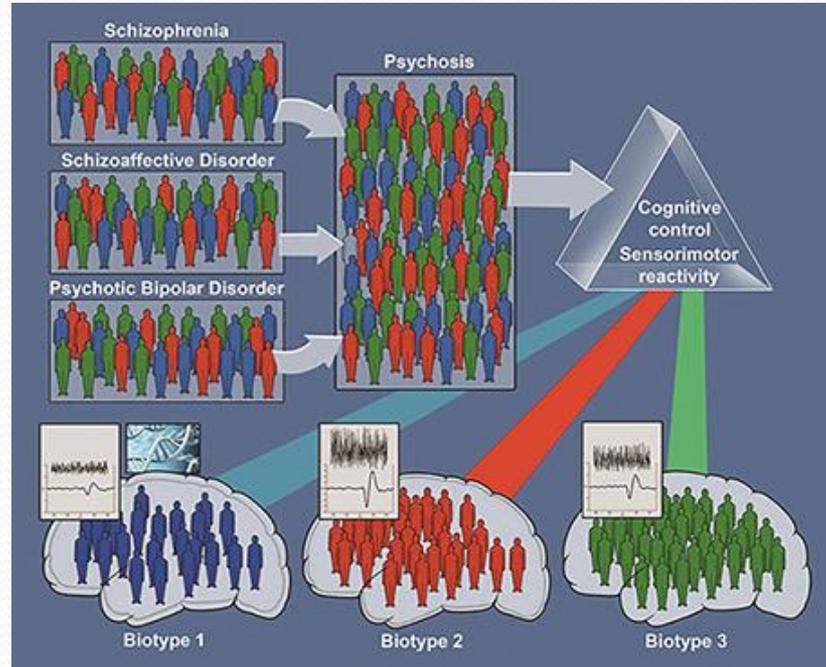
Risk Identification

Charting Genetic Risk – Supporting the Psychiatric Genomics Consortium



Biomarkers

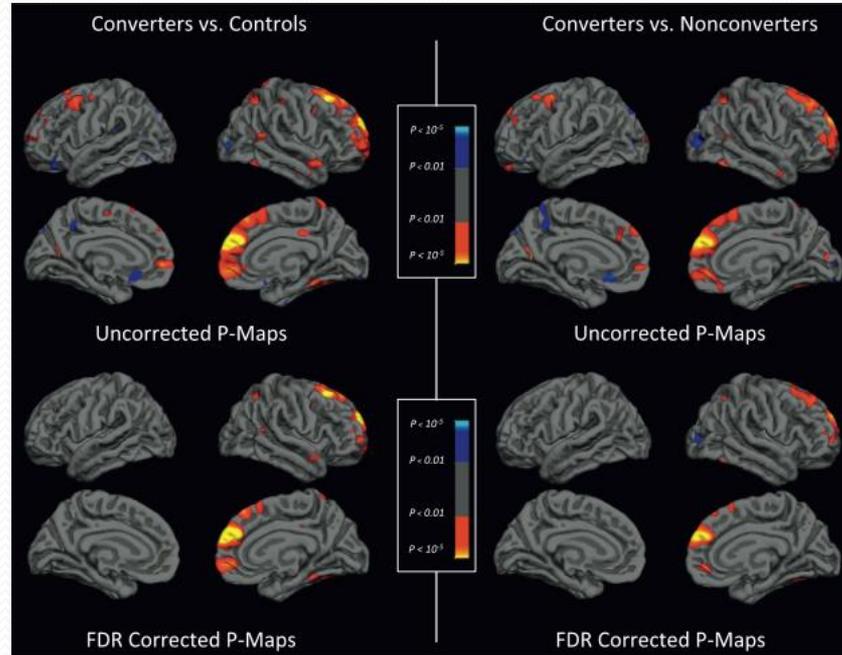
Bipolar-Schizophrenia Network for Intermediate Phenotypes (BSNIP)



Clementz, *Am J Psychiatry*, 2016

Chart Illness

North American Longitudinal Prodrome Study (NAPLS₂)



Cannon, *Biological Psychiatry*, 2015

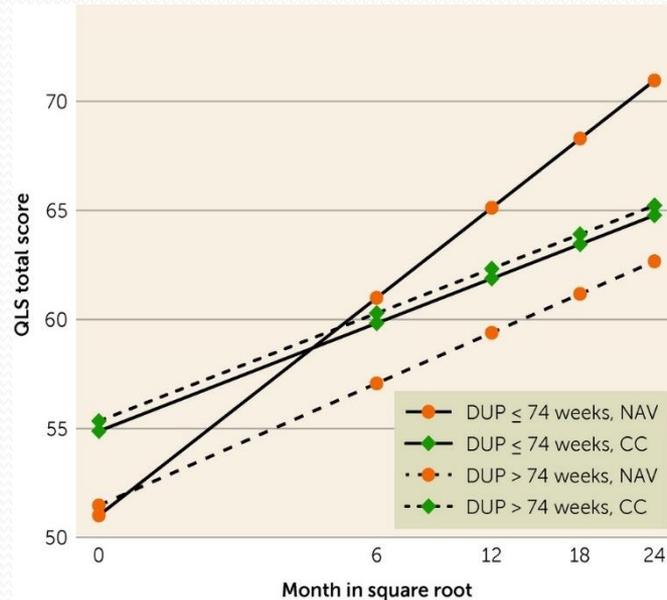
Early/Personalized Intervention

Recovery After an Initial Schizophrenia Episode (RAISE) initiative

RAISE

Recovery After an Initial Schizophrenia Episode

A Research Project of the NIMH



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

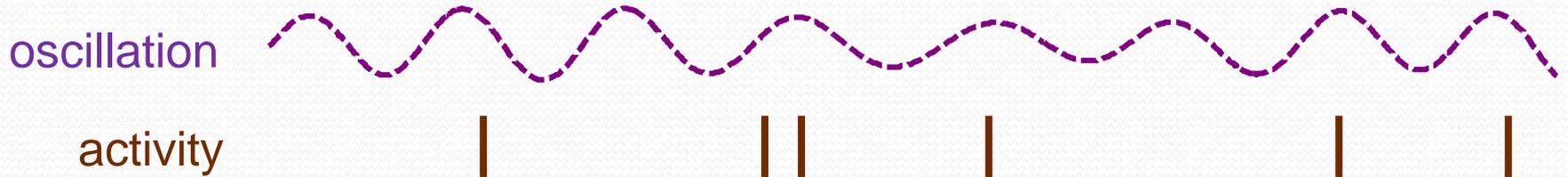
Early/Personalized Intervention

- 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)



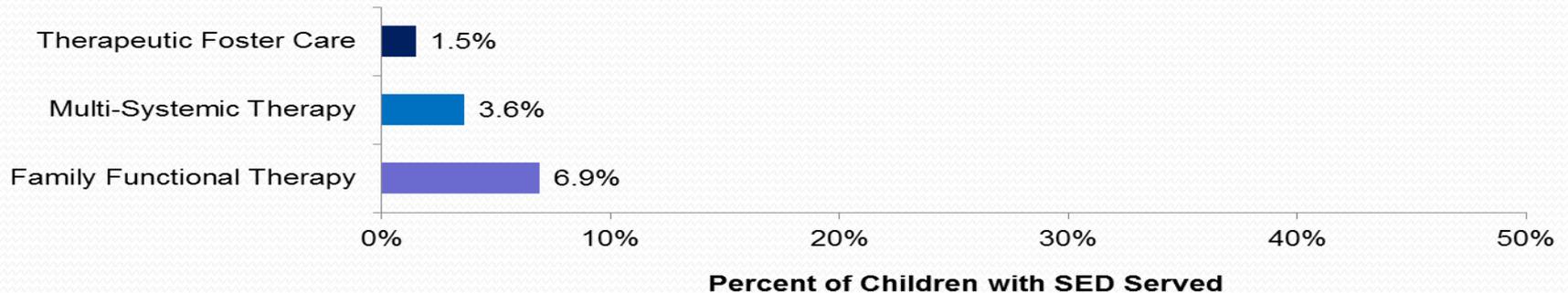
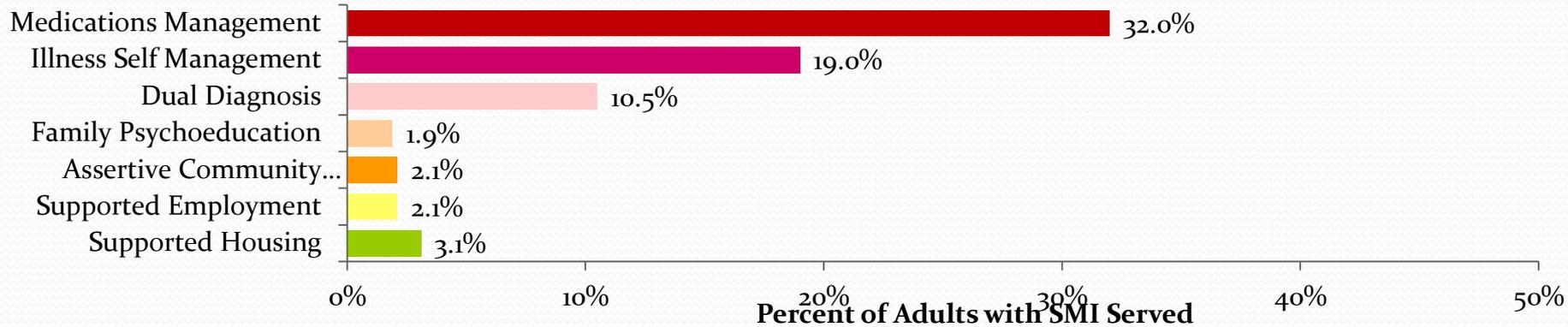
Federal Advances to Address Challenges in SMI and SED

Thursday, August 31
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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)



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

Recovery
Supports

Therapy

Medications/Medical Interventions

<https://www.samhsa.gov/treatment/mental-disorders>

Behavioral Health Treatments and Services

Treatments for Mental Disorders

Anxiety Disorders
ADHD
Bipolar Disorders
Borderline Personality Disorder (BPD)
Depression
Disruptive Behavior Disorders
Eating Disorders
Insomnia Disorders
Obsessive-compulsive Disorder (OCD)
Post-traumatic Stress Disorder (PTSD)
Schizophrenia

Treatments for Substance Use Disorders

Publications and Resources

- 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

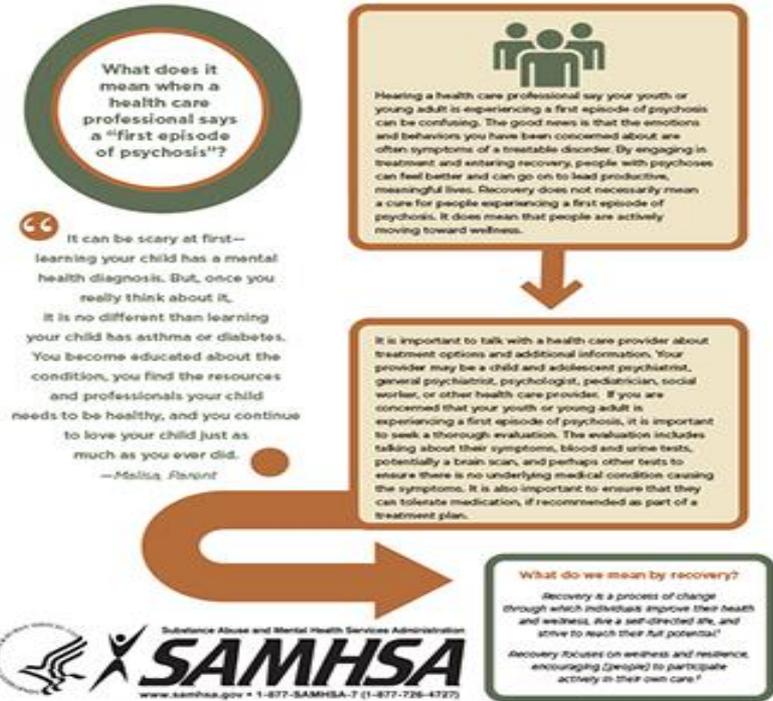


- **Coordinated Specialty Care for First-Episode Psychosis**
- **Primary and Behavioral Health Care Integration: health homes, co-location**
- **Certified Community Behavioral Health Clinics**
- **Assisted Outpatient Treatment (AOT)**
- **Trauma-Informed Care**
- **Assertive Community Treatment**

Effective Coordinated Care Starts Early

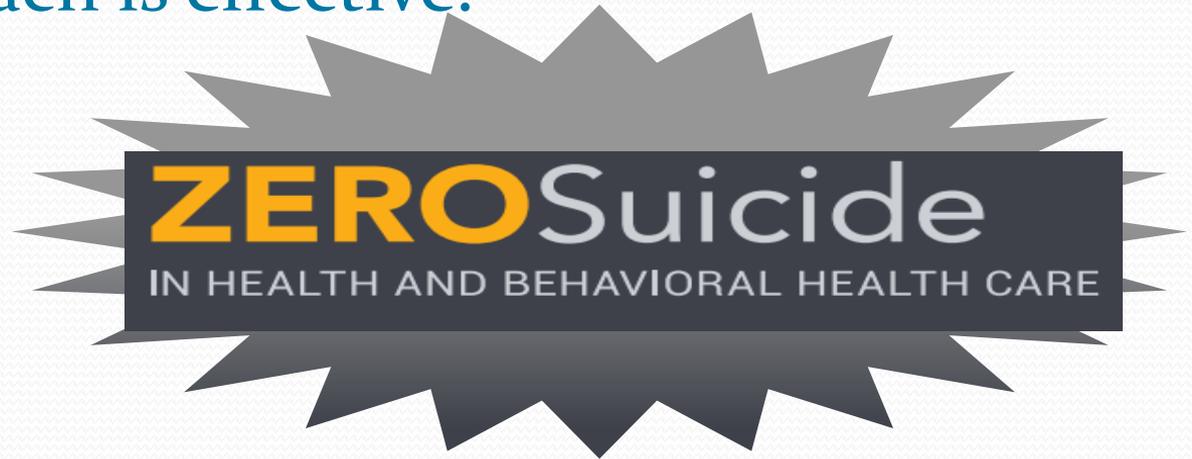
- First-episode psychosis
- Clinically high-risk Populations/Prodrome
- Social-emotional development: *Good Behavior Game*
- School-based mental health
- Systems of Care
- Infant and Early Childhood Mental Health Consultation

UNDERSTANDING A FIRST EPISODE OF PSYCHOSIS Caregiver: Get the Facts



The Acute Care Challenge

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



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

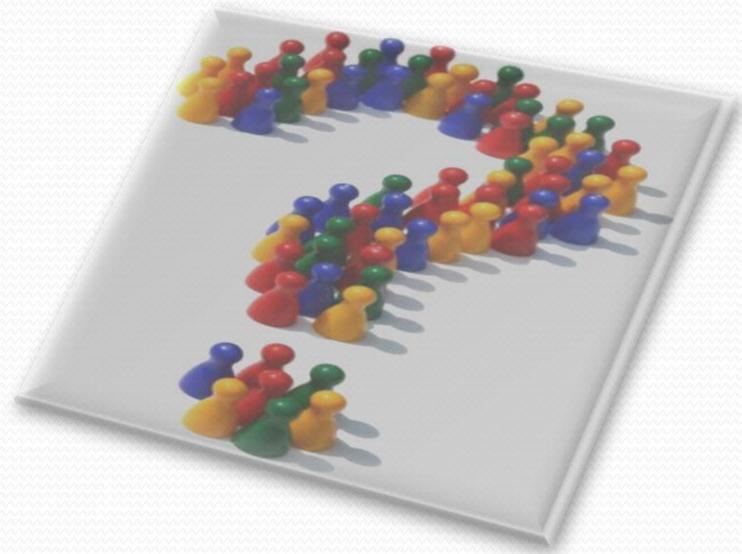
Fax: 240-221-4292

<http://www.samhsa.gov>

CMHS

Phone: 240-276-1310

Fax: 240-276-1320



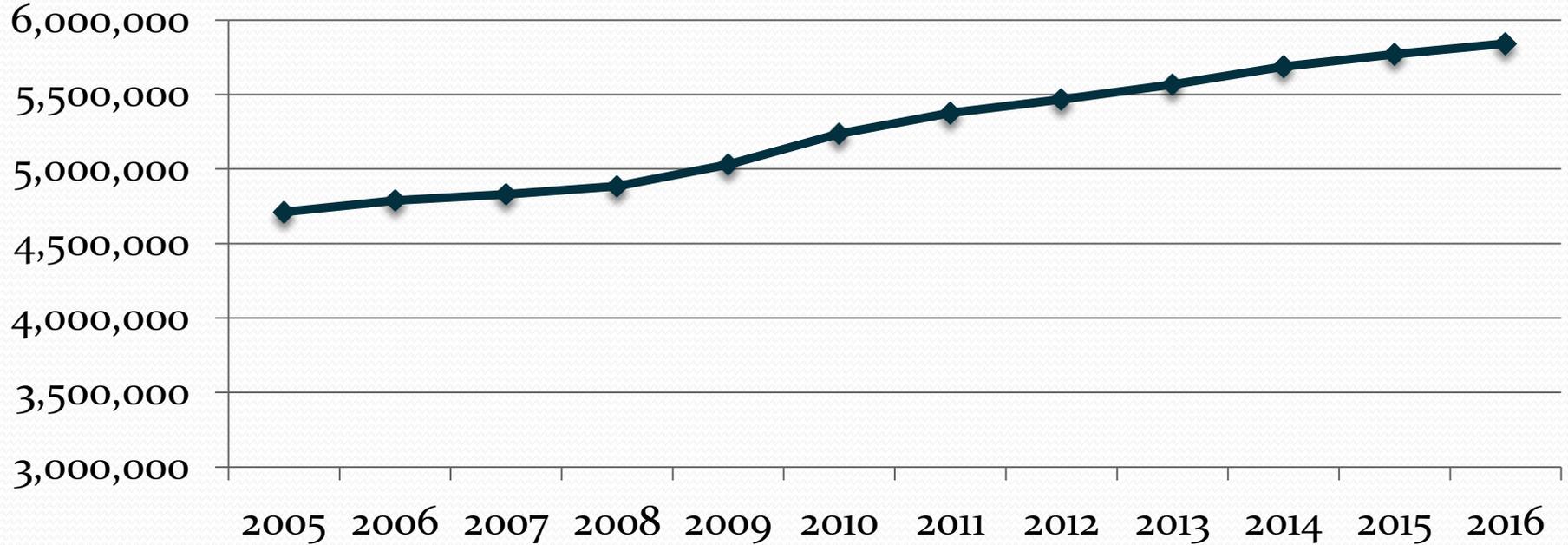


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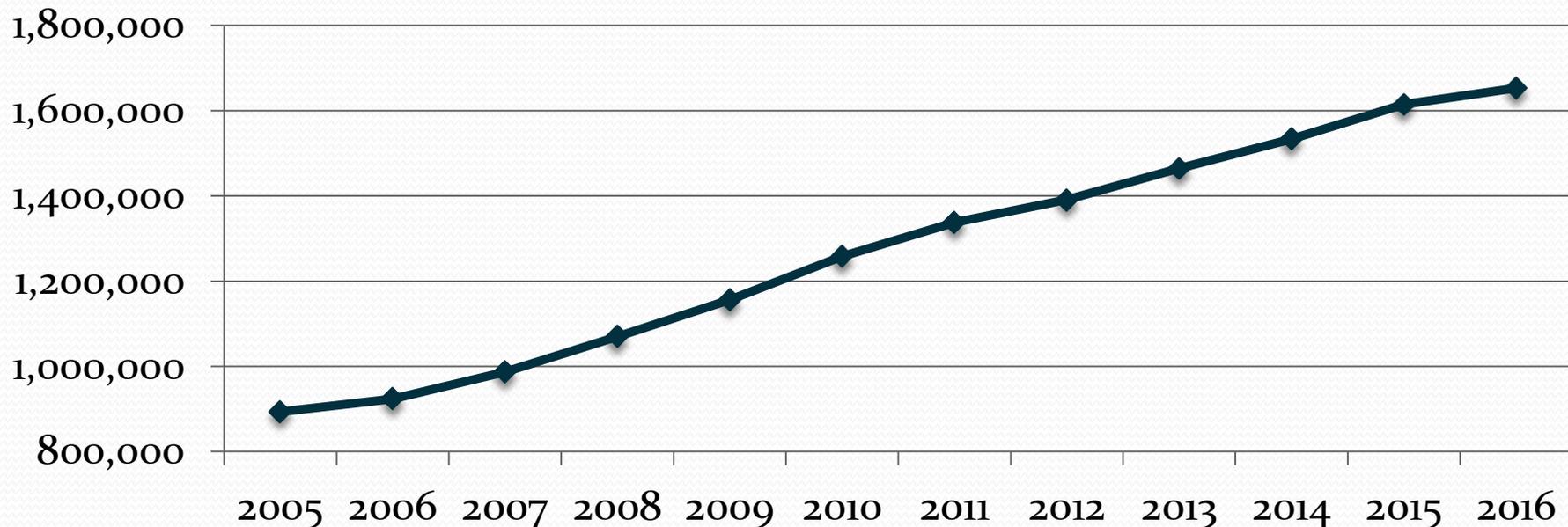
John McCarthy, Ph.D., M.P.H.
Director, Serious Mental Illness Treatment Resource and Evaluation Center
Veterans Affairs Office of Mental Health and Suicide Prevention

Number of Veterans Who Utilized VHA Services, 2005 - 2016



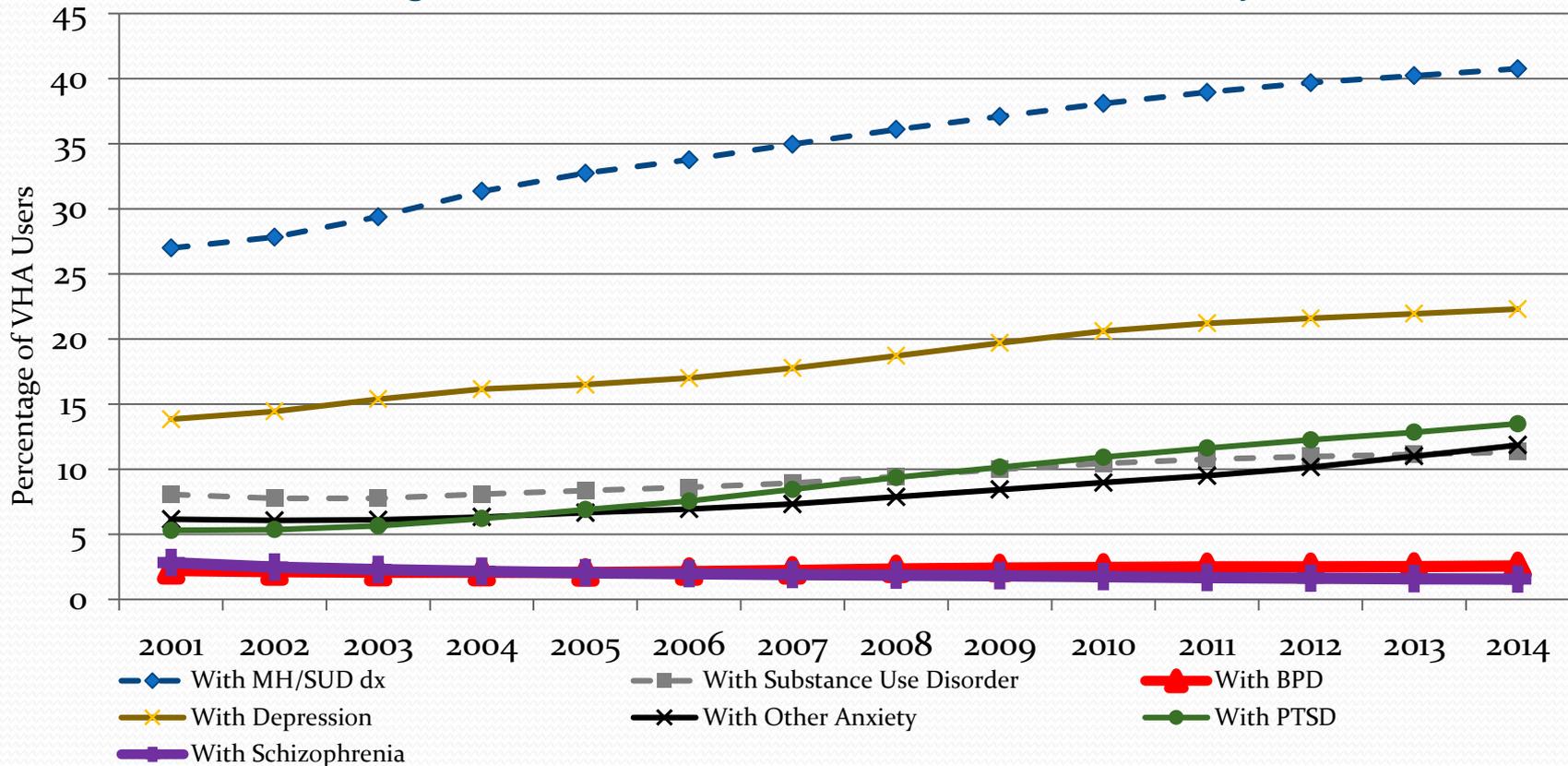
The number of Veterans who utilized VHA services **increased by 24%** during this time.

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

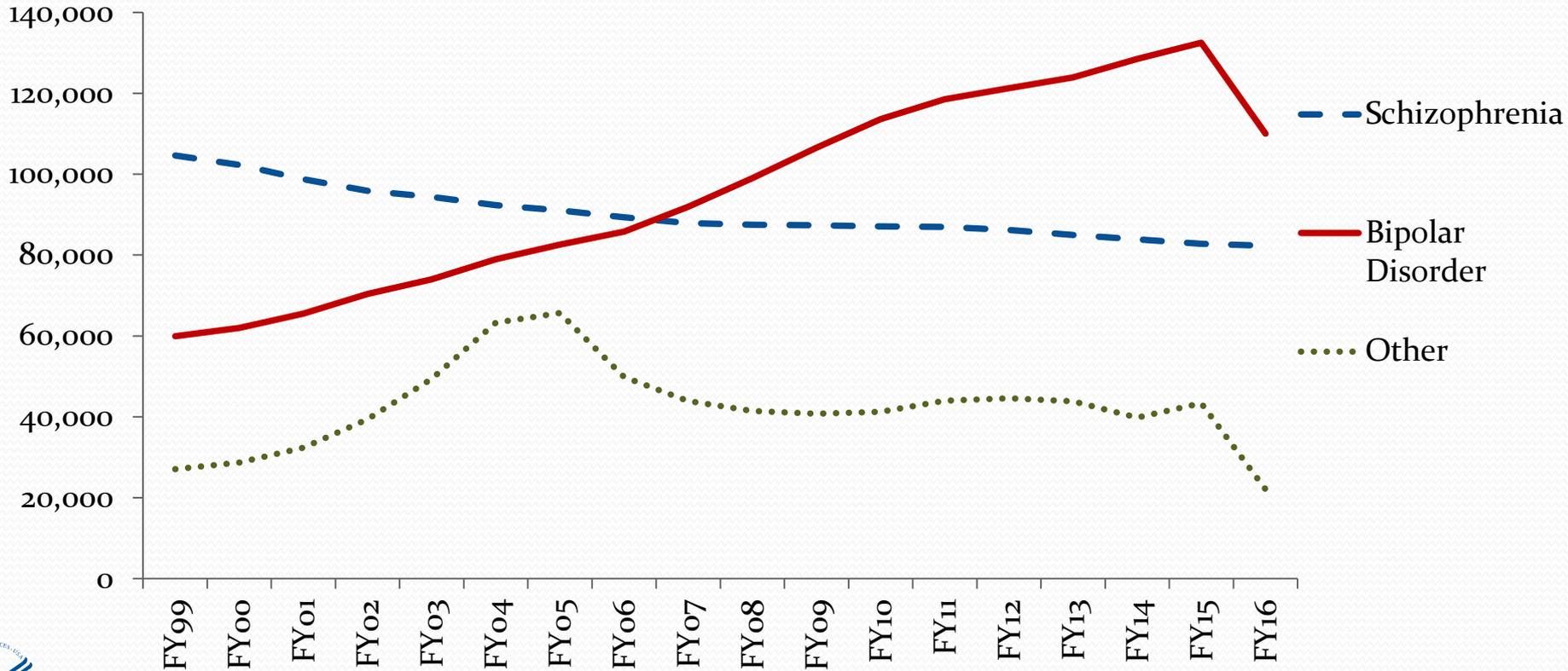
Monitoring and evaluation for VA patients with Serious Mental Illness (SMI)
- VHA National Psychosis Registry

<i>FY2016</i>	<i>N</i>	<i>Mean</i>		<i>With Suicide Attempt Indication in FY2016</i>	
		<i>Age</i>	<i>Male %</i>	<i>N</i>	<i>%</i>
Bipolar disorder	110,013	53	82%	3,101	2.8%
Schizophrenia	82,292	59	92%	1,140	1.4%
Other psychoses	22,079	61	93%	553	2.5%

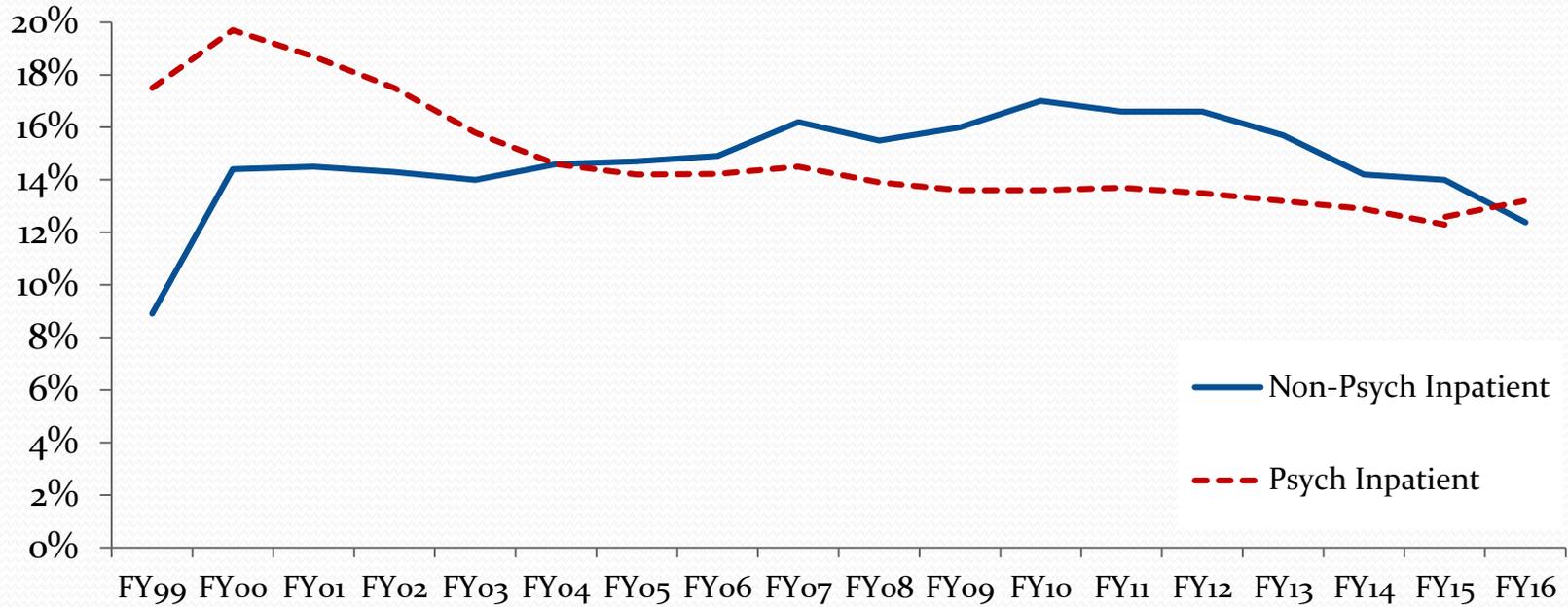
- SMI Re-Engage Initiative

Ongoing VA health system suicide monitoring and analytics

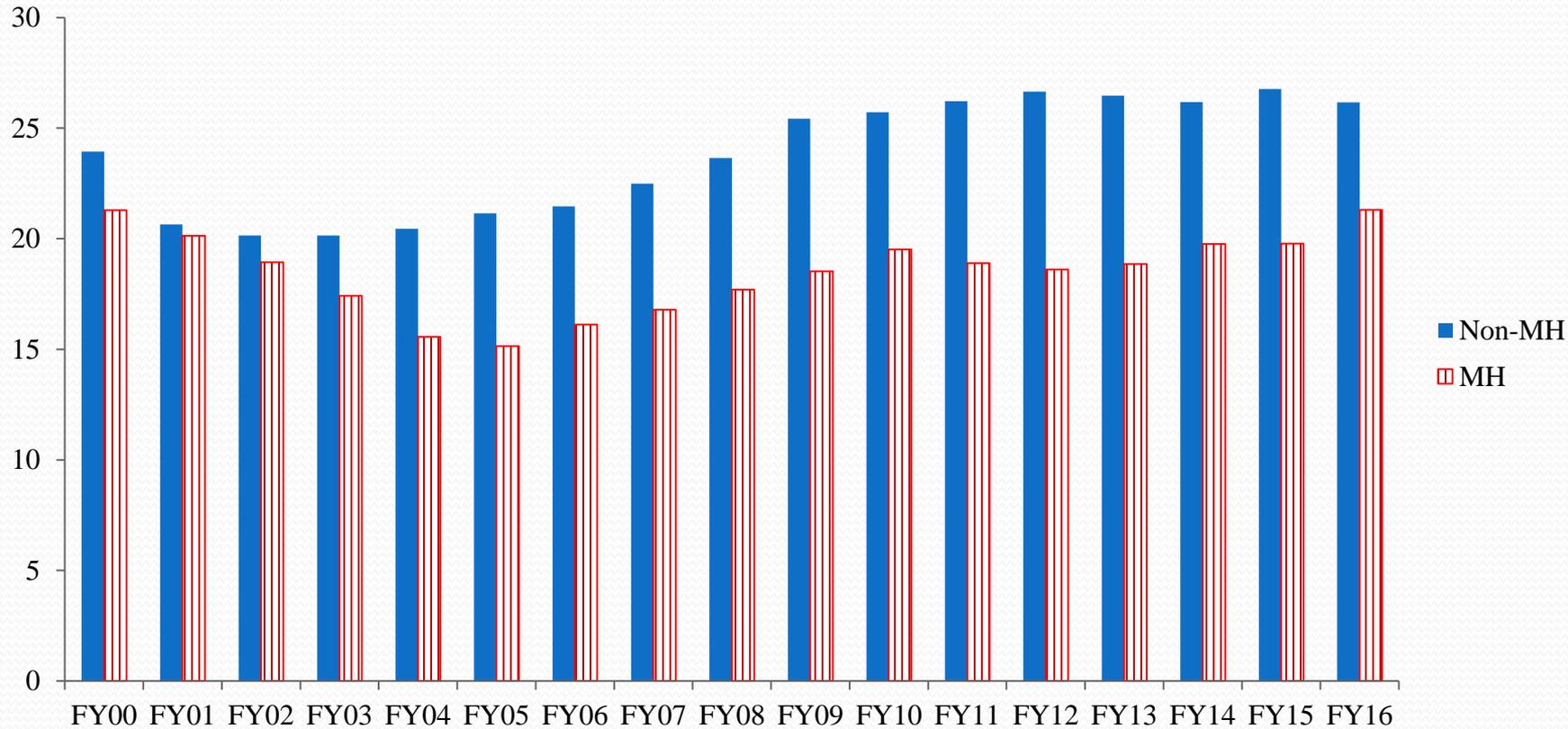
Annual Cohorts of VHA Patients with SMI, Fiscal Years 1999-2016



Percent with VHA Inpatient Use, Psychiatric & Non-Psychiatric, 1999-2016



Average Outpatient Encounters, VHA Users with SMI, 2000-FY2016



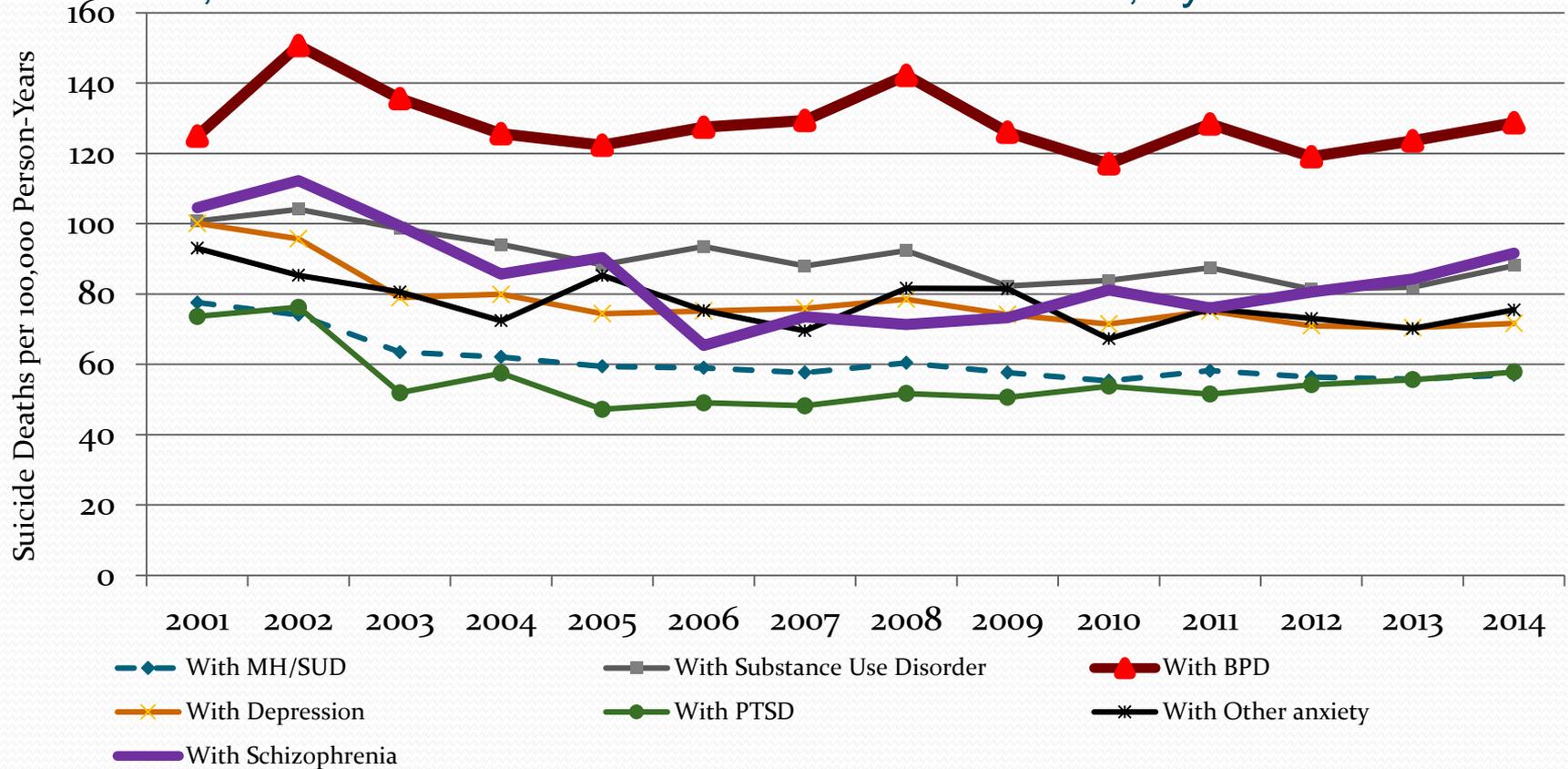
Bipolar disorder and schizophrenia are substantial suicide risk factors, particularly among women receiving VHA care

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

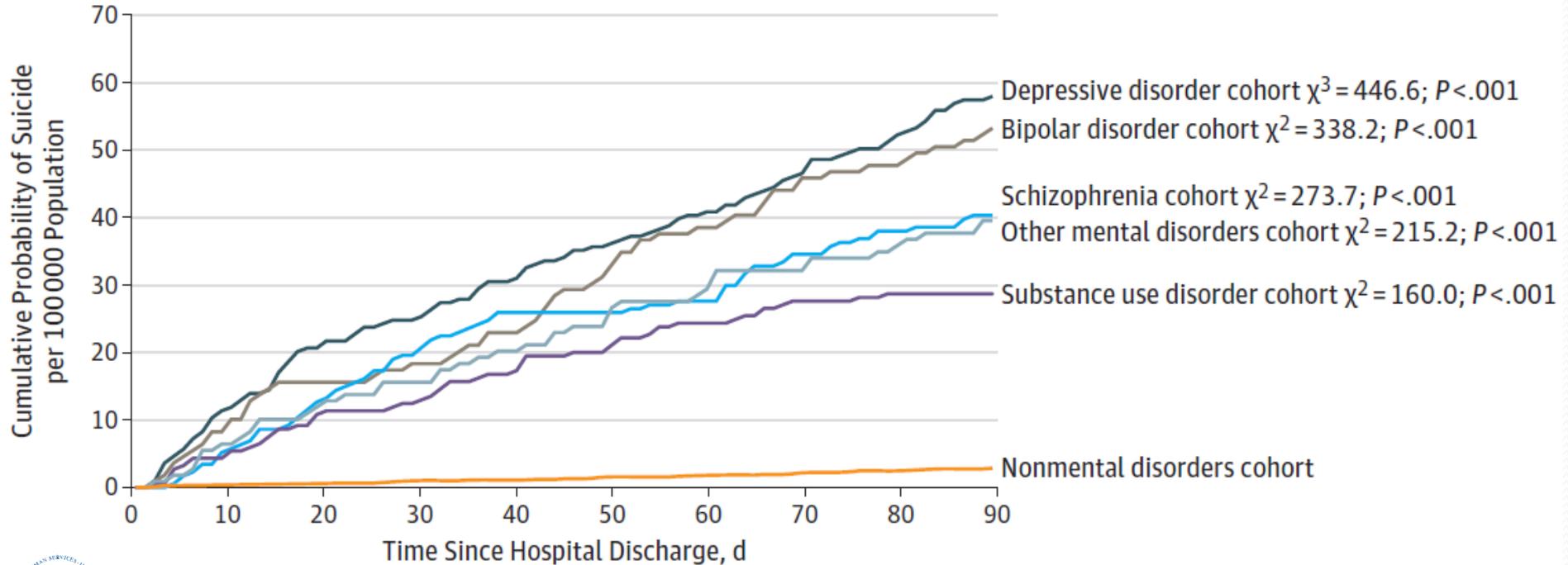
Characteristic	Hazard Ratio (95% Confidence Interval)	
	Male	Female
Any psychiatric diagnosis	2.50 (2.38-2.64)	5.18 (4.08-6.58)
Any substance abuse or dependence	2.27 (2.11-2.45)	6.62 (4.72-9.29)
Alcohol abuse or dependence	2.28 (2.12-2.45)	6.04 (4.14-8.82)
Drug abuse or dependence	2.09 (1.90-2.31)	5.33 (3.58-7.94)
Bipolar disorder	2.98 (2.73-3.25)	6.33 (4.69-8.54)
Depression	2.61 (2.47-2.75)	5.20 (4.01-6.75)
Other anxiety	2.10 (1.94-2.28)	3.48 (2.52-4.81)
Posttraumatic stress disorder	1.84 (1.70-1.98)	3.50 (2.51-4.86)
Schizophrenia	2.10 (1.93-2.28)	6.08 (4.35-8.48)



Suicide Rate, VHA Users with Mental Health Conditions, by Year



Cumulative Probability of Suicide Following Hospital Discharge



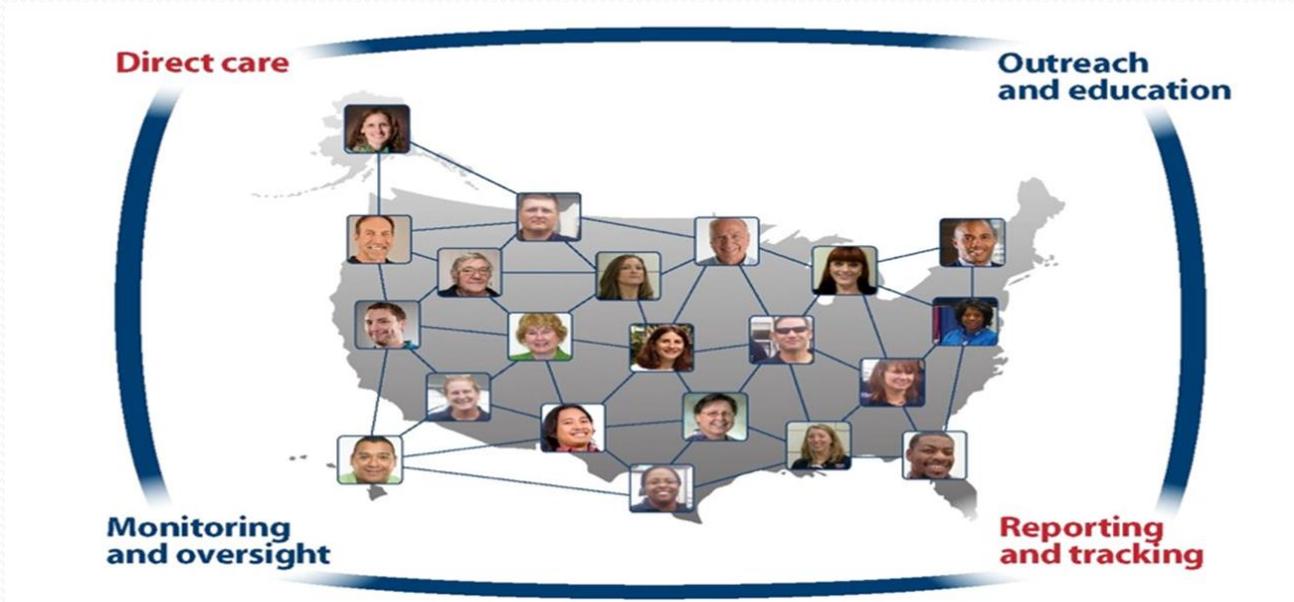
Suicide Prevention: Everyone's Business

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](https://www.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

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

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

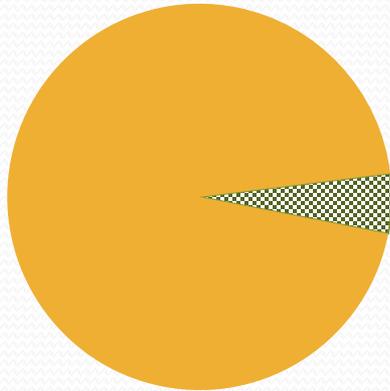
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Ruby Qazilbash
Associate Deputy Director
Bureau of Justice Assistance

Prevalence of SMI in the criminal justice system

General Population

4% Serious Mental Illness



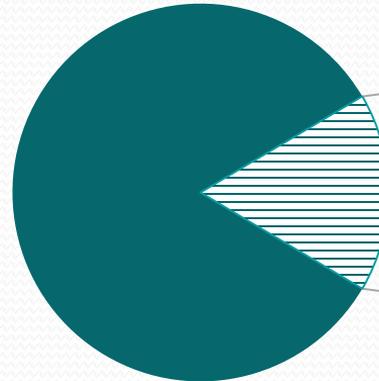
Center for Behavioral Health Statistics and Quality, *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health, 2016* (HHS Publication No. SMA 16-4984, NSDUH Series H-51), <http://www.samhsa.gov/data/>.

8/31/2017

ISMICC Meeting

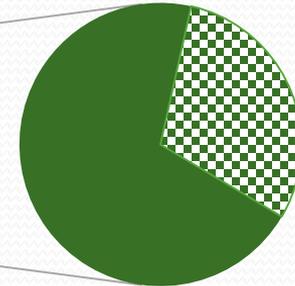
Jail Population

17% Serious Mental Illness



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.

72% Co-Occurring Substance Use Disorder

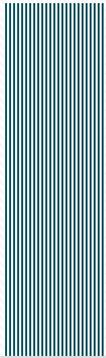


Abram, Karen M., and Linda A. Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (1991): 1036-1045.

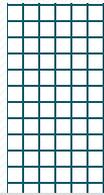
Jails are where the volume is

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

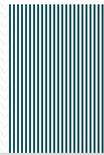
26%



14%



11%



Jail inmates

Prisoners

Under Supervision

Bureau of Justice Statistics, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-2012*, Washington, DC: GPO, 2017, <https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf>.

Annual admissions to Jails vs. Prisons

10.9 million



626,644



Jail admissions

Prison admissions

Bureau of Justice Statistics, *Jail Inmates in 2015*, by Minton and Zheng, Washington, DC: GPO, 2016, <https://www.bjs.gov/content/pub/pdf/ji15.pdf>.

Bureau of Justice Statistics, *Prisoners in 2014*, by Carson, Washington, DC: GPO, 2015, <https://www.bjs.gov/content/pub/pdf/p14.pdf>.

Impact on Law Enforcement Agencies

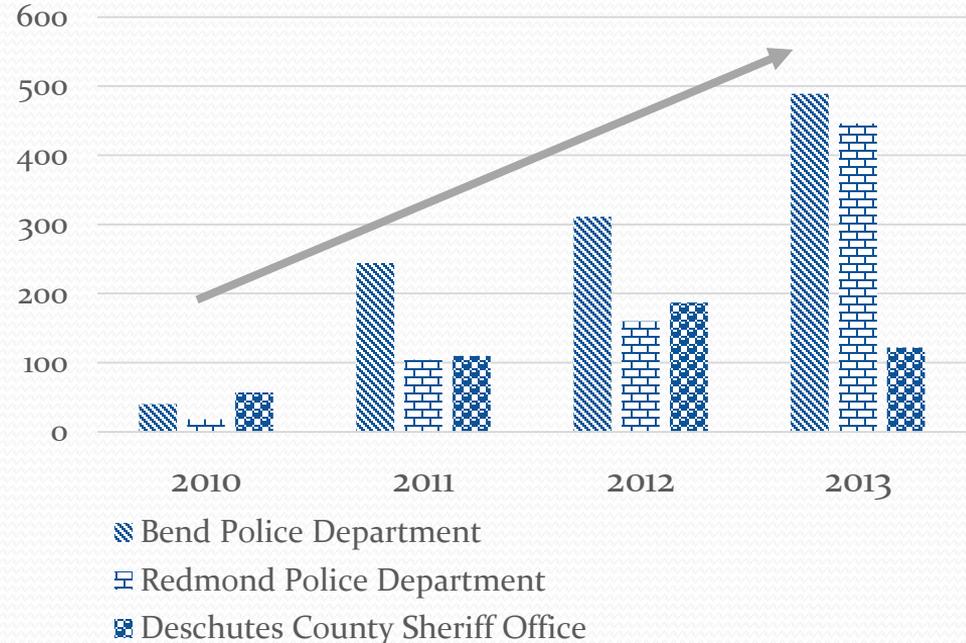
1 in 10 calls for service involves an individual with a **severe mental illness**

(Chappell, D. (Ed.). (2013). Policing and the mentally ill: International perspectives. Boca Raton, FL: CRC Press).

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



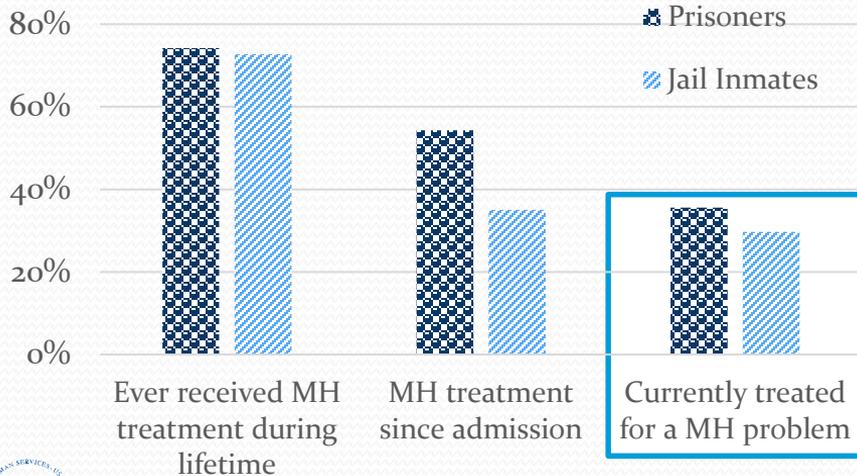
Source: Bend Police Department



Behind the Walls

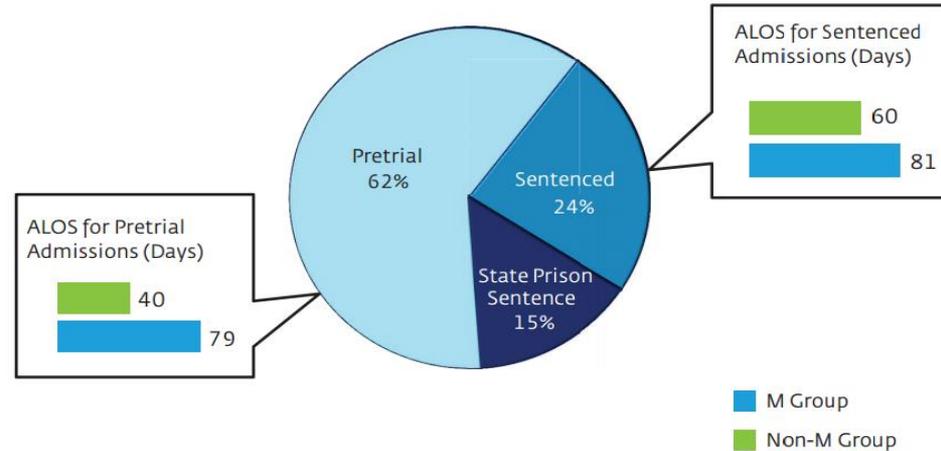
About a third of people with a mental health indicator were **currently receiving treatment** while in jail or prison

For inmates who indicated psychological distress...



Source: <https://www.bjs.gov/content/pub/pdf/imhprpj11112.pdf>

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: The City of New York Department of Correction, 2008 Department of Correction Admission Cohort with Length of Stay > 3 Days (First 2008 Admission)

Source: CSG Justice Center, "Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems," December 2012



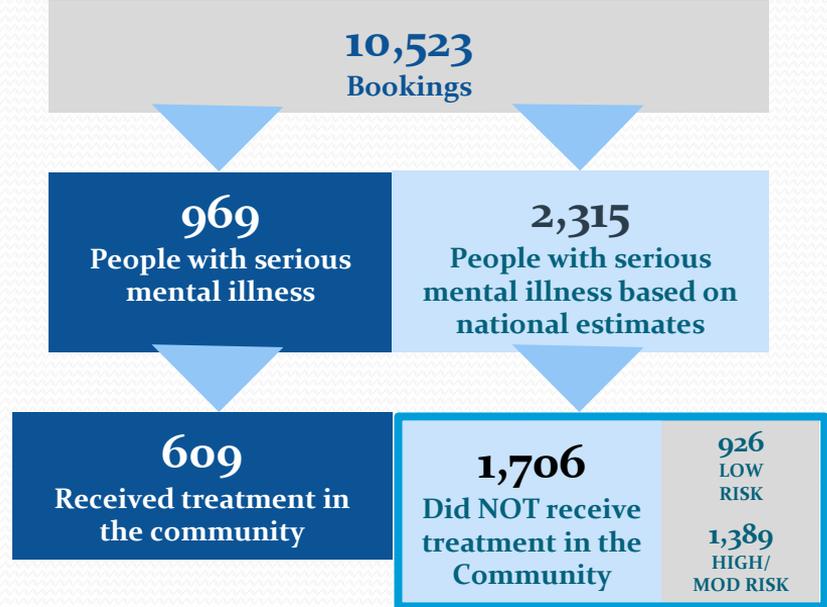
Community-Based Programs Work, but Gaps Remain

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

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

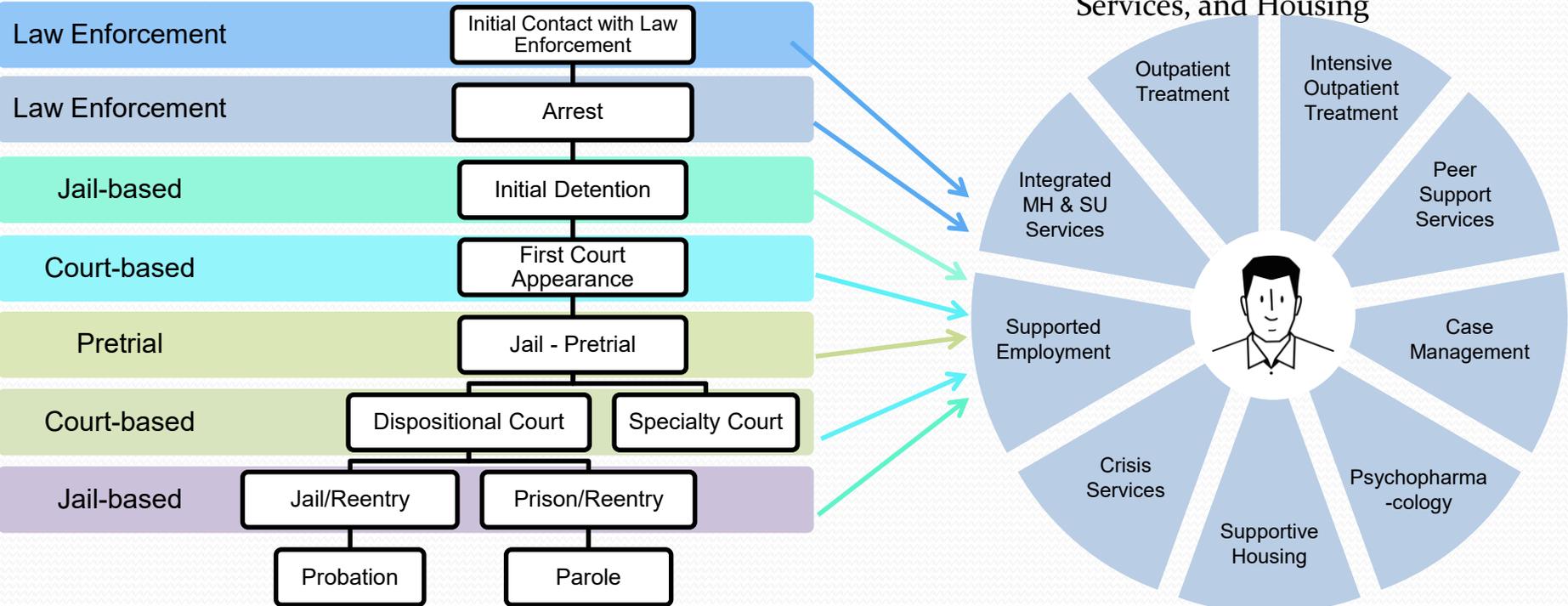
However, county analyses reveal gaps in such connections.



Source: CSG Justice Center, "Franklin County, Ohio: A County Justice and Behavioral Health Systems Improvement Project," May 2015

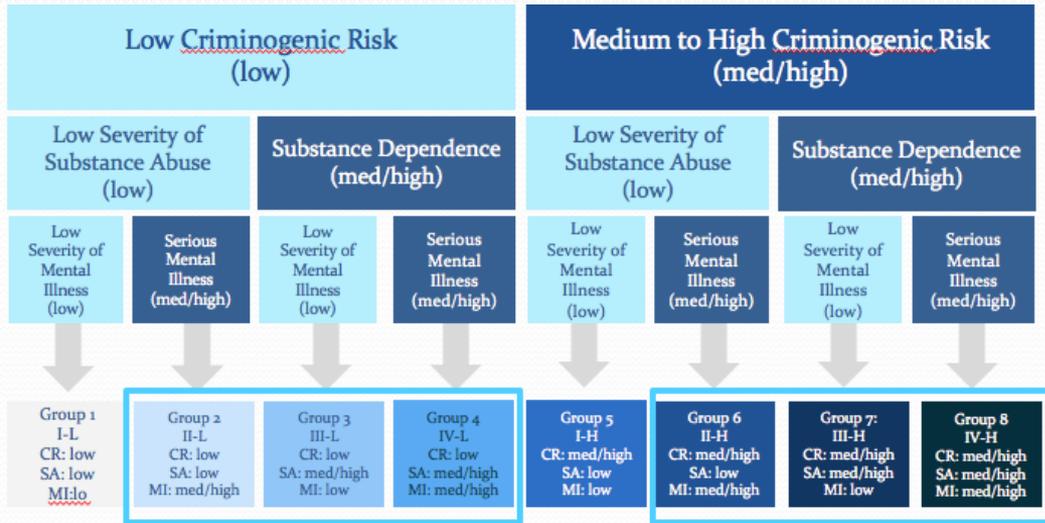
Policy Focus: Building Systems of Diversion with Connections to Community-Based Systems of Care

Community-Based Continuum of Treatment, Services, and Housing



A Framework for Prioritizing Resources

Criminogenic Risk and Behavioral Health Needs Framework



Subgrouping A

Subgrouping B

Low
criminogenic
risk/ some
significant BH
treatment needs

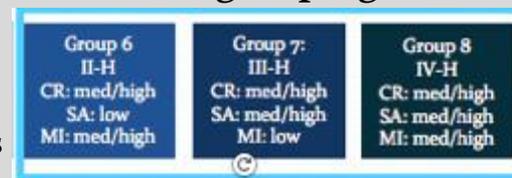
Subgrouping A



Divert from criminal justice system without intensive community supervision if connected to appropriate treatment and supports

High
criminogenic
risk/ some
significant BH
treatment needs

Subgrouping B



Prioritize for intensive supervision (in lieu of incarceration or as condition of release) coordinated with appropriate treatment and supports

Justice and Mental Health Collaboration Program (JMHCPC) Grants

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

Grants awarded

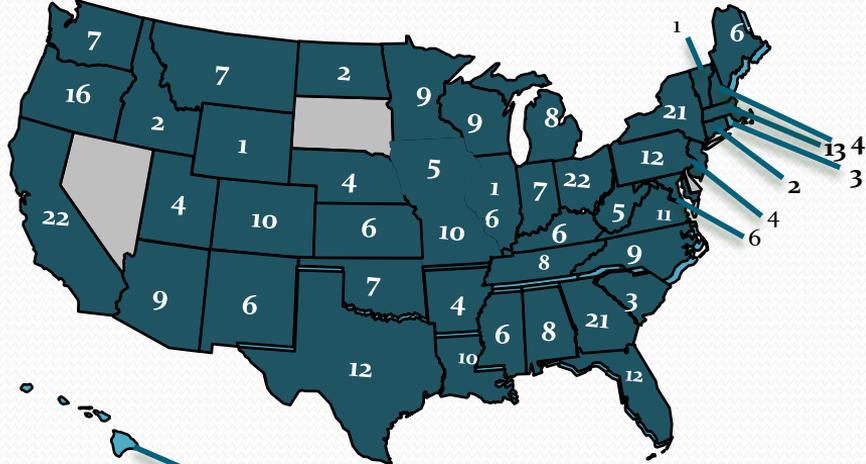
2006-2016: 380 awardees

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

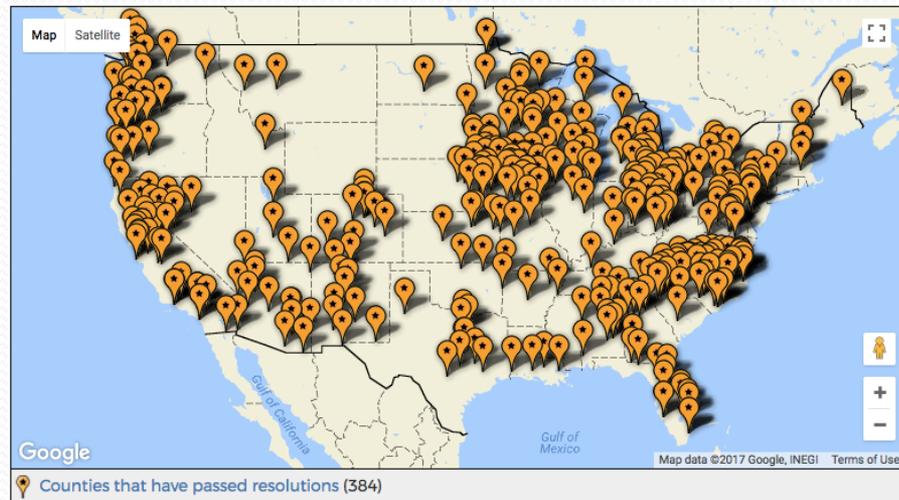


3) Diversion and reentry programs

THE STEPPING UP INITIATIVE

GOAL: There will be fewer people with mental illnesses in our jails tomorrow than there are today.

Over 380 Counties “Step Up”



Approximately 115 million people reside in Stepping Up counties

A Common Framework for County-Level Action



Released in January 2017

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?

Strategies Should Focus on Four Key Measures



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.