BEYOND THE BORDERS:

Lessons from the International Community to Improve Mental Health Outcomes

Project Support

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ABSTRACT:

Concerns about the fragmented mental health system have been present for many years. In the United States, Presidential commissions, legislative action, policy, administrative efforts, and local advocacy have attempted to fix areas of the mental health system in need of repair. More recently, new federal initiatives have been attempting to address current challenges. Representative is the initial work of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), and subsequent strategic planning for 2019 to 2023 by the Substance Abuse and Mental Health Services Administration (SAMHSA). This committee has brought government and non-governmental stakeholders together to develop a roadmap for mental health system improvements. To support these various efforts, the National Association of State Mental Health Program Directors (NASMHPD) has published in 2017 and 2018 a series of technical assistance papers on a range of topics relevant to mental health services, and does so again in 2019. This work has focused on the need to look beyond psychiatric beds in the United States and to instead ensure attention to the full and vital continuum of care needed to promote mental health recovery. Now, *Beyond the borders: Lessons from the international community to improve mental health outcomes*, pivots from that previous work to look beyond the borders of the United States to other countries for examples of successful and promising strategies across nine areas of focus. This paper's highlighted examples from the international community aim to further illuminate strategies and inspire ongoing crucial dialogue in an effort to improve mental health in the United States.

Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes

Background

Widespread interest in improving mental health outcomes is gaining ground in the United States. There are many reasons for this, including ongoing discourse about health care and its financing, as well as increased focus on physical wellness and the growing recognition that physical health and mental health are integrally related to overall well-being. With that recognition comes numerous calls for more integrated services in which access to mental health care is on par with physical health care.[1] Rising suicide rates,[2] persistent troubling rates of homelessness among vulnerable populations,[3] the disproportionate prevalence of people with mental illness and serious emotional disorders in criminal and juvenile justice settings,[4] emergency department boarding,[5] and the opioid crisis as well as a host of its collateral impact issues[6] are among the challenges that are driving further debate and scrutiny of mental health services targeting all age groups and populations. As a result, it seems not a day goes by across the country without a headline related to these topics and others.

Many of the challenges have shifted over time, but some are not new. The need to repair the mental health system in this country has been highlighted by presidential efforts, such as President John F. Kennedy's Community Mental Health Act and President George W. Bush's New Freedom Commission on Mental Health.[7][8] More recently, at the federal level, a roadmap was created for improved mental health services moving forward. Operationalized through the Substance Abuse and Mental Health Services Administration (SAMHSA), the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) is one part of the work needed to address approaches to mental illness and systems of support for individuals and their families touched by the various conditions mental illness encompasses. Established in 2017 and comprised of broad-based experienced government and non-governmental stakeholders, ISMICC sought to delineate strategic priorities within that roadmap, outlined in its 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*.[9] Subsequent important effort folded those recommendation into the SAMHSA Strategic Plan for FY2019-2023.[10] Derivatives of all this work have resulted in further guidance to the field.

Beginning in 2017, a series of technical assistance papers written by numerous subject matter experts and produced by the National Association of State Mental Health Program Directors (NASMHPD) have provided useful information for state mental health authorities, providers, advocates, legislative and policy makers, and persons with lived experience with mental illness and their families. Content from these papers has spanned topics focused on mental health services including those related to homelessness, justice-involved individuals, trauma-informed care, children and adolescents, older adults, forensic systems, intellectual and developmental disabilities, technology, workforce development, suicide prevention, substance use disorders, school resources and others (See Appendix A for a full list of papers). These themes have been knitted together through "Umbrella Papers," focused on looking at some of the big issues facing mental health services in the United States and the need to improve the mental illness outcomes for individuals across the lifespan. In the 2017 paper, *Beyond beds: The vital role of the full continuum of psychiatric care*,[11] the authors address the critical

importance of moving past a cry for "more beds" as a single system solution and instead call for the availability of an array of services and policies to ensure timely access to a full and vital continuum of care to address serious emotional disturbances and serious mental illness. Then, in 2018, the paper *Bolder goals, better Results: Seven breakthrough strategies to achieve better mental illness outcomes,*[12] set the stage for thinking big in the mental health arena, as has been done with HIV, cancer and other medical conditions for which the United States has delivered incredible positive results.

NASMHPD has furthered its efforts in linking mental health leaders to new ideas by expanding its horizons, particularly with its growing partnership with the International Initiative for Mental Health Leadership (IIMHL), to build more global collaborations and facilitate learning from practices around the world. With that as background, *Beyond the borders: Lessons from the international community to improve mental health outcomes* steps beyond the borders of the United States and explores promising and successful practices from around the world. Looking outside the country for new ideas has yielded some new programs and paradigms in mental health services already,[13,14] and exploring mental health from other countries provides enlightening perspectives.[15] With that in mind, contained within this paper is an overview of nine newly consolidated important thematic areas that align with enhancing a vital continuum of psychiatric care. Each area of focus relates to themes already delineated by NASMHPD in *Beyond Beds* and *Bolder Goals* as well as to recommendations spelled out in the SAMHSA Strategic Plan FY2019-2023. For ease of reference, these links are highlighted in this paper. In *Beyond the Borders*, each of the following areas is explored:

1) Big data as a driver for improved mental health services and individual outcomes
2) Access to effective medication and promising therapies
3) Supported decision-making and personal autonomy
4) Culture and spirituality integrated into mental health care
5) Mental health community care and prioritization of continuity
6) Emerging models to identify targeted inpatient bed needs
7) Improved correctional conditions and alternatives to incarceration
8) Disaster response and opportunity for sustained improvement
9) Mental health as public health

The thematic areas aim to inspire out-of-the-box thinking. By examining these areas of international practices, policymakers, practitioners, state mental health leaders, persons with mental illness and family members can consider ideas and practices that could drive further improvements in mental health services and outcomes in the United States.

Nine International Themes to Consider for Improving Mental Health Outcomes in the United States

1. Big data as a driver for improved mental health services and individual outcomes

> In *Beyond Beds*, there was a call for data-driven solutions, and *Bolder Goals* called for 100% compliance with legal requirements for health care networks- which would require data to analyze such compliance. A key SAMHSA Strategic Plan FY2019-2023 priority calls for data collection strategies to help identify and track mental health and substance use needs in the United States. To that end, much is happening in the data space in the United States, but lessons from the international community can foster further improvements.

In mental health services, the notion of data-driven practices is common dialogue among policy makers, government entities and advocates. There is a recognition that enhancing data within the United States and breaking down silos that create barriers to interagency data will help drive better outcomes. In Camden, New Jersey, the Camden Coalition of Healthcare Providers has developed a data-sharing network that can examine high utilizers of specific health care services such as emergency departments, and combine the information obtained with the criminal justice system data to identify hot spots of service needs. This data sharing happens in real-time to foster integrated solutions.[16] In addition to this example of data sharing across a community, ideas for how data can drive change includes concepts of using big data, which runs across large systems at high levels, to create new and endless opportunities for understanding mental illnesses, services and outcomes.[17]

Around the world large population-based data systems are commonly used to aid countries in making informed decisions about health care. In England, big data is being used to help provide guidance to leadership through data analyses on mental health outcomes.[18] In Scotland, big data is being used to help prevent suicide by examination of trends and other factors.[19] In Taiwan, a National Health Insurance Research database captures health information from 96% of the population through the nation's single-payer insurance system. The database has been used for research studies to yield answers questions such as determining the prevalence of diabetes among those with schizophrenia,[20] and finding that occupational injury was a significant factor in developing a psychiatric disorder.[21]

Other important information from big data includes findings related to mortality associated with mental illness. Mortality rates among 270,770 patients admitted for care for a psychiatric disorder were studied in Denmark, Finland and Sweden using these longitudinal national psychiatric registries, finding life expectancy was approximately 15 years shorter for women and 20 years shorter for men compared to the general population.[22]

BEYOND BEDS:

Recommendation #6: Data-Driven Solutions
Prioritize and fully fund the collection and timely publication of all relevant data on the role and intersystem impacts of severe mental illness and best practices.

Recommendation #8: Technology
Create and expand programs that incentivize and reward the use of technology to advance care delivery, promote appropriate information sharing, and maximize continuity of care. Policymakers should require as a condition of such incentives that outcome data be utilized to help identify the most effective technologies, and they should actively incorporate proven technologies and computer modeling in public policy and practice.

Scandinavian countries in many instances have developed the gold standard when it comes to health data. The Norwegian Patient Registrar, for example, provides a comprehensive and mandatory health and welfare registry from which analyses can be determine best practices.[23] In one study, data were used to examine costs associated with schizophrenia as it related to health care needs and employment rates to measure burden of disease. The Danish National Patient Registry is one of the oldest in the world and has been used extensively to expand understanding of mental illness, psychiatric hospitalization and related topics.[24] The patient data registry is has been capturing data related to psychiatric hospitalization since 1995 and is linked with other Danish registries with administrative data, population surveys and clinical information, vastly expanding research possibilities. For example, combining the Danish Twin Registrar and the Danish Psychiatric Research Registrars has advanced understanding of the heritability of schizophrenia, influencing genetic research into the illness throughout the world.[25] Although the use of such data is exciting, there are also caveats, as similar European data examining the heritability of depression was recently called into question by American researchers.[26] No doubt that as data analytics and scientific knowledge evolve, old findings can be challenged, but this will allow knowledge to advance, making improved data even more critical.

> **BOLDER GOALS:**
> *100%* compliance with legal requirements for health care networks to make the full continuum of psychiatric care accessible to patients

> **SAMHSA Strategic Plan FY2019-2023:**
> Objective 4.1: Develop consistent data collection strategies to identify and track mental health and substance use needs across the nation.

Although the European data sets provide incredible models for these advancements, data harmonization (or the linkage of administrative data in a meaningful way) itself within and across systems has other challenges and limitations.[27,28] And of course, privacy protection especially related to mental health and substance use disorders is a critical issue to consider in big data sharing agreements and part of the responsibility that comes with data sharing.[29] Nonetheless, countries around the world have been working with large and sometimes mandatory data sets to answer difficult questions. Lessons learned from the international community about the use of big data can lead to results that help policymakers and practitioners in the United States better understand the trajectory of mental disease across the life span and across systems.

2. Access to effective medication and promising therapies

> Making trauma-informed, whole-person health care a priority is a goal that neatly ties into the *Bold Goal* of 100% access to effective medication and other evidence-based therapies for individuals with psychiatric conditions. The vital continuum articulated in *Beyond Beds* calls for a comprehensive approach that incorporates a full spectrum of services to improve outcomes for individuals of all ages with mental illness. And the SAMHSA Strategic Plan FY2019-2023 calls for closing the gap in treatment between what works and what is offered.

Medication and treatment practices for serious mental illness across the lifespan follow different patterns around the world. Although reasons for these differences are multifactorial, lessons from international practices are worth noting.

Clozapine, for example, is a well-established and highly effective medication for treatment-resistant schizophrenia, referred by some as the gold standard for such patients.[30] Though it does require attention to unique safety issues, and safety is a critical fundamental principle of prescribing, it is noteworthy that clozapine is utilized less in the United States than elsewhere in the world,[31] with Finland and New Zealand having the highest utilization.[32] In addition, clozapine is prescribed widely in China[33] and Australia.[34] SAMHSA has recently awarded a competitive grant to the American Psychiatric Association (APA) to help transform care for people who have serious mental illness so they can live their best lives. The APA works with a team of experts from 30 other mental health organizations, as well as families, peers, policy makers and others. This national technical assistance center, called SMI Adviser, was designed to support real-world clinical practice with education, evidence and consultations, including in areas such as clozapine prescribing.[35] This activity is promising. To realize its potential, it is also important to examine why the United States still falls behind other countries, and what more could be done to close that gap. As one example, international researchers, practitioners and policymakers have called for harmonization of the variable regulations related to prescribing this medication throughout the world as a way of improving access.[36,37] Exploration of other reasons could also assist in improved access to this important medication.

> **BEYOND BEDS:**
> *Recommendation #1: The Vital Continuum*
> Prioritize and fund the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services known to improve outcomes for individuals of all ages with serious mental illness.

Access to long-acting medications (LAMs) also shows variability around the world. These medications, which traditionally come in injectable formulations in the treatment of serious mental illness (and are often referred to as long-acting injectables or LAIs), have been shown to improve treatment adherence.[38] One research study showed that LAMs were prescribed for a quarter to one-third of patients across the United Kingdom depending on the clinical setting.[39] Prescribing trends in France, show greater access to LAMs for first-generation compared with second-generation antipsychotics.[40] In a U.S. sample, less than 20% of psychiatrists prescribed long acting injectable medication in patients with schizophrenia with a known history of difficulty with medication adherence.[41] Researchers and practitioners have called for further study of prescribing patterns across countries to better understand trends and maximize critical access when appropriate.[42,43]

Although a full review of the treatment of substance use disorders is beyond the scope of this paper, treating these conditions with the most up to date medications when indicated is just as important for people with serious mental illness as it is for individuals without these conditions. Yet, similarly to clozapine and LAMs, there are a host of differences in utilization of medications to treat substance use disorders that warrant further study,[44] and reviewing this information could further understanding in what might be barriers to accessing effective medications more consistently across the United States.[45] Medications used to treat alcohol use disorder and opioid use disorder provide examples.[46] Medications for substance use disorders have been shown to improve outcomes and should be available to those that need them.[47]

> **BOLDER GOALS:**
> *100%* access to effective medication and other evidence-based therapies for individuals with psychiatric conditions

Variable access around the world to effective therapies for people with mental illness extends to non-medication-based treatments. In Argentina, for example, it is reported that receiving psychotherapy is

so common it is the rule rather than the exception.[48] Cognitive Behavioral Therapy for psychosis (CBTp) has been shown to have a positive effect on improving functioning in individuals with psychotic disorders,[49] although some studies point out that positive effects might be shorter term.[50] Internationally, CBTp is seen frequently. The National Institute for Care and Health Excellence (NICE) in the UK, Canadian Schizophrenia Guidelines, the Scottish Intercollegiate Guidelines Network (SIGN), and the Royal Australian and New Zealand College of Psychiatrists have produced clinical guidelines that help practitioners implement CBTp. [51,52,53] This therapy is beginning to be more widely recognized in the United States. The Schizophrenia Patient Outcomes Research Team recommends that when a person has enduring positive (e.g., voices and delusions) and negative (e.g., blunt affect, apathy, and poverty of speech) psychotic symptoms, adjunctive CBTp might be helpful in reducing them and improving functioning.[54] Still, more is needed to have this type of therapy available across the United States.

Open Dialogue, an approach to working with people with psychosis that emphasizes family and social networks, is yet another example of a practice stemming from outside the United States that has some preliminary promise. The therapy originated in the Western Lapland region of Finland and has shown positive outcomes as a model of treating people with psychosis in their homes and with their families.[55] Studies have examined its impact of managing crises, encouraging dialogue and flexibility, and working with networks, finding the approach can lead to a reduction in the duration of untreated psychosis for the cohorts under study.[56] The United Kingdom and Australia have examined its effectiveness and suggested it has shown promise.[57,58] In the United States, one research trial concluded some feasibility related to implementation of Open Dialogue for individuals with psychosis in outpatient services[59] and one study found that the application Open Dialogue tenets on an inpatient psychiatric unit in Boston also showed promise in treating people with psychotic disorders.[60] Given some of its successes overseas and the newer trials in the United States, the model warrants further analyses and perhaps more widespread availability.

Taken together, the ideas emanating from practices outside the United States yield some interesting potential. Policy makers and practitioners, as well as the research academic community should explore these and other therapeutic approaches and expand access to effective approaches—in all its forms—to treating serious mental illness throughout the United States.

3. **Supported decision-making and personal autonomy**

Beyond Beds included a call for inclusion of a broader range of stakeholders around mental illness policy and practice. The SAMHSA Strategic Plan FY2019-2023 embraced the critical need to develop educational and training tools to address workforce core competencies as part of planning to improve the lives of individuals with serious mental illness and youth with social emotional disturbances. In many ways, these goals turn on how well mental health services support personalized decision making in mental health care and respect for autonomy even when legal and policy mandates exist for individual participation in treatment. Given the complexity of these issues, it is important to take stock of what is occurring around the world in this area.

A prioritization of self-directed and person-centered care for adults with mental illness as well as children's services that focus on youth-guided, and family-driven care, shapes mental health service provision in the United States. These values connote respect for autonomy of those impacted most by mental illness and SED, and support least restrictive approaches to care. Lessons for these principles can also be taken from working with persons with intellectual and developmental disabilities, who commonly receive care in the mental health system, and for whom federal laws and focused practices help providers frame services toward maximizing autonomy and respect for persons.[61] Attending to the rights of the most vulnerable of persons, including those with serious mental illnesses and other conditions such as intellectual and developmental disabilities, is of critical importance in mental health services, even when legal mandates might exist or be necessary in certain circumstances that impinge on aspects of personal autonomy. In the United States, increased efforts to support Psychiatric Advance Directives exemplify important attention to the rights of individuals to make their own decisions about health care.[62,63,64] Regarding individual rights, it is also helpful to take a world view on how other countries are grappling with similar complex issues for individuals receiving mental health services.

BEYOND BEDS:
Recommendation #10: Partnerships
Recognize the vital role families and non-traditional partners outside the mental health system can play in improving mental health outcomes and encourage and support the inclusion of a broader range of invited stakeholders around mental illness policy and practice.

The United Nations recently examined human rights in mental health care delivery, where coercive interventions are at times used. This examination has incorporated two main arguments—one that posits that coercive care in its various forms can be justified from a human rights perspective—provided it is necessary and proportionate to achieve positive aims and with proper safeguards—and one that states that coercion is never justifiable.[65] This discussion sets the stage for examining a balancing test and considering how various approaches fit into this balance. As an example, a Finnish study described the therapeutic approaches of Open Dialogue from a human rights perspective.[66]

Examining these issues from another angle, many studies both in the United States and abroad have looked at the concept of perceived coercion in the receipt of mental health services, often in the context of being under some official mandate for care.[67,68,69] In the international realm, the EUNOMIA study examined decisions in mental health care regarding the use of coercive measures such as restraint, seclusion and medications over objection across 11 countries.[70] The study's findings included that patient satisfaction with treatment predicted the degree to which patients perceived coercion in that treatment. A study of psychiatric patients in Zurich found greater perceptions of coercion and loss of autonomy correlated with a stronger negative sense of the relationship between the patient and the clinician.[71]

BOLDER GOALS:
100% of homeless people with serious mental illness permanently housed

Enhancing the sense of voluntariness also relies on the ability to support an individual's personal decisions. A recent Institute of Medicine Health Care Quality Initiative report emphasized findings to help examine how best to maximize persons with mental illness or substance use disorders in feeling more in control of decisions regarding their treatment.[72] In England and Wales, where an estimated 2 million people live who may lack personal decision-making capacity, National Institute for Health and Care Excellence (NICE) Guidelines for supported decision-making have been developed to guide practitioners on how to help individuals

make personal decisions while maximizing their autonomy.[73] The guidelines also provide training and assistance for staff working with these individuals. In Australia, recovery-oriented mental health services affirm an individual's right to self-determination.[74] Article 12 of the United Nations Convention on the Rights of Persons with Disabilities asserts the right of an individual to make decisions for themselves, based on a principled right to have equal recognition before the law, and explores supported decision-making to maintain personal autonomy for persons with intellectual and

developmental disabilities.[75] Though rights are critical, the assertion that full autonomy should never be limited raises concerns in contexts where legal mandates like civil commitment and guardianship might be considered by many as the most prudent option. Nevertheless, the international dialogue has moved increasingly toward supported decision-making frameworks as an approach that favors self-determination.[76,77] Supported decision-making efforts originated in Canada and Australia in circles where individuals with intellectual and developmental disabilities are served.[78] It is distinguished from shared decision-making,[79] in that it assumes individuals make their own decisions but with support in making and communicating them. Implications for supported decision-making for people with mental illness in addition to those with intellectual disabilities is important.[80] These concepts are not brand new to the United States but have emerged more recently. The American Bar Association has signed a resolution in favor of supported decision-making,[81] several states in the United States have enacted laws related to supported decision-making efforts,[82] and advocacy organizations such as the Center for Public Representation in Massachusetts highlight this practice.[83] Still, lessons from global experience are useful. A review examining studies of supported decision-making for persons with mental illness spanning 16 countries revealed that this is a promising and beneficial practice, but there is a need for more research in this area.[84]

The international literature reveals a growing trend examining the importance of self-directed care and respect for autonomy to achieve better mental health outcomes and further highlights the need to continue to study these issues. These approaches have the potential for better engaging persons with mental illness in their treatment through respect, maximizing autonomy and helping individuals achieve their personal goals. The recommendations of *Beyond Beds. Bolder Goals* and the SAMHSA FY2019-2023 Strategic Plan align with the notion of enveloping these considerations into laws, policies and practices and educating the workforce about them to achieve more successful outcomes.

4. Culture and spirituality integrated into mental health care

In *Beyond Beds*, recommendations for partnerships, including families and non-traditional partners were emphasized to further improve mental health outcomes. In *Bolder Goals,* 100% access to effective medications was highlighted. The SAMHSA Strategic Plan FY2019-2023 focused on fostering credentialed peer providers and other paraprofessionals as an integrated component of the comprehensive care with a goal of best addressing the needs of individuals with serious mental illness and serious emotional disorders and their families. The United States is a melting pot of cultures, religions and ethnicities. Thus, to achieve these aims, services and therapies should embrace culturally competent approaches to care. Non-traditional and paraprofessional partners should include those that help foster cultural, spiritual, and ethnic connectivity and sensibilities. Around the world, there are examples worth noting of mental health services designed to support individual culture, religion and ethnicity.

Much has been done in the United States to advance cultural competence to improve mental health outcomes and address disparities in care. For example, the 2017 NASMHPD paper, *Cultural and Linguistic Competence as a Strategy to Address Health Disparities in Inpatient Treatment*[85] gives guidance on unique aspects of improving competencies along cultural and linguistic lines to help improve specific types of mental health care in inpatient psychiatric settings. SAMHSA has put forth efforts to address unique population needs, as exemplified by many grants that offer priority to programs that focus on tribal populations. Awareness of health disparities is increasingly recognized. These are a start, but the international community also has examples of approaches that can further guide improvements in addressing culture, spirituality and religion in mental health service delivery in the United States.

> **BEYOND BEDS:**
> *Recommendation #10: Partnerships*
> Recognize the vital role families and non-traditional partners outside the mental health system can play in improving mental health outcomes and encourage and support the inclusion of a broader range of invited stakeholders around mental illness policy and practice.

In New Zealand, for example, a great deal of work has been done to better address the needs of the Māori people, the indigenous people of the region whose tribal ways were significantly impacted after European colonization of the country. Māori professionals have assisted in health care for years, which has been found helpful for practitioners.[86] These individuals can function as cultural consultants, and provide cultural information to non-Māori or "Pakeha" practitioners, which augments the delivery of psychiatric services by providing assistance in assessing symptoms in the context of cultural beliefs or in general treatment planning.[87,88]

The use of traditional Māori customs to help address mental health difficulties and facilitate healing by recognizing the role of family and community has been noted as a promising practice.[89] Research in New Zealand has studied various models of care to elucidate how traditional healing and health belief models can inform service delivery.[90] Training on working with indigenous people has been recognized as an important ongoing need throughout the country.[91] Putting weight on these approaches as a practice matter, the Royal Australian and New Zealand College of Psychiatrists has identified improving mental health of Māori people as a 2018-2020 strategic objective.[92]

> **BOLDER GOALS:**
> *100%* access to effective medication and other evidence-based therapies for individuals with psychiatric conditions

Beyond New Zealand, the Movement for Global Mental Health, a virtual network of individuals and organizations interested in improving mental health services, suggests using indigenous psychologies in lieu of western psychiatric and psychological strategies to achieve greater positive impact in helping indigenous psychiatric patients and their families navigate mental illness through their own cultural lens.[93] Results of this approach seem to also yield a greater positive sense of self by empowering native beliefs and ways.[94]

Religious views and spirituality among patients can also impact effectiveness of care. There is recognition that a provider's consideration of an individual's spirituality can have positive value in psychiatric services, promoting a bio-psycho-socio-spiritual model in psychiatry.[95] In South Africa, traditional healers and religious advisors are viewed as an important part of the mental health delivery service system.[96] Culturally-sensitive mental health care in psychiatric treatment among ultra-orthodox Jews in Israel has been found to positively affect the way the patients see their social functioning.[97] Educating providers about the importance of delivering of culturally sensitive care is a key message in these models.

In the United States, more emphasis on addressing unique cultures and religion within the melting pot could be an important step forward in realizing greater culturally competent mental health services. Taken together, lessons learned from other countries that have focused efforts on specific cultural, religious or ethnic groups can help move the needle toward maximizing the availability of effective treatments, a ready and more able workforce, and the engagement of non-traditional partners to improve mental health outcomes.

5. Mental health community care and prioritization of continuity

Although there has been much emphasis on health homes that provide fully integrated care for individuals with complex medical, mental health and other conditions, what has been less emphasized has been examining practices from the lens of the communities in which the individuals receive care. In *Beyond Beds*, recommendations included incorporating a full spectrum of integrated services, as well as examining the vital role of families and non-traditional partners outside the mental health system to help improve outcomes. A critical *Bolder Goal* in this light was that there should be access without delay to needed levels of care. These both align with the SAMHSA Strategic Plan FY2019-2023 to facilitate access to quality care and engagement.

Examination of mental health services at the community level can help practitioners and policy makers in the United States improve outcomes. Examples from around the world can shed light on whole-system reform, positive change, and the potential risks to ongoing gains from political changes. For example, in the early-1990s, the Caracas Declaration set the stage for mental health reform across

several Latin American countries by calling for integration of mental health into primary care, prioritizing community-based services and emphasizing human rights.[98] Several countries in Latin America implemented initiatives aimed toward these reforms to improve the mental health of children, adolescents and adults of all ages.[99] Brazil received recognition from the World Health Organization and others after it shifted its policies and funding toward community advances.[100] An application of the World Health Organization Assessment Instrument for Mental Health Systems found that although more development was needed, Brazil's innovative services included psychosocial community centers and a Return Home program to help transition individuals with mental illness from institutions.[101] Subsequent political decisions have raised concerns about budgetary shifts that could restrict further advances in this area but also provide some important lessons about the challenges of sustainability.[102] A Pan American Health Organization 2013 report examining mental health care across Latin American and Caribbean countries demonstrates a means of systematically assessing progress in mental health service

improvements across different national approaches, even in countries with numerous social, economic and political challenges.[103]

As countries have shifted from institution-based care, studies about specific needs of various age groups provide further instruction from a community perspective. A recent Australian review examined service delivery for the adult population, noting that children and older adults had different avenues for funding.[104] In Ireland, increased attention to the physical and mental health needs of older adults and the need for geriatric psychiatry has resulted in several high-level reports to drive system improvement for this population at a local level.[105]

> **BOLDER GOALS:**
> *100%* access without delay to the most appropriate 24/7 psychiatric emergency, crisis stabilization, inpatient or recovery bed

Regarding community services, data from a longitudinal study of the aftermath of deinstitutionalization demonstrated the feasibility of community-based services in England.[106] In Norway, recent research has looked at the distribution of community-based supported accommodation for individuals with schizophrenia providing lessons for resource allocation.[107]

In examining communities as a whole and the redesign of mental health services, much recent attention has landed in a small community in Trieste, Italy. The Italian mental health system is not without its own challenges, but this community is raising awareness of what might be possible if one geographic regional service system were to examine its practices across all levels of care at a grassroots level. Italian mental health law reform occurred in 1978, leading to the emptying of the country's traditional psychiatric hospitals and creating a network of regional mental health departments.

Annual conferences take place in Trieste,[108] bringing people from all over the world to understand its focus on community-based services and the importance of individual rights to promote recovery.[109] The model includes very specific components, calculated and sized by a formula to address the service needs per 100,000 population. It includes acute care beds embedded within local general hospitals, community mental health centers with 24/7/365 access, group living environment beds that allow for rehabilitation and residential based support services, "social cooperatives" that serve as day programs, integrating individuals with mental health issues into a social network, as well as a calculated staff ratio to ensure a sufficient multi-disciplinary workforce equipped to provide the services at each of these levels of care.[110]

> **SAMHSA Strategic Plan FY2019-2023:**
> Objective 2.2: Facilitate access to quality care through services expansion, outreach, and engagement.

Trieste's is considered the pioneer and most successful model of these de-institutional efforts. The World Health Organization considered it to be a pilot for de-institutionalization in 1974 and reconfirmed its commitment in 2018 to the model to help provide guidance to other countries.[111] In the United States, Los Angeles County, is seeking to replicate some of the Trieste model, creating innovative accountability and payment systems to address certain barriers that have interfered with the ability to realize a true recovery model.[112] Researchers in San Francisco have also examined Trieste to determine the feasibility of applying its structure to that city.[113]

Workforce development is also deliberately planful in Trieste, with the social cooperative model leading to jobs for service users at the end of the training period.[114] The model prioritizes social inclusion, where one's work in treatment is a partnership between the individual and their provider

that focuses on helping to give meaning and purpose to life. Although in some ways these aspects of the model are similar to the clubhouse model and Fountain House framework,[115] what makes the Trieste model unique is how all these aspects of care are embedded into one community's continuum with a shared vision and mission of supporting people on their own paths to live as well as possible with their illnesses and challenges. Even crisis services are embedded into the infrastructure to support continuity.[116]

In Trieste, outcomes such as rates of unnecessary hospitalizations, suicides and arrests of individuals in crisis are routinely measured and reviewed.[117] This systematized approach requires funding and governmental support, which was noted years ago by prominent psychiatrist Loren Mosher, who spent time studying this mental health system in the 1980s.[118] Since its inception, the Trieste model has become a laboratory of innovation that some have defined as a "whole system, whole community approach."[119]

Trieste represents one community worth understanding although it remains to be seen if its components can be adapted or are adoptable across the United States. Still, the idea of building the supports across a community and enveloping a network to best meet the needs of individuals with mental illness as they need them is a design that could address fragmentation in services and improve, one community at a time, the mental health system in the United States.

6. Emerging models to identify targeted inpatient bed needs

> In *Beyond Beds*, the case is made for the critical importance of a full continuum of psychiatric care and calls for clearer definitions of the word "bed." This clarity is needed so that a community or region can determine which types of beds are sufficient in number and which are insufficient. The *Beyond Beds* paradigm began as a way of helping policymakers understand that more inpatient psychiatric beds–whether in a state hospital or an acute psychiatric hospital– are not a panacea to fixing the whole system, and a more nuanced approach is necessary. These concepts align well with SAMHSA Strategic Plan FY2019-2023 and *Bolder Goals* in attempting to use evidence and data in evaluating programs in an effort to set bed targets and looking at systemic barriers to accessing successful mental health services.

In constructing and designing a full continuum of psychiatric care, inpatient (in hospital) level of care beds are a critical component. Inpatient psychiatric care is often indicated during the acute phase of psychiatric illness just as inpatient medical care is indicated during the acute phase of heart disease and other physical conditions. Furthermore, inpatient psychiatric services, such as those in a state hospital, can be a critical part of the service array for work with complex patients. These include those with forensic involvement or others whose conditions require extended rehabilitative focus when other less restrictive interventions are not appropriate.[120]

Around the world, there are vast differences in inpatient psychiatric bed numbers per a specific population count, and there is no well-established formula for the appropriate number of beds for a particular region.[121] The depth and breadth of the continuum of services and their accessibility, regulatory and legal structures, and societal variability contributes to the complexity of identifying the right numbers of needed inpatient psychiatric services. Indeed, although some organizations have espoused inpatient bed targets,[122] others have questioned the validity of utilizing an expert consensus approach in developing such metrics.[123] Still there is much to learn about the differences in inpatient

bed availability around the world, with Japan having high bed numbers, and Italy having almost none.[124]

The Organisation for Economic Cooperation and Development has analyzed comparative numbers of bed counts in numerous countries.[125] In addition, researchers in Canada, Australia, and the United States and elsewhere have continued to share ideas on bed need calculations that might have merit for a particular community. At the 2018 meeting of the American Psychiatric Association, these researchers proposed different methodologies to calculate bed need.[126] The two most promising approaches include a *population health* approach, that looks at bed need as it relates to illness management, and an *observed outcomes* approach.[127] The *population health approach* considers average service needs for a defined population, considering, for example, how long on average a person with acute schizophrenia symptoms might need a hospital bed and the prevalence of schizophrenia in a given community.[128] The *observed outcomes* approach examines outcomes imputed to inpatient bed access or lack thereof and utilizes hospital or population indicators that are considered to be a result of bed availability, assuming that the right number of beds would be sufficient to achieve access to inpatient beds and avert negative outcomes.[129] Examples of observed outcomes indicators include emergency department boarding of psychiatric patients, homelessness, and suicide rates, which the model assumes would be eliminated or significantly reduced if the right number of beds exists in a community. Hospital-based indicators in the observed outcomes methodology include occupancy or readmission rates, which may be the most sensitive to bed changes within the community.[130]

A theme in the international discussion of the observed outcomes approach is the concept of a "tipping point," at which bed demand exceeds bed availability.[131] Much of this discussion stems from Australia after a National Mental Health Commission issued a report in 2015 recommending a shift in funding from acute psychiatric beds over five years to expand resources into other community services.[132] Backlash from medical professionals and others cited that such a shift in funding would yield a host of challenges, given their view that mental health services had reached that tipping point,

which had led to already high bed occupancy rates and long waits in emergency departments.[133] For example, the researchers determined that when bed availability increased above a critical threshold, emergency department boarding decreased substantially. The researchers therefore argue that this indicates a tipping-point of bed need and that emergency department boarding of psychiatric patients can serve as an indicator of psychiatric bed need in South Australia.[134]

While the debate continues about appropriate inpatient bed numbers as part of the vital continuum of care, inpatient bed capacity need is also dependent on community programming and warm handoffs (i.e., tight linkages for continuity from one level of care to another) and coordination among services for people with mental illness.[135] For example, in Canada and Scotland, the transitional discharge

model utilizes peer support and creating key linkages with practitioners to promote effective discharge planning and transition into the community after psychiatric hospitalization.[136] Providing this service has the potential to reduce the need for inpatient beds due to re-hospitalizations.

Borrowing from the work done by research emanating from these other countries, it might be feasible to see how particular regions could calculate reasonable bed numbers, with recognition that this will differ based on a host of other factors as noted above. The momentum in other countries is growing to look at means of determining the right balance for the continuum, and lessons can be learned in the United States from these efforts.

7. Improved correctional conditions and alternatives to incarceration

> There are disproportionately high numbers of individuals in the criminal and juvenile justice systems with mental illness, intellectual and developmental disabilities, and serious emotional disturbances. To address this increasingly palpable problem, both the SAMHSA Strategic Plan FY2019-2023 and *Beyond Beds* recommend expanding jail diversion in all its forms and improving care. Combined with the *Bold Goal* of 100% diversion from incarceration, part of the work must also involve examining practices within and across justice settings and linkages to communities.

The United States has the highest rate of incarceration in the world.[137] Policymakers, advocates and researchers are making efforts to look at systemic and social factors that contribute to this reality and implement reforms to minimize justice involvement for all. People with mental illness and other mental disorders are however disproportionately represented in correctional institutions, and special attention is needed for these populations. Data released by the U.S. Bureau of Justice Statistics in 2017 revealed that, for those individuals in a jail or prison in 2011–2012, a history of mental illness was the "rule rather than the exception."[138,139] Persons with intellectual and developmental disabilities are also over-represented in criminal contexts.[140] Thus, focusing on these populations for criminal and juvenile justice deflection and alternatives to incarceration could potentially reduce incarceration rates in general and of these populations in particular. The sequential intercept model and the Stepping Up initiative provide frameworks to facilitate community efforts to reduce the prevalence of individuals with mental illness, as well as those with co-occurring substance use conditions, from the criminal justice system.[141,142] The sequential intercept model has even been codified into law through the 21st Century Cures Act, marking its place as a vehicle for system reform,[143] and efforts at jail diversion and reducing populations of individuals with mental illness from the justice system have been clear areas of focus for *Beyond Beds, Bolder Goals and the SAMHSA Strategic Plan FY2019-2023*.

BEYOND BEDS:
Recommendation #3: Criminal and Juvenile Justice Diversion
Fund and foster evidence-based programs to divert adults with serious mental illness and youth with serious mental illness or emotional disorders from justice settings to the treatment system. These programs should operate at all intercept points across the sequential intercept framework and be required to function in collaboration with correctional and other systems.

In both the United States and internationally, a focus on crisis response in early intercepts of the sequential intercept model has emphasized structured approaches such as Mental Health First Aid training stemming from Australian efforts, and law enforcement based Crisis Intervention Teams.[144] These initiatives can serve to keep people with mental illness out of correctional facilities. Later points

of interception specifically focus on individuals moving from jails to court to prison to community through reentry and back again through parole or probation.[145] There is much to be learned from other countries about the justice and mental health interface, not to mention the significantly lower incarceration rates overall, as well as the fact that the duration of incarceration is generally lower even for serious crimes in many countries.[146] That said, although prisoners in the United States have a constitutional right to treatment,[147] it is increasingly recognized that care and treatment in settings of incarceration is variable and too often lacking, contributing to worse health outcomes.[148] Moreover, linkages to community supports post-release continues to vex our systems[149] and lack of such linkages contributes to a vicious cycle of release, return, and re-arrest.[150]

What is less discussed in mental health system policy circles is the potential of re-conceptualizing correctional conditions of confinement to advance better mental health outcomes when deflection or diversion is not available. This has potential importance because the conditions of jail and prison can contribute to a person's mental illness outcomes.[151] Factors such as basic architectural design of and conditions within jails and prisons can help make these environments generally less traumatizing as well.

> **BOLDER GOALS:**
> *100%* diversion from arrest, detention or incarceration when individuals with mental illness intersect with the justice system and can be appropriately redirected

There is a movement in the United Stated wherein architects with a social justice interest have started working on design concepts that can help mental health outcomes for inmates.[152] Although European correctional systems still have their challenges, there is more to learn and to do by examining certain advances in other countries.[153]

Designs emerging around the world have been reflecting the values behind setting up correctional structures with proper lighting, temperature control and quiet spaces for both staff and inmates to improve conditions and reduce the traumatic nature of the prison setting itself.[154] For example, in Norway, one facility had more than $1 million dollars invested in paintings and light installations, provided every 10 inmates with a shared kitchen and living room, and removed bars from the windows.[155] In addition, although there is more work to do with psychiatric services for incarcerated people,[156] some newer prisons in Germany have recently been recognized for their humane physical amenities and resultant approaches to managing inmates while incarcerated. Even staunch prison rights

> **SAMHSA Strategic Plan FY2019-2023:**
> Objective 2.4: Increase opportunities for diversion and improve care for people with SMI or SED involved in the criminal and juvenile justice systems.

advocates such have reported favorable impressions about this system.[157] In Denmark, Suomenlinna Island has had an open prison system since 1971, where it operates more like a university dorm than a cellblock and the inmates leave the grounds each day to go to work.[158] These examples point out that conditions of incarceration can still serve their purpose with more flexible and person-focused environments.[159]

Practices and programs in other countries can also provide lessons about strategies to reduce the disruptions in care for mental illness and serious emotional disturbances produced by detention, incarceration and court involvement. It is critical to recognize that correctional systems house individuals who require all levels of treatment, yet in the United States mental health care is often disrupted upon entry, and then fractured or disconnected upon community reentry.[160] Efforts to

improve this seem to be everywhere, but system silos too often present barriers. For example, some early data from Michigan showed that treatment engagement after release was less likely when service providers within jails were not well-integrated with community mental health.[161] In this regard, practices in other countries are enlightening. In England, the National Health Service provides for a "principle of equivalence," which conveys that the health needs for the population should not be compromised by the setting or level of service.[162] Although this principle has not solved all problems and there remains room for improvement in correctional healthcare practices,[163] its application provides certain lessons. For example, the National Health Service England Health and Justice has the responsibility of commissioning health care across juvenile and adult secure settings, including correctional settings, and works with courts and law enforcement, and in doing so its efforts intersect with a variety of justice system and other stakeholders to provide a seamless continuum of services. The system fosters linkages and supports with local authorities as individuals move in and out of detention and secure settings. Examination of these efforts has shown broad-based benefits of attending to the healthcare needs of people in correctional settings.[164]

At the court level, there are also lessons from other countries. Israel, for example, has established several community courts, which have some similarities to the drug and mental health courts in the United States but with important differences. These community courts take an approach that looks beyond the individual community court participant and focuses on framing the efforts at the court to build back public trust.[165] The court program works to foster individual participants' belief that the courts apply procedural justice and helps to use that strategy to improve the well-being of the community as a whole.[166]

The unfortunate truth is that no one system in the world has solved the problems faced in correctional and justice settings by persons with mental illness and other behavioral health challenges. This further supports the critical importance of emphasizing diversion efforts to keep people out of jails and prisons when incarceration and detention are not needed to enhance public safety. Still, examples of promising approaches and facets of this interface around the world are worth noting. These models reflect the potential to shift the focus toward care continuity and maximizing access to better, more humane conditions for people with mental illness and serious emotional disorders confined in- and intersecting with- the justice system.

8. Disaster response and opportunity for sustained improvement

> The SAMHSA Strategic Plan 2019-2023 recommends improving coordination among federal agencies to improve the lives of people with serious mental illness and youth with serious emotional disturbances and their families, which includes making trauma-informed, whole-person health care the expectation. *Beyond Beds* called for emergency treatment and stabilization to lead to access to a full continuum of care, and *Bolder Goals* called for 100% access without delay to appropriate care settings. These should all be true at times of crisis, including in the context of interpersonal violence and natural disaster, as these events may escalate mental health symptoms. Lessons can be learned from other countries in how to create mental health disaster response plans that are sustainable even after an immediate community crisis is resolved.

Perhaps nowhere are systems taxed more than when communities are facing urgent and emergent stressors from large-scale acute disasters or smoldering socioeconomic challenges that lead to

traumatized populations. Take for example how Hurricane Katrina, 9/11, and mass shootings created huge needs for health care and mental health care.[167,168,169] The aftermath of these incidents can be long-lasting. In the United States, disaster preparedness has been recognized as a critical component of the infrastructure of mental health services.[170] Additionally, given that individuals with serious mental illness often have trauma histories already, trauma-informed care is seen as a critical approach in adult and children's behavioral health systems, not to mention the child welfare and justice systems. Recommendations for trauma-informed approaches have been outlined as part of the NASMHPD series of technical assistance coalition papers.[171]

BEYOND BEDS:
Recommendation #4: Emergency Treatment Practices
Monitor hospitals for adherence to the Emergency Medical Treatment and Labor Act in their emergency departments and levy sanctions for its violation, including the withholding of public funding. Hospitals with licensed psychiatric beds that refuse referred patients should similarly be sanctioned if monitoring shows they have a record of refusing referred patients without legitimate cause.

On a global scale, community efforts focused on improving mental health have been promulgated to improve outcomes after regions have been hard hit with a variety of traumatic events and adverse circumstances. One example is citiesRISE, a global platform aimed at transforming mental health practices and policies in cities across the world to meet the mental health needs of their populations.[172] For example, the Kenyan Ministry of Health has made efforts to address the growing stressors for young people in Nairobi and has partnered with citiesRISE to develop a plan to address their mental health needs. Similarly, with high levels of homelessness, violence and substance misuse, local leaders in Bogotá have partnered with citiesRISE to look at community-based models to address these challenges.

Although the world has learned a great deal from the United States, tragic disasters and circumstances around the world can provide profound and humbling lessons for the United States in considering mental health needs that could exist or emerge as well as approaches to address them. After the devastating 2010 earthquake in Haiti, one of the poorest countries in the world, lessons were learned about the socio-cultural beliefs of Haitians and the challenges of engaging the population to increase people's willingness to seek and accept mental health care.[173] Collaborative models to address systemic needs across services are shown to be of value in the region to help improve mental health outcomes.[174] Lessons in the aftermath of trauma have been gleaned from studies of survivors of the 1994 genocide in Rwanda.[175] Mental health services specifically focused on treatment for post-traumatic stress disorder in post-genocide Rwanda led to system modifications to decrease disparities and increase access to care.[176]

BOLDER GOALS:
100% of suicides prevented
100% access without delay to the most appropriate 24/7 psychiatric emergency, crisis stabilization, inpatient or recovery bed

Clearly it is always hoped that disasters and socioeconomic stressors can be averted or limited, yet, given that this is not always possible, disaster preparedness is essential. The Inter-Agency Standing Committee (IASC), a group of the United Nations, International Federation of Red Cross and Red Crescent, among other humanitarian organizations, released the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings to help inform communities about preparedness with a focus

SAMHSA Strategic Plan FY2019-2023:
Objective 2.1: Strengthen federal coordination to improve care.

on mental health.[177] These guidelines foster as a priority outcome the sustaining of well-being of community and family after an emergency. The World Health Organization produced a guide entitled, *Building back better: Sustainable mental health care after emergencies* focused on the need to rebuild and improve following an emergency.[178] This guide takes 10 case examples from around the world and highlights how systems can learn about their gaps and leverage political will for sustained positive change in mental health services following an emergency.

During an emergency, mental health services can be overwhelmed by demand, and the ability of the workforce to address the unique needs of the people being served with a trauma-informed lens can be threatened. Preparedness, and taking stock of global experiences with disaster relief and sustained improvements can help mental health services in the United States do better.

9.   Mental health as public health

The SAMHSA Strategic Plan FY2019-2023 recommended screening and early intervention among children, transition-age youth, and young adults as a national policy and urged that quality measurement efforts in health care should include mental health. Suicide prevention efforts were recognized in the SAMHSA Strategic Plan FY2019-2023 and *Bolder Goals,* and *Beyond Beds* called for policies to close gaps across systems to improve mental health outcomes. Yet, mental health services are well behind public health practices in taking on prevention, and public health systems have historically not incorporated mental health into its framework.

Lessons can be learned from other countries that are recognizing mental health as component of public health. In the United States, there is a distinction between the health delivery system and public health. A fully developed public health model focuses on illness prevention itself, early identification of disease and ongoing treatment of already emerged conditions. For mental health treatment services, the focus has traditionally been downstream treatment of disease. Integrated treatment models between physical and mental health care are growing,[179] despite a long history of running in parallel. In public mental health, collaborations between primary care health clinics and community mental health care are examples of this growth.

BEYOND BEDS:

Recommendation #7: Linkages
Recognize that the mental health, community, justice, and public service systems are interconnected, and adopt and refine policies to identify and close gaps between them. Practices should include providing "warm hand-offs" and other necessary supports to help individuals navigate between the systems in which they are engaged.

From a public health perspective, physical illness prevention can be seen everywhere, such as when clinics and even employers offer benefits and programs that foster nutrition and exercise. Yet, the public health system in the United States has historically not incorporated mental illness prevention in its framework, other than suicide prevention.[180] The increasing rates of suicide alone in the United States,[181] however, are indicative that more is needed, as well as emerging discussion related to social determinants of health and adverse childhood events contributing to the development of chronic disease including mental health conditions.[182] Conceptualizing mental health as part of public health, without having the public health system subsume mental health treatment and support services, is one way to address this need. There are important lessons from the international community that can be taken from this approach.

International examples along these lines include large scale prevention and population-based wellness strategies that are emerging in Europe. For example, a national Mental Wellbeing Impact Assessment Coalition toolkit in England was developed to provide an evidence-based framework for improving well-being for people and organizations to ensure programs and polices maximally impact well-being.[183] In Scotland, an initiative titled *Good Mental Health For All* was established to help improve mental health of the country's population and was promoted as a national priority.[184] Developers of this effort note that inequalities in mental health care and future projections on the prevalence of mental health problems raise legitimate concerns that costs may become unmanageable, thus supporting a large scale prevention strategy to shift the paradigm by incorporating mental illness prevention into public health.

> **BOLDER GOALS:**
> *100%* availability of early screening, identification and timely response after the onset of mental illness symptoms in youth and adults
> *100%* compliance with legal requirements for health care networks to make the full continuum of psychiatric care accessible to patients
> *100%* of suicides prevented

As another example focused on well-being in the workplace, in 2008, the National Health Service Lanarkshire of Scotland started a program to help connect absent workers to occupational health care, demonstrating that a phone communication geared to support workers and connect them to care was more effective in reducing sickness absence than just tightening sick-leave policies.[185] More recently in the United Kingdom, an experimental trial called *Thrive Into Work* was launched to ascertain whether a specialized employment support service could assist people with a mental health or physical condition find suitable work or support their success in the workplace.[186] The program involves a collaboration between the health service and the Department of Work and Pensions, among others. Meanwhile, the National Health Service noted in its "Five Year Forward View" that tackling mental health early can serve to reduce problems downstream.[187]

> **SAMHSA Strategic Plan FY2019-2023:**
> Objective 2.3: Improve treatment and recovery by closing the gap between what works and what is offered.

Identifying youth at risk of developing serious emotional disturbances and mental illness is increasingly recognized as important.[188] Early identification of psychosis can improve outcomes, which has led to first episode psychosis programs, very much promulgated in Australia,[189] and now adopted in the United States. In the substance use services arena, one model, the "Screening, Brief Intervention and Referral to Treatment" approach, has been studied extensively for its promising public health impact for certain conditions.[190] As prevention of physical illness has been gaining ground with the emerging strategies of health care helping the whole person, health home models and other payment mechanisms are broadly moving care delivery to attend to well-being as a whole—including mental wellness and prevention of mental illness—as a strategy to decrease both poor mental health and physical health outcomes. To achieve some of the goals outlined between ISMICC, *Beyond Beds* and *Bolder Goals*, the ideas of population-based mental wellness and mental health as an equal part of public health should be examined for more widespread adoption in the United States.

Conclusions and Recommendations

There are daily success stories for countless people in the United States with serious mental illness and serious emotional disturbances. Yet, all too often many others face challenges including, disrupted social networks, unemployment, school retention challenges, complexities at the interface with older adult services, homelessness, revolving appearances in correctional and juvenile justice systems, victimization, high suicide rates and much earlier mortality related to physical illness. As such, where mental illness is concerned, there is much more to know and learn. This paper highlights one major recommendation—to look not only locally, but also internationally for approaches that will lead to better results.

In *Beyond the Borders*, nine thematic areas for improving outcomes for people with mental health issues are described based on various approaches from the international community. Lessons contained in this paper cover a broad range of ideas including the use of big data, differential access to effective therapies, strengthened policy related to supporting self-determined decisions, true integration of culture and religion into practice, and alternative correctional system models to name a few. The themes within the nine areas of focus complement the recommendations of ISMICC, *Beyond Beds* and *Bolder Goals,* which all delineate approaches to attain better outcomes in mental health. By intentionally taking stock of work that has been done in other countries over recent years as a reference point for efforts in the United States, practitioners, policy makers and families have the potential to further augment and align improved services with a worldwide vantage point. Now is the time to do so. Ongoing attention is needed to support and strengthen mental health services, and this report attempts to add a global perspective to advance toward critical goals.

Appendix A: National Association of State Mental Health Program Directors Technical Assistance Coalition Assessment Working Papers

2019:
- Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes
- Effects of CMS' Measure of Antipsychotic Prescribing Practices for Nursing Facilities on Utilization of Antipsychotic Medications and Changes in Diagnostic Patterns
- Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders
- The Suicidal Patient in Crisis: A Comprehensive Systemic Response
- A Public Health Approach to Trauma and Addiction
- Traumatic Brain Injury and Behavioral Health Treatment
- Recovery-Oriented Cognitive Therapy: A Theory-Driven, Evidence-Based, Transformative Practice to Promote Flourishing for Individuals with Serious Mental Health Conditions that is Applicable across Mental Health Systems
- Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?
- Schools as a Vital Component of the Child and Adolescent Mental Health System
- Addressing Intersecting Social and Mental Health Needs among Transition-Aged Homeless Youth

2018:
- Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes
- Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements
- Speaking Different Languages- Breaking Through the Differences in the Perspectives of Criminal Justice and Mental Health Stakeholders on Competency to Stand Trial Services: Part 1
- Medical Directors' Recommendations on Trauma-informed Care for Persons with Serious Mental Illness
- A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness
- Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness
- Changing the Trajectory of a New Generation: Universal Access to Early Psychosis Intervention
- Making the Case for a Comprehensive Children's Crisis Continuum of Care
- Achieving Recovery and Attaining Full Employment through the Evidence-Based IPS Supported Employment Approach
- Weaving a Community Safety Net to Prevent Older Adult Suicide

2017:
- Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care
- Trends in Inpatient Psychiatric Capacity, United States and Each State, 1970-2014
- Crisis Services' Role in Reducing Avoidable Hospitalization
- The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity
- Quantitative Benefits of Trauma-Informed Care
- The Role State Mental Health Authorities Can Play in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, including those with Co-Occurring Substance Use Disorders
- The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System
- Older Adults Peer Support: Finding a Source for Funding
- Cultural and Linguistic Competence as a Strategy to Address Health Disparities in Inpatient Treatment
- Forensic Patients in State Psychiatric Hospitals: 1999-2016

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