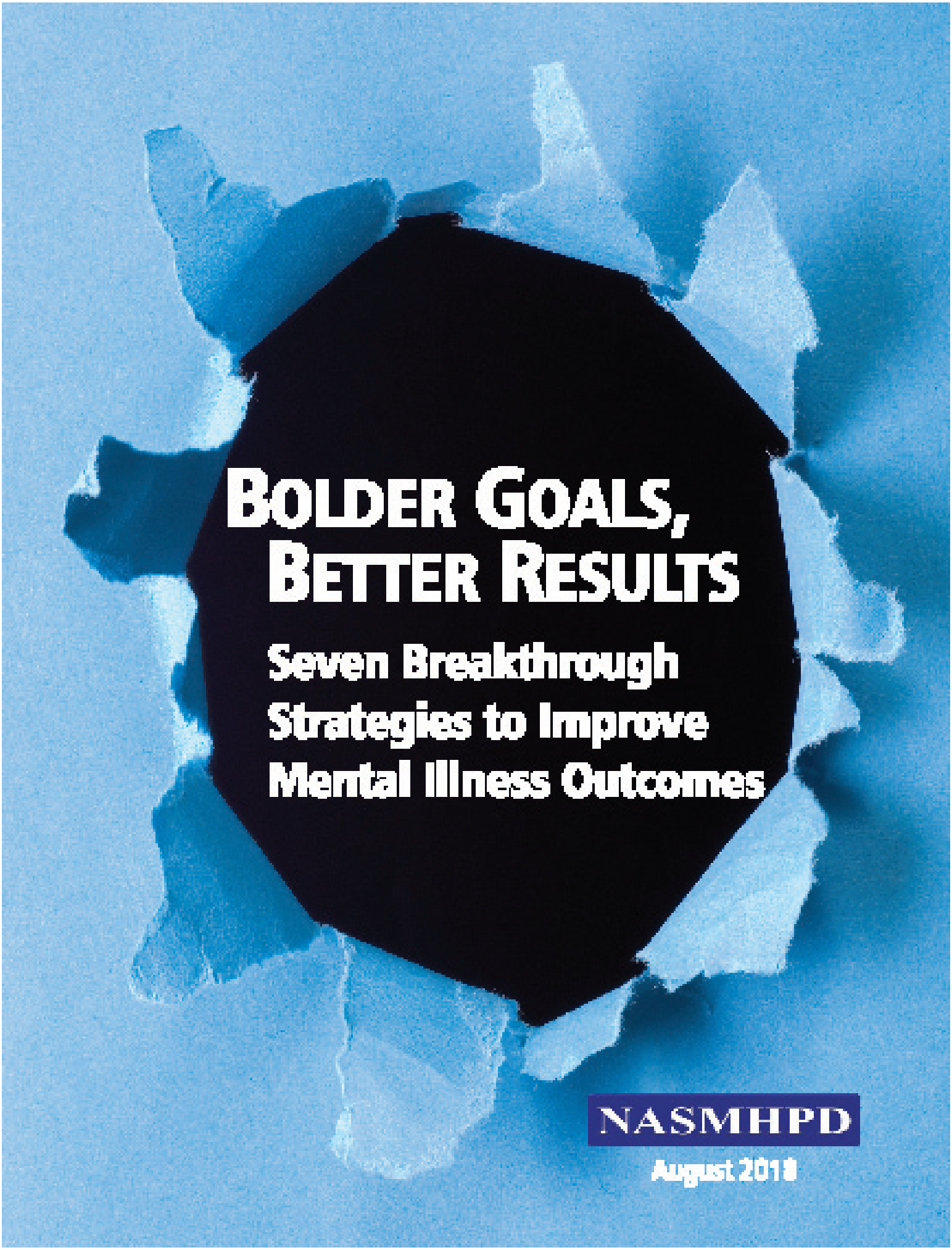

Bolder Goals, Better Results

Seven Breakthrough Strategies to Improve Mental Illness Outcomes

NASMHPD

August 2018

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Bolder Goals, Better Results

Seven Breakthrough Strategies to Improve Mental Illness Outcomes

Debra A. Pinals, MD
Medical Director, Behavioral Health and Forensic Programs
Michigan Department of Health and Human Services
Clinical Professor of Psychiatry
Director, Program in Psychiatry, Law and Ethics
University of Michigan

Doris A. Fuller, MFA
Principal, Mental Illness Research Associates
Chief of Research and Public Affairs (ret.)
Treatment Advocacy Center

First in a Series of Ten Briefs Addressing:
Bold Approaches for Better Mental Illness Outcomes Across the Continuum of Care

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Executive Summary

The National Association of State Mental Health Program Directors (NASMHPD) in 2017 issued a series of technical assessments exploring the theme *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*. The series proposed 10 global recommendations and many detailed ones for building and invigorating a robust, interconnected, evidence-based system of mental health care to reduce the human and economic costs associated with untreated and undertreated severe mental illness.

In the year since that series was released, a formal collaboration of public and private stakeholders that convened under provisions of the landmark 21st Century Cures Act issued its preliminary roadmap for improving mental illness prevention and intervention. The Intergovernmental Serious Mental Illness Coordinating Committee (ISMICC) report included many of the *Beyond Beds* strategies for improving mental illness outcomes. At the same time, initiatives to address system gaps, reduce personal suffering and decrease the societal costs of psychiatric disease were being launched or expanded at every level of government and in the private sector.

Psychiatric diseases occur on a spectrum of severity and are described by a variety of terms among professionals and in the public. Unless otherwise specified, the contents of this paper apply to:

- ***adults with severe and persistent mental illnesses such as schizophrenia, schizoaffective disorder or severe bipolar disorder; and***
- ***children and adolescents with serious emotional disorders or mental illness.***

Many of the goals laid out here would also benefit individuals with intellectual or developmental disabilities, whose distinctive challenges are beyond the scope of this paper.

Despite these efforts, mental illness outcomes are still not good enough. More than half a century has passed since President John F. Kennedy called for a "bold new approach" to treating mental illness and nearly 20 years have gone by since President George W. Bush established the President's New Freedom Commission on Mental Health. Through those years, there has been no shortage of proposals for improving mental illness prevention and treatment, but they have produced little measurable improvement in collective benchmarks. Despite innumerable cases of individual success, employment rates and life expectancy for the population with serious psychiatric disease have not risen, and the likelihood of criminal justice involvement and suicide has not fallen. Mental illness is still rampant among the nation's homeless. Bitter battles over the role and number of inpatient beds have not stopped. Meanwhile, through the years, people with serious mental illness have continued to languish or die.

In the same time period, other medical conditions have benefited from the power unleashed by dedication and funding of concrete goals for solving seemingly unsolvable problems. In 1971, Congress passed the National Cancer Act that made curing cancer a national priority. Survival rates have since improved for all but two common cancers, and countless lives have been spared.[1] In 1990 and 1992, when the disease was considered a death sentence, Congress enacted laws to fast-track AIDS research and treatment.[2] In less than a decade, medical breakthroughs transformed the infection that causes the disease into a chronic rather than a fatal health condition.[3] Meanwhile, in the private sector, the Bill & Melinda Gates Foundation committed at the outset of the 21st century to eliminating malaria worldwide; in less than 15 years, the number of annual new malaria cases fell 25% globally and the number of deaths by 42%.[4]

Serious and persistent psychiatric diseases are overdue for similar commitment and breakthroughs.

In Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes, NASMHPD proposes the following bold goals to produce similar breakthroughs for people living with serious mental illness.

- 100% availability of early screening, identification and timely response after the onset of mental illness symptoms in youth and adults
- 100% access to effective medication and other evidence-based therapies for individuals with psychiatric conditions
- 100% compliance with legal requirements for health care networks to make the full continuum of psychiatric care accessible to patients
- 100% access without delay to the most appropriate 24/7 psychiatric emergency, crisis stabilization, inpatient or recovery bed
- 100% diversion from arrest, detention or incarceration when individuals with mental illness intersect with the justice system and can be appropriately redirected
- 100% of homeless people with serious mental illness permanently housed
- 100% of suicides prevented

Each goal is a measurable objective building on previous groundbreaking by NASMHPD, ISMICC or other initiatives. Each one is bold but supported with sufficient evidence or progress to make the ambition achievable. Each would improve the lives of countless children, adolescents, adults and families living with serious mental illness.

These are not the only steps that would produce improved mental illness outcomes in America, but they are steps of such magnitude that achieving any one of them would transform and save countless lives. The combined effect of achieving all seven would be incalculable.

Background

The 20th Century's Legacy

In February 1963, President John F. Kennedy publicly called for a "bold new approach" to addressing the needs of people with mental illness or intellectual disabilities. In a special message to Congress, the president decried the reliance on large state hospitals that were notoriously understaffed, overcrowded and under fire for their conditions. In their place, he called for a system of smaller, local mental health centers where mental illness prevention would be a priority, and treatment would be kept close to home. Through these centers, President Kennedy said, patients would move along a continuum of care from diagnosis to cure, rehabilitation and, ultimately, recovery, without delay and without leaving their communities.

The president challenged Congress to fund a nationwide system of such centers and build on them a continuum of care that embraced –

- Scientific discovery
- Emphasis on recovery and community integration
- Workforce development
- Community connectedness and better outcomes

The resulting Community Mental Health Centers Construction Act (CMHCA) survived Kennedy's 1963 assassination by only a few years; a succession of later presidents and Congresses reduced and eventually eliminated federal funding for the centers that were the cornerstone of his vision. The rest, as the saying goes, is history. The large institutions he criticized were mostly shuttered in a trend known as deinstitutionalization or dehospitalization, but not nearly enough of the new ones were built. Where community-based clinics did open, the comprehensive continuum of psychiatric care Kennedy envisioned grew unevenly, incompletely or not at all. Individuals with the most serious mental illness who experienced insufficient community support increasingly reached the public eye only when they produced dire statistics or grim headlines.

Persistently, almost intractably, issues of untreated or undertreated serious mental illness devolved into an outcry for more state hospital beds instead of dedication to building the full continuum of care that had been envisioned as the counterpart to closure of the old hospitals. Poor personal and societal outcomes associated with untreated psychiatric conditions – homelessness, criminal justice involvement, victimization, suicide and others – increasingly became debate points in ongoing ideological battles over how many psychiatric beds was enough. Too often lost in the crossfire was the affected population itself, especially children and adolescents with emerging mental health issues and geriatric patients with longstanding ones.

***"SED" is often used as shorthand for serious emotional disorders in children and adolescents and "SMI" as an abbreviation for serious mental illness. For clarity and readability, the full names of these conditions or common synonyms (e.g., "psychiatric disorder/disease," "mental health condition," "mental illness") are used in* Bolder Goals, Better Results.**

The 21st Century's Opportunity

The persistence of these issues and all the misery and costs associated with them contributed to a mental health reform movement that climaxed in December 2016 when Congress passed the 21st Century Cures Act, the most sweeping legislation addressing serious mental illness since the CMHCA. The goal of the Cures Act was to speed the discovery, development and delivery of cures for a number of debilitating diseases including serious mental illness.[5] To signal and elevate the seriousness of the cause, the act established a new post of assistant secretary of mental health and substance use and mandated a collaboration of public and private stakeholders to share and generate solutions to the problems facing the mental health system and the individuals served by it.

The collaboration became known as the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), which convened in March 2017. Comprised of senior leaders from 10 federal agencies and 14 members of the public, the group met intensively for months before issuing its initial report in December 2017.[6] In *Bolder Goals, Better Results* and the technical assessment collaborations that accompany this overview, NASMHPD builds on the ISMICC findings and other mental health initiatives that already are breaking ground toward evidence-based solutions to some of the most devastating consequences of serious mental illness.

Seven guiding bold goals and their rationales are described in the pages that follow.

1 Early identification and diagnosis of psychiatric disorders

Ideally, science and medicine would possess the tools and means to prevent serious mental illness. Those breakthroughs are still to come. Until that happens, early identification and intervention offer our best opportunity for reducing the disability and suffering associated with serious mental health conditions and improving outcomes for individuals who experience them.[7]

In this, the United States has long lagged other Western democracies. The United Kingdom requires by law that more than 60% of patients with signs and symptoms of psychosis be identified and treated within two weeks; the average lag from symptoms to intervention is 22 days.[8] Meanwhile, in the United States, the average lapse between the onset of psychotic symptoms and treatment in 2015 was 74 weeks – more than 20 times the average in the United Kingdom.[9]

Breaking Through for Early Intervention

Compared to typical care for first-episode psychosis, coordinated specialty care has been shown to be more effective at reducing symptoms, improving quality of life and increasing involvement in work or school.

National Institute of Mental Health

To reduce that gap, significant funding and research have been committed in the past decade to identifying and propagating early-intervention practices to assure that children, adolescents and young adults are diagnosed faster and treated more appropriately in early stages of serious psychiatric disease. The National Institute of Mental Health (NIMH) in 2008 launched a large-scale research project that produced a national model for coordinated specialty care for young adults experiencing a first episode of psychosis. From 2014, Congress repeatedly increased block grant funding to promote use of the model, and the Cures Act reinforced that practice. The approach has produced results: Coordinated specialty care programs for youth were available in only two states when the NIMH research began in 2008; by 2016, programs were operating in 36 states, and the NIMH projected the number would reach 48 states in 2018.[10]

At the same time, pediatricians increasingly are screening their patients for symptoms of serious emotional disorders and circumstances known to make children vulnerable to developing such conditions, such as trauma. Schools have been implementing programs to identify students at risk for mental health issues and their potential consequences.

Ground is being broken, but universal early identification and intervention remain more ideal than reality when it comes to mental health. Prevention and early intervention have become cornerstones of American health care for heart disease, breast and prostate cancer, hypertension and a host of other potentially terminal diseases. If individuals with psychiatric disease are ever to experience the same life-saving results, they must be given the same early and effective treatments.

BOLD GOAL 100% ***Early screening, identification and timely response after the onset of mental illness symptoms in youth and adults***

Strategies relevant to reaching this objective are included in technical assessment #7 of this series: *Changing the trajectory of a new generation: Universal access to early psychosis intervention*.[11]

2

Access to effective mental health therapies

For a host of reasons beyond the scope of *Bolder Goals, Better Results*, non-treatment and under-treatment of serious mental illness are commonplace. The National Institute of Mental Health reports that, at any given time, approximately half of people with schizophrenia or bipolar disorder are receiving no treatment for their mental health conditions.[12] No data quantifies how many people are receiving treatment that is intermittent, not fully effective or otherwise less than ideal, but mental health professionals routinely see patients with these patterns in their practices.

Consumers, family members and clinicians often lament the shortage and limitations of effective pharmacological and psychosocial therapies for reducing mental illness symptoms, and with good cause. Although advances have occurred in formulas and medication delivery methods (e.g., longer-acting injectables), it has been more than 20 years since the last true psychiatric medication innovation, and the pipeline of new and better drugs is drying up.[13] Meanwhile, evidence-based psychosocial therapies for serious mental illness remain relatively few in number and often inaccessible for geographic, economic or other reasons. Effective strategies for retaining psychiatric patients in treatment are also in short supply.

The gaps are especially acute for people with co-occurring mental health and substance use issues. Even though this population is at significantly higher risk for virtually every consequence of non-treatment or under-treatment, the treatment tool box for these dual diagnoses is all but empty. For example, promising addiction interventions such as medication assisted treatments have emerged for substance use disorders but are not widely available to individuals with co-occurring mental illness.

Troubling as these limitations are, they do not negate the fact that many effective therapies for mental illness already have been validated but are being under-utilized, to the detriment of the people who would benefit from them, their families and their communities.

Clozapine is a case in point. Available in the United States since 1990, clozapine is well-established as the most effective antipsychotic for patients with schizophrenia who do not respond to treatment with first- or second-generation antipsychotics. Additionally, it is approved by the Food and Drug Administration for reducing suicidal thoughts.[14] Nonetheless, the medication is prescribed infrequently in the United States, and its use is declining.[15] Psychosocial therapies, including trauma-informed care, are similarly underused. Cognitive behavioral therapy, for example, is a standard treatment for schizophrenia in the United Kingdom but is not widely available in the United States.[16] For the youth population, promising therapeutic approaches that incorporate the entire family system have been identified but are also under-used.

Better prevention and treatment tools await development. Until then, it is essential that those interventions already validated are available to those who would benefit from them.

BOLD GOAL **100%** ***Access to effective medication and other evidence-based therapies for individuals with psychiatric conditions***

Strategies relevant to reaching this objective are included in technical assessment #4 of this series: *Medical directors' recommendations on trauma-informed care for persons with serious mental illness*.[17]

3

100% compliance with requirements for adequate availability of mental health services along the full continuum of care

In the 2017 assessment, *Beyond Beds: The Vital Role of the Full Continuum of Psychiatric Care*, NASMHPD and the Treatment Advocacy Center called on policymakers at every government level to take 10 steps toward "reducing the human and economic costs associated with severe mental illness by building and invigorating a robust, interconnected, evidence-based system of care that goes beyond beds."[18] (See Appendix A for the *Beyond Beds* recommendations).

For such a continuum to successfully serve all its intended beneficiaries, those individuals require access to treatment and providers at all levels of care, whenever and wherever needed. Beginning in the 1990s, this care for youth and adults with the most serious psychiatric disorders has increasingly been delivered through managed care organizations (MCOs) that develop networks of approved providers who accept set payments for services. In 2016, 81% of all Medicaid beneficiaries were receiving services through an MCO.[19]

By the early 2000s, it was apparent MCO networks were not adequately serving all their qualifying clients. States had not been required to set quantifiable standards for assuring access to care, which resulted in a mental health care safety net that was patchy and regionalized. A 2014 report by the Office of the Inspector General for Health and Human Services found many states did not have adequate MCO networks, and many of those states that did have standards were not enforcing them.[20] Compliance and enforcement left much to be desired. This threatened to undermine the standards in much the same way that inadequate follow-through already has undermined the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

The Affordable Care Act established new federal "network adequacy" rules to assure that private insurance, managed Medicare and state Medicaid MCOs were meeting the needs of their clients, including consumers of mental health and substance use services. In January 2018, new rules took effect. These rules called on states to develop definitions, measures and standards for network adequacy and to address gaps in the continuum of care. For example, standards could be set for the time and distance a beneficiary has to travel for care, or for the ratio of providers to beneficiaries in the population being covered. The rules apply to primary care, behavioral health care and other medical services for youth and adults and behavioral health care for all ages. Oversight mechanisms to ensure the standards are met are being developed and refined.

The rules alone will be insufficient to make every mental health and substance use network adequate and guarantee a full and robust continuum of care to every patient. Many measures of care (e.g., the number or kinds of providers, hours that services are available, language translators and other network characteristics that impact access to care) remain unregulated. Because states may set different standards, regional differences may persist.

Nonetheless, the new legal requirements are a first step toward building a more complete continuum of care. Given the vital role of the full continuum in mental health, it is essential for states to rigorously monitor and enforce compliance with this federal rule.

BOLD GOAL **100%** ***Compliance with legal requirements for health care networks to make the full continuum of psychiatric care available to patients***

Strategies relevant to reaching this objective are included in technical assessment #8 of this series: *Making the case for a comprehensive children's crisis continuum of care*.[21]

4

Timely access to the right 24/7 mental health bed at the time it is needed

The shift of psychiatric care from state hospitals to a community focus did not begin with President Kennedy's mental health initiative, but it accelerated significantly with the CMHCA legislation and subsequent federal programs, chiefly Medicare and Medicaid. Within two decades, the number of state hospital beds had plummeted by nearly two-thirds;[22] by 2016, only 3.5% of the state beds that existed at their all-time high in 1955 remained.[23]

Ironically, the cumulative result of these closures is now often called "trans-institutionalization" because so many of those in the population that once occupied state psychiatric hospitals are today living in nursing homes or other systems, including jails and prisons.[24] Multiple factors – from financial disincentives for new psychiatric beds through criminal justice trends like the "war on drugs"– have contributed to this phenomenon. Regardless of the roots, there is widespread recognition that the number of 24/7 crisis, hospital, respite and rehabilitation beds in the United States is not currently sufficient to meet the needs of individuals with psychiatric conditions. Inpatient bed waits in emergency rooms and forensic bed waits in correctional facilities are the most commonly cited evidence of a beds shortage, but others are often proposed.

Breaking Through for Access to Care

In 2017, metro area Phoenix law enforcement engaged 22,000 people and transferred them directly to crisis facilities and mobile crisis without visiting a hospital ED.

Crisis Now

NASMHPD and the National Action Alliance for Suicide Prevention

Psychiatric beds remain a vital element of the full continuum of psychiatric care. Some individuals in mental health crisis continue to require 24/7 inpatient care to achieve stabilization, just as individuals in cardiac arrest require intensive care to stabilize. Some people recovering from psychiatric episodes no longer need round-the-clock clinical care but still need crisis or other residential support, just as people recovering from stroke move from hospital to rehabilitation beds. Sadly, some individuals with psychiatric disease are unresponsive to treatment and unable to live safely or successfully on their own, much as individuals with late-stage Alzheimer's often require residential settings that provide support and security not available in their own homes.[25] Although some children and adolescents require similar treatment settings appropriate to their age group, many youth and their families benefit when children stay at home in their own beds and go to school.

In a civilized and moral society, it is not acceptable that a selected population in medical need is left in the hallways of hospital emergency departments, turned onto the streets or shunted into the criminal justice system because no appropriate treatment setting is available and accessible to them. All individuals with mental illness who require inpatient or residential services deserve to have access to the appropriate mental health bed when 24/7 care is essential for their recovery.

BOLD GOAL **100%** ***Access without delay to the most appropriate 24/7 psychiatric emergency, crisis stabilization, inpatient or recovery bed***

Strategies relevant to reaching this objective are included in technical assessment #2 of this series: *Experiences and lessons learned in states with on-line databases (registries) of available mental health crisis, psychiatric inpatient, and community residential placements*.[26]

5

Diversion of those individuals appropriate for redirection from the justice system

America's jails and prisons house so many individuals with serious mental illness they are often called the "new asylums." Overall, approximately 26% of inmates in jails and 14% of inmates in state prisons are estimated to have a serious mental illness.[27] In any given year, two million adults with mental health conditions cycle through U.S. correctional facilities; most of them have co-occurring substance use disorders.[28] In the juvenile justice system, youth with serious emotional disturbances are similarly overrepresented.[29]

Correction and detention facilities are, by definition, not designed to be therapeutic environments, which makes them ill-equipped to be providers of psychiatric services.[30] The concept of "jail diversion" emerged in the 1990s as a public policy strategy for turning this human tide away from America's houses of corrections. Early efforts were funded by the federal government, and later initiatives arose from both public and private sources. In all their many forms, the diversion efforts shared a common goal of redirecting individuals with mental health conditions who intersect with the justice system away from incarceration and into treatment.

Among the enduring initiatives, it was the sequential intercept model that the 21st Century Cures Act codified into federal law. The model establishes a framework for identifying individuals with mental illness at various "intercept points" within the justice system and re-routing them from there into treatment. The framework assumes that, at each stop in the justice system (arrest, court, incarceration, supervision after release from incarceration), proper screening and triage will produce more therapeutic and desirable results than further criminal justice involvement. Although the juvenile justice system works differently from the adult criminal justice system in key regards, it, too, contains intercept points at which children and adolescents can be diverted to treatment.

Breaking Through for Justice Diversion

Stepping Up asks communities to come together to develop an action plan that can be used to achieve measurable impact in local criminal justice systems of all sizes across the country.

Stepping Up

An initiative of the National Association of County Governments

There is a growing embrace of the sequential intercept model and other initiatives to reduce the number of people with mental illness behind bars. Nonetheless, individuals with serious mental illness who need treatment continue to be booked into jails and sent to prison. When needed care is not adequate there, their mental health often deteriorates further, and their already troubled prospects grow dimmer.

It is imperative that juvenile offenders and adult defendants with mental health conditions be offered treatment in appropriate therapeutic settings rather than be incarcerated, provided circumstances warrant and public safety is not compromised.

BOLD GOAL **100%** ***Diversion from arrest, detention or incarceration when individuals with mental illness intersect with the justice system and can be appropriately redirected***

Strategies relevant to reaching this objective are included in technical assessments #3 of this series, *Speaking different languages: Breaking through the differences in the perspectives of criminal justice and mental health stakeholders on competency to stand trial services, and #5: A comprehensive crisis system: Ending unnecessary emergency room admissions and jail bookings associated with mental illness*.[31,32]

6

Housing for individuals with serious mental illness

In major U.S. cities, homeless men and women with easily recognizable psychiatric symptoms are a common part of the urban landscape – readily spotted riding subway trains through the night, sleeping under highway overpasses, bathing in public library bathrooms and calling bus stations their homes. Overall, these individuals make up an estimated one-third of the total homeless population in the United States.[33]

Efforts to eradicate homelessness go back to the early decades of deinstitutionalization, when the phenomenon first emerged on a large scale.[34] Congress in 1987 passed the Stewart B. McKinney Homeless Assistance Act to coordinate "the federal response to homelessness and (create) a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation."[35] Since then, the Interagency Council on the Homeless mandated by the McKinney Act has repeatedly been "re-energized" or "re-vitalized," most recently with the Homelessness Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.

Breaking Through for Housing

Homelessness is a solvable problem that has lost its sense of urgency. Built for Zero is a rigorous national change effort designed to help a core group of committed U.S. communities end chronic and veteran homelessness.

Built for Zero

New York City-based social services nonprofit

Under the HEARTH Act, a federal strategic plan to prevent and end homelessness was prepared in the belief that "no one should experience homelessness – no one should be without a safe, stable place to call home."[36] In the seven years after the plan was implemented, overall homelessness as measured by the federal government's annual point-in-time count was reduced by 18%. This trend sharply reversed in 2016, when overall homelessness rose anew.[37]

In the same time period, the Veterans Administration dedicated resources to its Opening Doors strategy for eliminating homeless in the subpopulation of veterans. The results were even more dramatic than for the general homeless population – a 50% drop in veteran homelessness within seven years. The reductions have held steady even when non-veteran homelessness was rising. Today, some municipalities report that veteran homelessness has been eliminated completely.[38]

While homeless individuals with serious mental illness no doubt are among the beneficiaries of any initiative that reduces homelessness, like veterans, they have distinctive characteristics and challenges that will benefit from strategies tailored to them. Those strategies need to be developed and promulgated without delay, especially with general homelessness again on the rise.

BOLD GOAL **100%** ***Homeless people with serious mental illness permanently housed***

Strategies relevant to reaching this objective are included in technical assessment #6 of this series: *Going home: The role of state mental health authorities to prevent and end homelessness among individuals with serious mental illness*.[39]

7

Suicide prevention

Suicide is an uncontrolled public health crisis in the United States. In 2016, it was the 10th leading cause of death overall, killing nearly 45,000 people, about the same number of women who died from breast cancer or more than seven times the number of people killed by AIDS.[40,41] It was the number two cause of death among people ages 10 to 34 and the number one cause of death in jails. In the same year, more than one million additional Americans attempted to kill themselves.[42] As grim as the numbers are, they likely are under-reported due to the shame surrounding suicide and attempted suicide, the difficulty of determining intent in some cases and imperfect suicide data collection practices.

At significantly higher risk of suicide than the general population are people with serious mental illness. Suicidal thoughts and/or actions are estimated to be more than 25 times higher among individuals with mood disorders such as major depression or bipolar disorder than those in the general population.[43] Among people with schizophrenia, the lifetime risk of suicide is estimated to average 10%, at least 16 times risk in the rest of the population.[44]

Dedicated efforts to prevent suicide began with the U.S. Air Force in the 1990s and were expanded to the general public with the first National Strategy for Suicide Prevention from the Office of the Surgeon General in 2001. Other public and private initiatives followed.[45] In 2010, an ambitious "Zero Suicide" care model was introduced by a public/private advocacy group called the National Action Alliance for Suicide Prevention. Only two years later, evidence was indicating it was a "type of approach (that) has a tremendous potential for saving lives."[46]

Breaking Through for Suicide Prevention

We can develop effective strategies to prevent suicide and its devastating aftermath. Everyone has a role to play.

National Action Alliance for Suicide Prevention

A public-private partnership advancing a national strategy for suicide prevention

Nonetheless, the Centers for Disease Control reported in June 2016 that the rate of suicide increased in nearly every state from 1999 to 2016. Suicide rates increased "significantly" in 44 states, and 25 states experience increases of at least 30% Every age group was affected.[47] The 21st Century Cures Act authorized or reauthorized a number of suicide prevention programs but provided no funding to launch or sustain them. In health care settings, suicide prevention is not a focus.[48]

The field of suicidology is relatively young, and the suicide prevention toolbox is still in development. Nonetheless, evidence-based practices for preventing suicide have been identified and validated. With more than one million youth and adults attempting suicide each year, and nearly 45,000 completing suicide, embracing prevention techniques to get to a zero suicide rate is critical.

BOLD GOAL **100%** ***Suicides prevented***

Strategies relevant to reaching this objective are included in technical assessment #10 of this series: *Weaving a community safety net to prevent older adult suicide*.[49]

Conclusion

The seven breakthrough strategies in *Bolder Goals, Better Results* are audacious – some might even say impossible.

Yet the history of humankind's greatest breakthroughs is a history of impossible tasks being proven possible by getting done.

In the case of every goal established in *Bolder Goals, Better Results*, ground already has been broken. Effective strategies and evidence have been developed that show they have potential for reducing the personal, societal and economic toll of untreated and undertreated psychiatric disease. Achieving these goals will not fill every gap in the current mental health system nor assure that every mental health care need is met. Nonetheless, reaching just these seven would improve the lives of millions of people in America and those around them.

The United States has repeatedly set lofty goals for itself and met them, from curing a fatal disease like AIDS to putting men on the moon and thousands of achievements in between. Setting measurable objectives for improving mental illness outcomes and holding ourselves and our leaders accountable for meeting them can begin the process of making the impossible possible for the millions who live with some of the most disabling conditions of our day.

Appendix A

In 2017, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care* made recommendations to policymakers in 10 areas of identified need in mental illness treatment. These recommendations continue to represent timely and relevant strategies for supporting achievement of the bold goals outlined in this paper.

#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.

#2: Terminology — Direct relevant agencies to conduct a national initiative to standardize terminology for all levels of clinical care for mental illness, including inpatient and outpatient treatment in acute, transitional, rehabilitative and long-term settings operated by both the public and private sectors.

#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.

#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.

#5: Psychiatric Beds — Identify those policies and practices that operate as disincentives to providing acute inpatient and other beds or that act as obstacles to psychiatric patients' accessing existing beds (e.g., the institutions of mental disease exclusion) and require hospitals benefiting from taxpayer dollar investments to directly provide or ensure timely access to inpatient psychiatric beds.

#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.

#7: Linkages — Recognize that the mental health, community, justice and public service systems are inter- connected, 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.

#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.

Appendix A (CONTINUED)

#9: Workforce — Initiate assessments to identify, establish and implement public policies and public-private partnerships that will reduce structural obstacles to people's entering or staying in the mental health workforce, including peer support for adults and parent partners for youth and their families. These assessments should include but not be limited to educational and training opportunities, pay disparities and workplace safety issues. The assessments should be conducted for the workforce across all positions.

#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.

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66 Canal Center Plaza
Suite 302
Alexandria, Virginia 22314

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