Testimony

of

Richard G. Frank, PhD.

Assistant Secretary for Planning and Evaluation

and

Pamela S. Hyde, J.D.

Administrator, Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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"Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness"

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Chairman Murphy, Ranking Member DeGette and members of the Subcommittee, thank you for this opportunity to discuss how the Department of Health and Human Services (HHS) is supporting the needs of people with serious mental illnesses. We share your interest in improving care for this population, and others with mental illness, and look forward to continuing to work with you on this important issue.

As a Nation, we have come a long way in understanding the causes of serious mental illnesses and how to treat and support the people who experience them. Indeed, a snapshot of the mental health system in the 1950s would have shown a system that spent around 80 percent of its resources on warehousing people in institutions.[1] Modern day behavioral health care for those with the most serious illnesses offers new opportunities for rehabilitation and integration into society that would not have been conceivable half a century ago. For example, during the 1950s and 1960s about 27 percent of people with serious mental illnesses were institutionalized and today it is only about seven percent (including those that are incarcerated).[2] Moreover, for people with serious mental illnesses, rates of treatment have grown dramatically. For example between 1990 and 2003 the percentage of people with serious mental illness receiving care increased by about 67 percent.[3] Nonetheless, serious mental illnesses can be devastating for individuals and families and much work is needed to reduce the burden of these disorders. We continue to work to address homelessness associated with those with serious mental illness, people with mental illness housed in the criminal justice system, and other painful consequences of people going without treatment and services.

Overview

HHS delivers treatment and supports to people with serious mental illnesses through its major health and social service programs – programs that serve this population along with Americans impacted by a wide range of diseases and conditions – as well as through specialized programs that provide targeted services to people with serious mental illness. HHS also conducts research on the biological processes that lead to serious mental illnesses. Although most of the funding for services for people with serious mental illnesses comes through our Federal insurance programs, especially Medicaid, the Substance Abuse and Mental Health

[1] Frank RG, Glied SA. Better But Not Well: Mental Health Policy in the United States Since 1950. Baltimore: The Johns Hopkins University Press, 2006.
[2] Frank and Glied see note 1.
[3] Kessler RC et al, US Prevalence and Treatment of Mental Disorders 1990-2003; New England J Medicine 352 (24) 2515-2523, 2005.

Services Administration's (SAMHSA's) programs are critical in supporting the coordination of services for people with serious mental illnesses and improving the quality and accessibility of these services and supports. We agree with the U.S. Government Accountability Office (GAO) that coordination is essential for improving care and outcomes for people with serious mental illnesses, who have such complex health care and support needs. Thus, we work at many levels – inter-Departmental, inter-agency, and most importantly at the individual patient-level – to ensure the efficient and effective coordination of the programs and resources aimed at meeting those needs. Finally, we want to assure you of our commitment to program evaluation and accountability through performance measurement and that the Department and its agency components are working together to continuously improve our programs.

How We Care for People with Serious Mental Illnesses

Medicare, Medicaid, Supplemental Security Income, and Social Security Disability Insurance (SSDI) represent the largest sources of support for people with serious mental illnesses. With respect to mental health services, Medicaid and Medicare account for 40 percent of total spending on mental health care and a substantially larger portion of spending for people with serious mental disorders.[4] In fact, Medicaid is the single largest source of financing for mental health care in the United States including for people with serious mental illnesses (27 percent in 2009).[5] Federal funding for mental health services from all other sources accounts for five percent of total spending on mental health. The GAO report is focused on programs that make up this five percent of overall spending. While these programs, including the programs funded by SAMHSA, are important for development and implementation of evidence-based treatments, improving coordination of available resources and supports, broadening specialty care capacity and infrastructure, and collecting impact and general surveillance data, they make up a relatively small portion of HHS's overall spending on serious mental illnesses.

We expect millions of additional low-income adults with mental illness to gain coverage through the Medicaid expansion in the Affordable Care Act.[6] Recently,

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[4] Substance Abuse and Mental Health Services Administration. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Available on-line at http://store.samhsa.gov/product/National-Expenditures-for-Mental-Health-Services-and-Substance-Abuse-Treatment-1986-2009/SMA13-4740.

[5] *Id.*

[6] Garfield RL, Zuvekas SH, Lave JR, et al. The Impact of National Health Care Reform on Adults with Severe Mental Disorders. American Journal of Psychiatry. 2011; 168(5): 486-494.

experts have estimated that Medicaid coverage expansion will also increase coverage for people with serious mental illnesses.[7] There is encouraging evidence from a pre-Affordable-Care-Act Oregon Medicaid demonstration that randomly assigned eligible individuals to a modest size Medicaid expansion. The evaluation of that effort showed, among other improved outcomes, increased care for depression resulting in lower levels of symptoms of depression in the newly covered population.[8] Improving access to mental health treatment through broad-based health and human service programs is a critical step toward improving outcomes for people with serious mental illness, who often are disengaged and disenfranchised as a result of their illness.[9]

Also not addressed in the GAO report is the increasingly important role that private health insurance plays in serving people with mental disorders,[10] particularly after enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the coverage expansions and protections for people with preexisting conditions in the Affordable Care Act. The Affordable Care Act also significantly extends the reach of the MHPAEA's requirements. The Affordable Care Act requires all non-grandfathered small group and individual market plans to comply with Federal parity requirements. Qualified Health Plans offered through the Health Insurance Marketplace in every state must include coverage for mental and/or substance use disorders as one of the 10 categories of Essential Health Benefits, and that coverage must comply with the Federal parity requirements set forth in the MHPAEA. Emerging evidence, such as significant increases in health care coverage among young adults,[11] and dramatic upticks in utilization of inpatient care for mental health and substance use conditions in that population,[12] suggests that these reforms are improving access to mental health care. Similarly, recent findings from SAMHSA's National Survey on Drug Use and Health (NSDUH) show this expanded coverage has resulted in a significant rise in the percentage of

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[7] Mark TL, Weir LM, Malone K, et al. National Estimates of Behavioral Health Conditions and their Treatment Among Adults Newly Insured under the Affordable Care Act. *Psychiatric Services in Advance*, accessed on-line February 3, 2015.

[8] Baicker K, Taubman SL, Allen HL, et al. The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. *N Engl J Med.* 2013 May 2; 368(18): 1713-1722.

[9] *See, e.g.,* American Mental Health Counselors Association, Broken Promises; More Despair; How the Lack of State Participation in the Medicaid Expansion Will Punish Americans with Mental Illness. February 2014. Available online at http://www.amhca.org/assets/content/AMHCA_DashedHopes_Report_2_21_14_final.pdf.

[10] Mark TL, Weir LM, Malone K, et al. National Estimates of Behavioral Health Conditions and their Treatment Among Adults Newly Insured under the Affordable Care Act. Psychiatric Services in Advance, accessed on-line February 3, 2015.

[11] Martinez ME, Cohen RA. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-September, 2012. March 2013. Available online at http://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201303.pdf.

[12] Health Care Cost Institute, Issue Brief No. 8: Selected Health Care Trends for Young Adults (ages 19025): 2007-2012. September 2014. Available online at www.healthcostinstitute.org.

young adults receiving mental health services in the past year – from 10.9 percent in 2010 to 11.9 percent in 2012. The study also shows that people in this age group who were insured were nearly twice as likely to receive mental health treatment as those without health insurance (13.5 percent versus 6.7 percent).

Targeted Programs Are Vital

The inclusion of mental health care into broader healthcare programs does not diminish the importance of targeted programs that direct specialized resources and expertise towards addressing the needs of people with serious mental illnesses and help us learn more about what works for them. Our success depends on making investments in specialized infrastructure and continuing our efforts to develop specialized treatment and support interventions. SAMHSA is central to this effort. The vast majority of SAMHSA's mental health spending targets individuals with serious mental illnesses. In FY 2014, over three-quarters of funding appropriated to SAMHSA for mental health services supported adults with or at risk for serious mental illnesses and/or children with serious emotional disturbances. This includes major programs such as the Community Mental Health Services Block Grant; the Children's Mental Health Initiative; and the Primary and Behavioral Health Care Integration (PBHCI) program. In addition, SAMHSA's homeless services programs, the largest of which are required in authorizing legislation to serve only those with serious mental illnesses, are prioritizing Veterans and people that are chronically homeless because such a high proportion of them have serious substance use disorders and/or serious mental issues.

The National Institute of Mental Health (NIMH) is also focused on improving care for individuals with serious mental illnesses through significant research investments to strengthen the evidence base for program and service delivery. One important project at NIMH is the Recovery After an Initial Schizophrenia Episode (RAISE) study. This study is a randomized controlled trial of specialized, team-based care for first episode psychosis in over 400 individuals at 34 community treatment centers across the United States. This project seeks to fundamentally change the trajectory and prognosis of schizophrenia through coordinated and aggressive treatment in the earliest stages of illness. Improving access to comprehensive specialized care is critically important to lessening the impact of serious mental illness. However, we know that, currently, it often takes over a year after a person first experiences psychosis – before they receive treatment for that condition.[13] As discussed in more detail below SAMHSA has been closely coordinating with NIMH to incorporate evidence developed from the

[13] Addington J, Heinssen RK, Robinson DG, et al. Duration of Untreated Psychosis in Community Treatment Settings in the United States. Psychiatric Services in Advance. Accessed on-line February 3, 2015.

RAISE project into SAMHSA's technical assistance efforts. Moving beyond first episode psychosis to earlier stages of psychosis risk, NIMH also developed the Early Psychosis Prediction and Prevention program to support high-quality research aimed at preventing psychosis onset among persons at clinical high-risk. NIMH funded five grants in FY 2014 that will inform a step-wise approach to clinical high-risk care that can be implemented rapidly in the U.S. healthcare system.

Coordination

There has been a long-standing interest among government officials and other stakeholders in improving coordination of the array of services and supports needed by people with serious mental illness.[14] Coordination can and should occur on multiple levels within the government and through a variety of means. Coordination can be achieved through formal interagency mechanisms, through program-level collaboration, or around a particular consumer's needs. We believe that coordination is needed at all levels, and a focus on consumer-centered care is critically important if outcomes are to improve for this very vulnerable population.

Consumer-Centered Care Coordination

People do not lead their lives according to program boundaries, and we have learned that we cannot run programs as if they do. That is why we devote substantial resources to models, programs, and demonstrations that focus on coordinating services for individuals across programs and agency boundaries. SAMHSA leads a number of our most important initiatives to coordinate services at the level of the individual beneficiary.

SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program is a prime example of how HHS' programs coordinate care for individual consumers through multi-agency cooperation. To date, over 125 community behavioral health centers across the United States have received PBHCI grants to provide integrated behavioral health and primary care services for adults with serious mental illnesses. Four main activities are required of PBHCI grantees: screening and referral for health care, systematically tracking consumers' physical health status and care needs, care management, and prevention and wellness services. SAMHSA has worked with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at HHS on an evaluation of this program that found that the program increased access to primary care services, as well as improved health

[14] Frank RG, Glied SA. *Better But Not Well: Mental Health Policy in the United States Since 1950*. Baltimore: The Johns Hopkins University Press, 2006.

outcomes for individuals with serious mental illness with co-occurring diabetes, high cholesterol, and hypertension. As part of PBHCI, SAMHSA and the Health Resources and Services Administration (HRSA) co-fund the Center for Integrated Health Solutions (CIHS). CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions – especially those with serious mental illness, whether seen in behavioral-health or primary-care provider settings.

We also know that people with serious mental illnesses and their families often find themselves facing crisis situations in which the only available care is overworked emergency rooms often ill-equipped to address the needs of such individuals. That is why the President's FY 2016 Budget includes a new demonstration program in SAMHSA designed to help states and communities test the best way to structure, fund and deliver services to prevent, de-escalate and follow-up after behavioral health-related crises to assure the individual, family, community and delivery systems are adequately supported in such circumstances. The goal of this program is to test how best to reduce the need for inpatient care by providing earlier and more effective crisis services that bring multiple local, state and Federal funding sources together to adequately fund coordination of care across multiple settings and multiple community systems.

We also have a number of important care coordination initiatives focused on individuals with serious mental illnesses in HHS's broad-based programs. The health home option in Medicaid is focused on promoting care coordination for high-need individuals with an emphasis on people with serious mental illness. The health home benefit provides an enhanced Federal Medicaid match for care coordination, transitional care, linkages to community and social support services, and health information technology for individuals with multiple chronic conditions or a serious mental illness. Eligible providers include community mental health centers that are lynchpins of the public mental health care system. A number of states are targeting their health home benefits to individuals with serious mental illnesses, including New York, North Carolina, South Dakota, Vermont, Ohio and Missouri. In implementing the health home benefit, the Centers for Medicare & Medicaid Services (CMS) has collaborated closely with other agencies in the Department including SAMHSA and ASPE. For example, SAMHSA has helped review states' plans for health homes and provided consultation to states that focus this coordination benefit on individuals with mental illness or substance abuse. ASPE has been working with CMS to carry-out a five year evaluation of the health home option that will include detailed information on how states have implemented the benefit, as well as impacts on quality of care, inpatient and

emergency room utilization, and costs for the individuals receiving this enhanced coordination benefit.

Our coordination efforts are especially evident with regard to the Department's work to improve coordination of care for those eligible for both Medicare and Medicaid, the "dual eligibles." We know that a high percentage of dual-eligible beneficiaries have serious mental health conditions.[15] These beneficiaries are among the sickest and poorest people covered by either Medicare or Medicaid. Integrated care demonstrations to coordinate service delivery and financing of both Medicare and Medicaid through a Federal-state collaboration have been implemented in twelve states.[16] The Massachusetts demonstration, for example, focuses on nonelderly dually eligible beneficiaries, a subpopulation of dually eligible beneficiaries with a high prevalence of serious mental illnesses and other behavioral health conditions. The Massachusetts demonstration incorporates an array of benefits designed to support persons with serious mental illness, including assertive community treatment, community crisis stabilization, psychiatric day treatment, and emergency services.

There are a number of new initiatives within Medicare focused on improving care coordination and promoting Accountable Care Organizations (ACOs), including the Medicare Shared Savings Program and the Pioneer ACO Model. Providers in these ACOs can receive shared savings for improving quality, care coordination, and reducing costs or pay shared losses in some cases for failing to meet certain benchmarks on quality and cost. These ACOs are accountable for care to Medicare beneficiaries assigned to the ACO, including individuals with serious mental illness.

SAMHSA also continues to prioritize and implement major programs designed to meet the needs of people with serious mental illness who experience criminal justice involvement, homelessness, and poverty (*e.g.*, Behavioral Health Treatment Court Collaborative, Cooperative Agreements to Benefit Homeless Individuals, and Projects for Assistance in Transition from Homelessness). For example, to improve consumer-centered coordination on the ground, SAMHSA administers the Cooperative Agreements to Benefit Homeless Individuals Program. The major goal of this program is to ensure, through state and local planning and service delivery, that Veterans who experience homelessness, as well as other homeless

[15] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. January 2015. Available on-line at http://www.macpac.gov/publications; Frank RG, Epstein AM. Factors Associated with High Levels of Spending for Younger Dually Eligible Beneficiaries with Mental Disorders. *Health Affairs*. June 2014; 33(6): 1006-1013.
[16] CA, CO, IL, MA, MI, MN, NY, OH, SC, TX, VA, and WA.

individuals (which is a population with high levels of serious mental illness), receive access to sustainable permanent housing, treatment, recovery supports, Medicaid and other benefits. Other SAMHSA programs that focus on care coordination for individuals with serious mental illness include the Behavioral Health Treatment Court Collaborative and Projects for Assistance in Transition from Homelessness.

Recently, SAMHSA has been working closely with CMS and ASPE to improve the quality and coordination of care for people with serious mental illness through implementation of a new demonstration program for Certified Community Behavioral Health Clinics established by the Protecting Access to Medicare Act. This program will provide enhanced Medicaid reimbursement for care coordination and comprehensive services at treatment centers that typically serve mostly individuals with serious mental illness. Just last week, SAMHSA released for public comment the draft criteria for community behavioral health clinics to be certified by states under the Section 223 demonstration program.

Participating centers will be required to meet staffing requirements, a comprehensive scope of services, standards for availability and accessibility of services, including prompt evaluation and crisis management services, and extensive requirements for enhanced care coordination. In addition, treatment centers will be required to report on quality measures that will include measures of care coordination. These data will inform an evaluation of this program that will be conducted by ASPE in close collaboration with SAMHSA and CMS.

Intra-Departmental Coordination

Beyond our focus on making sure services are coordinated for people with serious mental illness at the point of service, we are also engaged in efforts to coordinate across agencies within HHS. While the GAO report does not focus on coordination at the program level, we believe this is vital. Collaboration and coordination among programs can be very effective at ensuring Federal efforts are not inconsistent or overlapping. This collaboration at the program level is critical for ensuring that our best understanding of how to improve care for individuals with serious mental illness is being shared and implemented.

Established in 2010 by HHS, the Behavioral Health Coordinating Council's (BHCC) chief goals are to share information and ensure that all behavioral health issues are being handled collaboratively and without duplication of effort across the department. The BHCC's Serious Mental Illness Subcommittee is co-chaired by SAMHSA's Administrator and NIMH's Director and is helping to facilitate cross-agency collaborations. Topics that are a current

focus of this subcommittee include: surveillance; early identification and intervention; engagement/outreach with consumers and their families such as psycho-education, peer and family support, shared decision-making, privacy and access to information issues; crisis response; provider capacity and training; and research priorities and opportunities for further collaboration across the Federal Government.

In addition to the cross-agency collaborations mentioned previously regarding PBHCI, Health Homes, and various other programs, SAMHSA has been closely coordinating with NIMH to incorporate information from the RAISE project into technical assistance for the states to use in implementing a new set-aside of Mental Health Block Grant funds for early intervention services. Recognizing the importance of engaging individuals with serious mental illnesses as early as possible in specialized services, the Congress recently required states to use five percent of the FY 2014 and FY 2015 Mental Health Block Grant funds they receive from SAMHSA to develop and support early intervention programs.[17] Multiple HHS agencies – including ASPE, SAMHSA, and NIMH – are working together to study how states are implementing the set-aside while also planning on a fuller evaluation of the impact of the set-aside in years to come.

Additionally, since 1989, SAMHSA has provided leadership by jointly funding, with the National Institute on Disability and Rehabilitation Research (NIDRR) of the Department of Education,[18] Research and Rehabilitation Training Centers that have conducted research on service delivery, employment, community living, health, and transition to adulthood for individuals with serious mental illness or serious emotional disturbance across their lifespan.

Inter-Departmental Coordination

At the interdepartmental level, there are also a number of coordinating bodies that focus on the needs of individuals with serious mental illness. Our approach to coordinating housing and services for the chronically homeless is an example of on the ground program coordination that is an outgrowth of Federal agencies reaching across program boundaries. The U.S. Interagency Council on Homelessness, co-chaired by Secretary Burwell along with Secretary Perez of the Department of Labor (DOL), has been invaluable in bringing together the resources and programs necessary to address the needs of individuals with chronic homelessness – the vast majority of whom have serious mental illness.

[17] Approximately $24.2 million in funds each year.

[18] With the signing of the Workforce Innovation and Opportunity Act of 2014, NIDRR became the National Institute on Disability, Independent Living, and Rehabilitation Research, and was moved to the Administration for Community Living in HHS.

We also engage in direct collaborative work with other Departments including collaborations with the Department of Housing and Urban Development and the Social Security Administration (SSA) on efforts to coordinate care and support of people with serious mental illnesses. For instance, HHS has been engaged in a workgroup led by the Office of Management and Budget (OMB) that includes representatives from DOL, the Department of Education (ED), and SSA to develop a demonstration project for intervening earlier and diverting individuals from reliance on SSDI. We are now working across these departments to plan this demonstration that will primarily focus on people in the early stages of a serious mental illness. The intervention is in its early stages of development but will combine evidence based clinical care with well tested work support approaches.

In addition, SAMHSA leads both the Federal Working Group on Suicide Prevention and the Federal Partners Committee on Women and Trauma. The Administrator of SAMHSA also represents the HHS Secretary as co-chair of the Interagency Task Force on Military and Veterans Mental Health that includes HHS, ED, the Departments of Defense (DoD) and Veterans Affairs (VA), OMB, and the White House to address these and other issues affecting service members, Veterans and their families. Further efforts that exemplify SAMHSA's interagency coordination include the National Suicide Prevention Lifeline which SAMHSA co-leads with the VA, and the SAMHSA-funded National Action for Suicide Prevention, co-led by the Under Secretary of Defense for Personnel and Readiness, at DoD.

For people with serious mental illness, employment contributes to stability and independence. Unfortunately, many people with serious mental illness are unemployed. In FY 2014, SAMHSA initiated a new program, Transforming Lives through Supported Employment, to promote the employment of people with serious mental illness, and this initiative includes collaboration with ED, DOL, and states, among others.

We know that part of the answer to keeping individuals and their families supported and gainfully participating in regular community life is coordination across systems of care. Across many Departments, we have made significant investments in coordination because we know that it is one of the critical engines driving our programs to success.

We believe that our current methods of program coordination are robust and effective; however, we continue to look for ways to improve that coordination. As such, we take seriously GAO's recommendation to develop a more formal

mechanism to further facilitate interagency coordination and thus enhance current coordination efforts.

Meaningful Program Evaluation is Key to Improving Services

GAO also challenges us to be rigorous about evaluation and performance measurement so we can monitor outcomes and progress. HHS is committed to evaluation of our programs, use of evaluation results in program design, and an on-going process to improve the reach and quality of our evaluation efforts. ASPE is engaged in reviews of our approaches to evaluation across the Department. Our programs that serve people with serious mental illnesses are the subject of rigorous and ongoing evaluation to measure their impacts.

SAMHSA's Center for Behavioral Health Statistics and Quality includes a Quality, Evaluation, and Performance Branch which conducts a variety of evaluations of SAMHSA programs. A cross-agency SAMHSA Evaluation Team helps determine which programs will be monitored through performance data and which programs will be evaluated more intensely through SAMHSA or external evaluation efforts. This branch also collaborates with ASPE, other HHS officials, and academic experts in planning, conducting, and reporting evaluation results to health professionals and the public. But SAMHSA's portfolio on evaluation work, like its investments in mental health system and service supports, is but one component of a multi-faceted evaluation approach.

Evaluations offer opportunities to coordinate across agencies regarding programs targeting individuals with serious mental illness. For example, ASPE has worked closely with SAMHSA for a number of years on an evaluation of the PBHCI program. In addition, ASPE is coordinating with CMS on an evaluation of the Medicaid health home benefit. Most recently, ASPE, SAMHSA, and CMS have been working together to develop the evaluation for the Certified Community Behavioral Health Clinic Demonstration. ASPE is also working with NIMH and SAMHSA to examine implementation of the set-aside of Mental Health Block Grant funds for early intervention services for individuals in the early stages of serious mental illness, including psychotic disorders.

ASPE, SAMHSA, and CMS are working together to look for opportunities to enhance the evaluation of HHS programs and also improve the availability of performance measures for monitoring the impact of our programs on people with serious mental illness

Key to the success of evaluation is having strong performance measures. SAMHSA, working with ASPE, has funded the development and testing of a

number of health care quality measures specific to people with serious mental illness. This work focuses on testing whether evidence-based care is being provided to persons with these conditions. Eleven of these measures have been submitted to and favorably reviewed by the National Quality Forum for measure endorsement as health plan quality measures. Such measures are part of SAMHSA's National Behavioral Health Quality Framework. NIMH and ASPE have also been co-leading an effort to develop a quality measure for evidence-based treatment for post-traumatic stress disorder. In addition, ASPE has been working with CMS to develop measures to include in the new reporting requirements in Medicare for inpatient psychiatric facilities – including a measure of whether individuals with serious mental illnesses coming out of these facilities are being adequately connected with services in the community.

In addition, NIMH, SAMHSA, VA, ASPE, and a number of mental health stakeholder groups have joined to fund the Institute of Medicine to chart a course forward on improving the quality of psychosocial interventions.

Lessons Learned

While we look for opportunities to continuously update and improve our programs, we have learned a lot about what works and what needs to be emphasized in supporting people with serious mental illness.

First and foremost, services must be coordinated on the ground so that they meet the often complex needs of people with serious mental illnesses. This is especially the case when the vast majority of services and supports for people with these conditions are delivered through general health and income support programs.

Second, coordination at high levels of Government is desirable and can help meet the needs of people at the point of service.

Third, coordination at the level of agencies that directly interact with people receiving publicly or privately funded services is vitally important.

Coordination at each of these levels is needed to best serve the needs of individuals with serious mental illness – and we are committed to achieving that goal.

Much progress has been made over the past half century and there have been many champions along the way. We look forward to partnering with the Congress to continue to improve care for individuals with the most serious mental illnesses.