

Making Health Care Better

Addressing Mental Health:

Progress in Research, Prevention, Coverage, Recovery and Quality

Health Care in America: Making Progress for People with Mental Health Conditions

President Obama finally made health care reform a reality for America. He also recognized that health and mental health are deeply intertwined. The reforms stemming from the Affordable Care Act (ACA), along with other efforts in health care and public health, are greatly improving health and mental health care across the nation, enabling Americans to get and stay healthy. Thanks to the ACA, 20 million Americans have gained health insurance coverage. For the first time ever, more than 9 in 10 Americans now have health insurance coverage.

Such change has made a meaningful impact on the lives of people across the nation. Americans can no longer be denied coverage because of pre-existing conditions, including mental health conditions; women cannot be charged more based solely because they are women; Americans with health coverage have access to recommended preventive screenings and services without cost-sharing, such as depression screening and behavioral assessments for children; and, there are no more annual dollar caps on the care patients receive.

This report highlights how the Affordable Care Act and other policy actions over the past eight years have expanded the resources and protections for people that are affected by mental disorders. While people with mental illnesses may also have substance use disorders and there is overlap in some of the systems and programs that serve them, this paper is focused on mental illnesses, also termed mental disorders. As a companion piece, the Department of Veterans Affairs has released a [summary](#) of the Administration's work to marshal efforts across government and partner with communities to ensure Servicemembers, Veterans, and their families get the mental health care they need and have earned.

Mental Illness Among Americans

Millions of American households are touched by mental illnesses. In 2014, nearly 1 in 5 – or roughly 43 million – American adults had a diagnosable mental health disorder over the past year, and nearly 10 million American adults experienced serious functional impairment due to a mental health disorder, such as a psychotic or serious mood or anxiety disorders.¹ Mental disorders can disrupt families and careers and even lead to death; suicide is the tenth leading cause of death in the United States, accounting for more than 41,000 deaths per year.

Untreated behavioral health conditions have serious effects on individuals' lives. People with mental disorders are more likely to be absent from work, lose jobs, experience the breakup of their families, and be unstably housed. Mental disorders also complicate the care of chronic health conditions. For example, co-occurring psychiatric conditions and chronic medical conditions are associated with significantly more expensive care due in large part to poor self-care and more acute episodes of needed health care.² Together, these circumstances serve to explain the fact that people with serious mental illness have an average life expectancy that is shorter than for similar people without these conditions.³

The nearly 10 million adults with serious mental illness face the most significant challenges in accessing and using quality care. They are among the heaviest users of public health and income support programs and of health services. Adults with serious mental illness are more than three times more likely than those without serious mental illness to be on Medicaid and significantly more likely to qualify for Medicare before age 65.^{4,5} In addition, they are highly likely to rely on Social Security Disability Insurance or Supplemental Security Income, are heavy emergency room users, and frequently have serious co-morbid health conditions.

The Consequences of Not Treating Mental Illness

Research studies have consistently found that it takes too long before most people receive treatment for behavioral health conditions, including the most serious conditions. For example, research has consistently found that, on average, it takes about three years from the time that a first episode of serious mental illness occurs and when people receive treatment for this condition.⁶ In the case of schizophrenia, this delay can worsen outcomes, whereas early comprehensive treatment can improve prognosis and is cost-effective.⁷ In 2014, among the 43.6 million adults with a mental illness, 55 percent did not receive mental health services in the past year and 31.5 percent of the 9.8 million adults with serious mental illness did not receive mental health services.⁸

Once people receive treatment, the quality of care they receive is often highly variable. High rates of co-morbid physical health conditions make improving care coordination for this population imperative. In addition, those with more serious mental health conditions often need non-clinical, supportive services to successfully engage in their communities and achieve their education and employment goals.

What's Changed for People with Mental Illness?

President Obama recognized the importance of making real, lasting changes to ensure that people with behavioral health conditions, including those with serious mental illness, have the services and supports they need. Since Barack Obama took office, there have been several key changes in access to and delivery of quality mental health services, including:

- New opportunities for coverage and quality of care under the ACA:
 - Expanded private insurance and Medicaid coverage, enabling people with behavioral health disorders to have the security of health coverage at affordable prices.
 - Delivery system reforms, including improvements in how hospitals, doctors, and other providers operate to deliver better care at lower cost.
 - New Medicaid initiatives that integrate behavioral health care and primary health care.
 - Improvements to the Medicare Part D program that make prescription drugs more affordable by reducing cost sharing while guaranteeing continued access to psychotropic medications.
 - Expanded preventive services and essential health benefits for children and adults.
- Improved approaches to quality behavioral health care.
- Regulations putting mental health and substance use disorder benefits on equal footing with medical and surgical benefits – mental health parity – in all types of private insurance and under the Medicaid and CHIP programs. Individuals will now be able to count on their mental health and substance use disorder coverage being comparable to their general medical and surgical coverage.
- Helping states and communities improve behavioral health care and put strong infrastructures in place.
- Improving prevention and early detection of mental illness.
- Making major strides and developments in bench science to help diagnose and treat mental illness and substance use disorders.

The Affordable Care Act and Mental Health

Access to quality, affordable health care is essential in the effort to improve mental health care in the U.S. The average cost of care for a person with a mental illness was estimated at \$1,849 per year in 2012.⁹ Those affected by mental illness should not have to choose between health care and other basic needs. That is why this Administration fought so hard for the ACA, which has helped 20 million uninsured Americans gain the security they deserve. Under the ACA:

- As many as 129 million Americans with pre-existing conditions, including mental health disorders, can no longer be denied coverage or charged more because of their health or family health history.
- Annual and lifetime dollar limits on coverage of essential health benefits, which could disrupt mental health treatments, are prohibited for most plans.
- Out-of-pocket costs for consumers enrolled in non-grandfathered coverage are limited, helping them to maintain financial stability even in the face of stigmatized illness like mental health disorders.
- Americans enrolled in non-grandfathered coverage have the right to appeal decisions made by their health plan to external review.
- Most health insurance plans are required to provide coverage for recommended preventive services without cost sharing. This includes services such as depression screening for adolescents and adults, alcohol misuse screening and behavioral counseling.

More Americans with insurance means more people are receiving mental health services and screenings. In 2014, almost half (44.7 percent) of the 43.6 million American adults (aged 18 and older) who experienced a mental illness in the past year received mental health care.¹⁰ The ACA created the largest expansions of mental health and substance use disorder coverage in a generation by requiring that most individual and small employer health insurance plans, including all plans offered through the Health Insurance Marketplace, cover mental health and substance use disorder services and expanding parity protections to this coverage, as well as covering rehabilitative and habilitative services that can help support people with behavioral health challenges.¹¹

Prior to the ACA, 47.5 million Americans lacked health insurance, and 25 percent of uninsured adults had a mental health condition, substance use disorder, or both.¹² Estimates indicate that the ACA expanded mental health and substance use disorder benefits and parity protections to

more than 60 million people.¹³ And, mental health can no longer be excluded from coverage as a pre-existing condition.

Further, the ACA increased mental health service utilization among young adults that obtained insurance coverage due to the ACA's requirement that young adults be able to remain on parent's plan until age 26, as expanded insurance coverage removes significant cost barriers to seeking treatment.¹⁴ The young adult policy has resulted in increased use of private insurance for behavioral health treatment, and it has lowered the odds of young adults with behavioral health conditions having to pay 75 percent or more of their medical expenses out of pocket by 54 percent.^{15 16}

The ACA enhanced coverage of preventive services. Most private health plans must now cover preventive services, like depression screening for adults and behavioral assessments for children, without charging a copayment, coinsurance, or deductible. This includes Women's Preventive Services guidelines that have provided more than 55 million women with guaranteed access to eight additional preventive services, including screening and counseling for interpersonal and domestic violence.¹⁷ In addition, states were offered incentives to offer preventive services to Medicaid beneficiaries. Today, about 137 million Americans have private insurance coverage of preventive services without cost sharing.¹⁸ Preventing mental and/or substance use disorders is critical to Americans' behavioral and physical health. When left undetected, behaviors and symptoms that signal the development of a behavioral disorder can often manifest into a more serious mental health

THANKS TO THE AFFORDABLE CARE ACT

The Affordable Care Act prohibits health insurance companies from denying or charging more for coverage because of an individual's health or family history. Here is one story that represents the countless people with a mental health disorder who gained coverage under the ACA.

"I spent the last 10 years fighting depression, virtually on my own. As a part-time waitress and college student, I couldn't afford health insurance to get the care I needed. Some days, I couldn't get out of bed. I had a sense of despair--but I'm so glad I don't have to feel that way anymore.

Having health coverage made seeking treatment for my depression easier. I was able to see a doctor who prescribed antidepressants, which cost me only \$4 a month. Now I'm moving forward. I can get up in the morning. I can walk the dog. I can go to work.

Because of the Affordable Care Act, depression screening for adults, and many other preventive services are covered by Marketplace insurance at no out-of-pocket cost. And I don't have to worry that my treatment for depression will prevent me from getting health insurance in the future. Thanks to the Affordable Care Act, insurers no longer can deny someone coverage because of a pre-existing medical condition.

Depression for me was despair, a black hole. With affordable, quality coverage, I can move forward."

Andrea Jahen
Austin, Texas

issue. In addition, people with a mental health illness are more likely to use alcohol or drugs than those not affected by a mental illness.¹⁴

In addition, Medicaid expansion is a significant benefit for individuals with mental health conditions. In the states that have expanded their Medicaid programs under the ACA, there has been a reduction in the unmet need for mental health and substance use disorder treatment among low-income adults.¹⁹

- The ACA created new Medicaid opportunities to improve services for people with mental illness. Notably, building on earlier investments in coordinating behavioral health care and primary care, the ACA authorized a new Medicaid state plan service, Health Homes, which allows states to provide comprehensive care management and coordination to individuals with two or more chronic conditions or serious mental illness. As of April 2016, 19 different health home programs with a focus on serious mental illness were active in 17 states and the District of Columbia.
- The ACA increased the options for states to provide home and community-based services through Medicaid, including for people with mental illnesses, by expanding the 1915(i) option to include individuals at higher incomes and to allow states to provide additional support services through this option. As of October 2015, 16 states and the District of Columbia had approved 1915(i) programs.
- Based on laws in place before the enactment of the ACA, Medicaid generally excludes coverage of services while a Medicaid beneficiary is an inpatient in Institutions for Mental Diseases (IMDs) that primarily serve people with mental illness (the “IMD exclusion”). In April 2016, HHS finalized rules expanding access to inpatient psychiatric care for Medicaid Managed Care Organization enrollees. The rule allows Medicaid managed care plans to support short-term stays in inpatient psychiatric IMDs of up to 15 days.

People with behavioral health needs make up nearly 30 percent of all low-income uninsured individuals in states that have not yet expanded Medicaid. Low-income adults with serious mental illness are significantly more likely to receive treatment if they have access to Medicaid coverage. If all states that have not yet expanded Medicaid did so, an estimated 371,000 fewer people each year would experience symptoms of depression, and 540,000 more people would report being in good or excellent health. States that choose to expand Medicaid may achieve significant improvement in their behavioral health programs without incurring new costs. State funds that currently support behavioral health care treatment for people who are uninsured but would gain coverage under expansion could become available for other behavioral health investments.²⁰

Improving Approaches to and Quality of Care

Mental health prevention and treatment can be complex, and its success is often dependent on the provision of quality, coordinated health care. The ACA includes numerous provisions designed to support healthy people and improve the overall health system.

The law promotes the adoption of new care models that improve care coordination, advance measurement of quality and star-rating systems that help patients choose high-performing providers, and that modify how care is paid for to promote the delivery of high-quality, efficient, and affordable behavioral health care.

The Administration has undertaken a number of other initiatives to improve the quality of care for individuals with mental health disorders:

- In 2014, President Obama signed into law legislation that provides funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the development of early psychosis treatment programs across the United States. The majority of individuals with serious mental illness, such as schizophrenia, bipolar disorder, and major depression experience the first signs of illness during adolescence or early adulthood, and there are often long delays between symptom onset and the receipt of evidence-based interventions – highlighting the importance of early identification and treatment.
- Since 2009, SAMHSA has funded more than 187 grantees through the Primary and Behavioral Health Care Integration (PBHCI) grant program. The purpose of the PBHCI program is to improve the physical health status of adults with serious mental illnesses by supporting communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings. At intake, individuals receiving PBHCI services had two times the rate at risk of having diabetes; three times the rate at risk of having high cholesterol; almost double the rate at risk of having hypertension; and triple the rate of smoking.
- The Comprehensive Primary Care (CPC) initiative launched by the Centers for Medicare and Medicaid Services (CMS) in 2012 to support primary care transformation through an enhanced payment model, data feedback, and a robust learning system. As of December 2014, 479 primary care practices with approximately 2,200 clinicians participate in CPC across seven regions, providing care for 2.7 million patients, including over 400,000 Medicare and Medicaid fee-for-service beneficiaries. Practice redesign in CPC centers on using team-based approaches to deliver comprehensive primary care. As part of their work, CPC practices commit to transforming their primary care workflows. Nearly 35 percent of practices selected behavioral health integration as a primary care management strategy to pursue in 2014. In addition to increased coordination and integration of

behavioral health services, CPC practices have also identified opportunities to broaden patient engagement in behavioral health by using shared decision making with their patients making choices in depression and anxiety treatment.²¹

Parity

The Obama Administration has taken action to implement the Mental Health Parity and Addiction Equity Act (MHPAEA), a major step forward in putting behavioral health care on equal footing with medical and surgical care. MHPAEA requires comparability between medical/surgical and behavioral health coverage. In addition, the ACA extended parity protections to individual health plans, and regulations implementing the ACA's "essential health benefits" requirements extended parity protection to the small group coverage.²²

Separate legislation extended parity protections to Medicaid managed care plans and CHIP and Alternative Benefit Plans (ABPs). The Administration recently implemented those provisions in a final rule adopted in 2016.

To further expand these efforts, earlier this year, the Department of Defense issued a proposed rule to apply the principles of mental health parity to TRICARE, the health benefits program from uniformed service members and their families.

Overall employer-sponsored large group plans have made meaningful improvements to their mental health and substance use disorder benefits. For example, the vast majority of these plans have eliminated higher cost sharing for inpatient and outpatient behavioral health care. There have also been significant declines in the use of day and visit limits for behavioral healthcare. This resulted in expanded access to care for adults and children with mental and addictive disorders.^{23,24,25,26,27,28}

To ensure that consumers and health care providers understand these parity protections and that health plans are appropriately comply with parity, , the President recently asked members of his Cabinet to establish a Task Force to promote compliance with parity best practices; support the development of tools and resources to support parity implementation; and develop additional agency guidance as needed to facilitate the implementation of parity.

Building Strong Communities and Supporting Recovery

Most people with mental health disorders can get better. Treatment and recovery are ongoing processes that happen over time. The first step is getting help. The adoption of recovery by

behavioral health systems in recent years has signaled a dramatic shift in the expectation for positive outcomes for individuals who experience mental and/or substance use conditions.

Recovery from mental disorders and/or substance use disorders is a process of change through which individuals: improve their health and wellness, live a self-directed life, and strive to achieve their full potential.

- In 2014, the President signed the Protecting Access to Medicare Act (PAMA), which included a bipartisan demonstration program to expand access to community-based mental health and substance use disorder services for Medicaid beneficiaries with a focus on adults with serious mental illness, children with serious emotional disturbance, and individuals with serious substance use disorders. States have planning grants for this Certified Community Behavioral Health Clinic demonstration, with the demonstration set to launch in 2017 in eight States.
 - The Administration's initiative to expand access to mental health care includes a Budget proposal to expand the PAMA demonstration to six additional States for a total of 14 pilot States.
- The ACA created new funding opportunities for Community Health Centers to build, expand, and operate health-care facilities in underserved communities. Throughout 2014 and 2015, HHS invested \$166 million to expand mental health capacity at health centers, which supports the establishment and expansion of services to more than one million people nationwide. As a result, health centers increasingly have opted to integrate mental health providers into their primary care operations, or have built strong relationships with other community mental health providers. In March 2016, HHS awarded an additional \$94 million to support 271 health centers in 45 states, the District of Columbia, and Puerto Rico to improve and expand the delivery of substance use disorder services in health centers, including medication-assisted treatment, with a specific focus on opioid use disorders.
- In 2014, SAMHSA established the Recovery Support Strategic Initiative to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence); increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in their chosen community.

SAMHSA offers a range of recovery services and supports that help people develop resiliency and recover from mental and/or substance use disorders, for example:

- *Recovery to Practice* helps behavioral health and general healthcare practitioners improve delivery of recovery-oriented services, supports, and treatment.
- *Partners for Recovery* offers technical support and information to those who deliver services to people with substance use and co-occurring mental health conditions.
- *Projects for Assistance in Transition from Homelessness* provides formula grants to the states and territories to support community-based outreach, linkages to mental health and substance abuse treatment, case management, and other support services to individuals who are experiencing homelessness, or at imminent risk of homelessness, and who have serious mental illnesses, with or without co-occurring substance use disorders.
- *Transforming Lives through Supported Employment* grant program enhances state and community capacity to provide and expand evidence-based, supported employment programs to adults with serious mental illnesses, including people with co-occurring mental and substance use disorders.

Improvements in Prevention and Changing the Conversation

We can all take steps towards reducing the stigma of mental health disorders by educating ourselves and the public on what mental health is, making access to mental health services available to everyone, and talking openly and candidly about mental health disorders. It is also important to understand risk factors and access preventive services that can help to detect these disorders early.

This Administration has invested in prevention and improving public understanding of risk factors and promoting healthy lifestyles. And, it has put laws like the ACA in place to ensure that evidence-based screenings and treatment are available and affordable.

This Administration continues to invest in prevention, early detection, and treatment as a public health priority:

- The ACA both expanded private insurance coverage for preventive services including behavioral health screenings and invested in community-based prevention initiatives through the Prevention and Public Health Fund which provides sustained national investments in prevention and public health to improve health outcomes and to enhance health care quality.²⁹
- The ACA also eliminates coinsurance and deductibles for Medicare beneficiaries for preventive services like depression screenings. An estimated 39 million people with Medicare

(including those enrolled in Medicare Advantage) took advantage of at least one preventive service with no cost sharing in 2015.

- The United States Department of Agriculture (USDA) investments increase access to mental health care in rural areas. The funding is used for construction, expansion, or equipping of rural mental health facilities. In 2013, USDA invested more than \$649 million in 130 rural health care facilities – serving nearly 3.2 million rural residents.³⁰
- Access to mental health services can be a particular challenge for veterans in rural areas. HHS is currently supporting a pilot program examining how to use telehealth, and health information exchange, to enhance the coordination of care for veterans in rural areas.
- The Administration has also doubled the size of the National Health Service Corps whose providers help reach communities that need them most and minimize patients' travel distances to seek care. Today, more than 3,000 mental health clinicians serve in the Corp and practice in designated areas of the country that need them the most, include psychiatrists, clinical psychologists, clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists.
- The President's Budget requests \$70 million in new funding in FY 2017 for the National Health Services Corps program to support an additional 1,200 behavioral health providers. This includes: (1) \$25 million as part of a new initiative to expand access to treatment to reduce prescription drug abuse and heroin use, with a focus on expanded use of medication-assisted treatment (MAT); (2) \$25 million as part of the Administration's initiative to expand access to mental health care; and (3) \$20 million to address the demand in high-need areas for mental and behavioral health providers.
- As part of the President's 2013 *Now is the Time* gun violence prevention strategy released after the Sandy Hook tragedy, the Administration proposed and Congress funded Project AWARE (Advancing Wellness and Resilience in Education). This project began in Fiscal Year 2014 with \$55 million. In FY 2016, Project AWARE is funded at \$65 million and raises awareness about mental health issues in schools and connects young people who have behavioral health issues and their families with needed services. Initiative components include Mental Health First Aid, which is a curriculum that prepares teachers and others to recognize and respond to signs of mental and/or substance use disorders in children. In FY 2015, the Mental Health First Aid program trained or served nearly 4.5 million individuals.³¹
- The President's Budget makes significant investments in suicide prevention. The Administration's \$500 million initiative to expand access to mental health care includes \$60 million over two years to support State suicide prevention demonstration projects focused on reducing key risk factors by increasing identification, referral, and treatment for suicidal behavior. The Budget also includes a new \$26 million Zero Suicide initiative in SAMHSA that will help identify those at risk for suicide and ensure they are served with evidence-based approaches and follow-up care.

- In March 2015, the First Lady launched the *Campaign to Change Direction*, a nationwide mental health public-awareness campaign promoting education and awareness of mental health issues. Since its launch, organizations have committed to teaching the “5 Signs” to 145 million people.
- *Joining Forces* is a comprehensive initiative, launched by the First Lady and Dr. Jill Biden, dedicated to ensuring that our service members, veterans, and their families can connect to resources that enhance their wellbeing. As part of the initiative, *Joining Forces* has coordinated efforts with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to combat post-traumatic stress (PTS) and Traumatic Brain Injury (TBI) through research and clinical trials. In addition, President Obama signed an Executive Order in 2012 directing HHS, the Department of Defense (DoD), and the Department of Veterans Affairs (VA) to collaborate and coordinate research and increase the number of mental health providers and counselors.
- Joining Forces and AAMC also produce Joining Forces Wellness Week, a week-long series of interactive trainings for clinical and non-clinical wellness professionals focused on specific health and wellness issues of veterans, service members, and their families.
- Older adults are vulnerable to mental health issues as well. Depression often co-occurs with other serious illnesses, such as heart disease, stroke, diabetes, cancer, and Parkinson's disease. Because many older adults face these illnesses as well as various social and economic difficulties, health care professionals may mistakenly conclude that depression is a normal consequence of these problems. To address the particular circumstances of older Americans, HHS invests in evidence-based treatment models like The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), which is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies, and Healthy IDEAS, which provides screening and assessment, education for clients and family caregivers, referral and linkages to appropriate health professionals, and behavioral activation.³² An estimated 30,000 older adults have participated in these programs.³³
- In 2013, there were 41,149 suicides in the United States—a rate of 12.6 per 100,000 is equivalent to 113 suicides each day or one every 13 minutes.³⁴ Suicide prevention is a serious public health concern in the United States, and SAMHSA supports three suicide prevention initiatives: the Garrett Lee Smith Youth Suicide Prevention grants fund state, tribal, and campus programs for individuals ages 10 to 24; the Suicide Prevention Resource Center (SPRC) advances the National Strategy for Suicide Prevention by providing technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide; and the National Suicide Prevention Lifeline helps provide free and confidential support to people in

suicidal crisis or emotional distress 24 hours a day, 7 days a week through local crisis centers by means of the national number, 1-800-273-TALK (8255).

- In 2012, the Surgeon General, in partnership with the National Action Alliance for Suicide Prevention, released a *National Strategy for Suicide Prevention*, to guide the nation's suicide prevention actions over the next decade.³⁵
- In 2014, in response to the Surgeon General's report, the National Institutes of Health (NIH) released *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*, to ensure that available resources target research with the greatest likelihood of reducing suicide morbidity and mortality.

Research

The Administration continues to invest in mental health research and prevention programs. The NIH's annual funding for mental health totals nearly \$2.4 billion per year.³⁶

The Administration's BRAIN initiative supports research to develop methods for measuring and understanding the structure and functions of the brain at levels never before achieved. Such detailed measurement is necessary to understand the individual patterns of brain activity and malfunction that are essential to the development of personalized interventions, and can offer promise for a range of illnesses, including mental health conditions.³⁷

Because of these investments, NIH research initiatives during the Obama Administration have produced exciting results such as:

- Researchers from the National Institute of Mental Health's (NIMH) Intramural Research Program (IRP), a part of the NIH, have shown that ketamine can rapidly lift depression in treatment-resistant patients, often within hours.³⁸ Further, Rapidly-Acting Treatments for Treatment-Resistant Depression (RAPID) is an NIMH-funded research project that promotes the development of speedier therapies for severe, treatment-resistant depression.³⁹
- NIMH launched the Research Domain Criteria (RDoC) initiative, a research framework designed to support studies that investigate particular neural systems and related behavioral functions (such as fear, memory, or executive function), recognizing that malfunctions in these systems vary considerably in pattern and severity across individuals both within and between disorders. The growing amount of research funded under this

program is intended to help understand individual differences among patients and thus lead to more tailored precision-medicine interventions and new approaches to prevention.

- NIH is building an Early Psychosis Intervention Network (EPINET) to create a learning health care system among early psychosis treatment clinics to address the issue that many people experiencing a first episode of psychosis face delays in seeking and obtaining care.⁴⁰
- Researchers in the NIMH IRP, in collaboration with multidisciplinary emergency staff at three pediatric hospitals across the United States, developed a risk of suicide screening tool for pediatric patients. The Ask Suicide Screening Questions (ASQ) is a brief, valid, screening instrument for assessing pediatric suicide risk, and is more accessible to non-mental health clinicians working in a variety of medical settings than the traditional 30-item suicide screening questionnaire. Early results indicate that this tool helps to identify patients' suicidality, which could have been missed because they were visiting the ER for a medical/surgical complaint.^{41,42}

In addition, the President's Precision Medicine Initiative was launched in 2015. Building on the \$200 million investment in 2016, the President's Fiscal Year 2017 budget proposed a \$100 million increase to develop a voluntary national research cohort of a million or more individuals to propel our understanding of health and disease and set the foundation for a new way of doing research through engaged participants and open, responsible data sharing.

These examples represent only a few of the many advances in research and prevention achieved during this Administration.

RAISE SUCCESS

The 2-year outcomes from the NIMH RAISE Early Treatment Program show that 223 recipients of NAVIGATE remained in treatment longer, experienced greater improvement in quality of life, and experienced greater involvement in work and school compared with 181 participants in community care.

"OnTrackNY builds on the successful RAISE initiative in New York State which showed that early intervention services helps young people who have just started to experience psychosis stay in school and work. We are excited to be able to enable more New Yorkers in need to access this innovative program."

Dr. Lisa Dixon, Director of the Center for Practice Innovation at the New York State Psychiatric Institute.

Our Work Continues

The work throughout the Obama Administration is a powerful testament to the Administration's commitment to preventing and treating mental illnesses. Yet, there is more work to do to continue to advance the goal of quality, affordable, and accessible health care and public health for all Americans. Together with patients, consumer advocates, researchers, and health care professionals, we will continue to invest in, and work for, better prevention, detection, and treatment for mental health disorders so that individuals affected by these conditions get the treatment they need, when they need it – allowing them to live healthy, productive lives.

Addressing Suicide

On average, someone dies by suicide every 12.3 minutes in the U.S. And for every one suicide, there are approximately 25 attempts. Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. Just as recently as 2014, suicide took the lives of nearly 43,000 Americans, with men more likely to take their own life at about 3.5 times the rate of women (77 percent of total). More people die by suicide than from automobile accidents.⁴³ And half of all suicides involve the use of a firearm.

The suicide rate has been rising over the past 15 years. From 1999 to 2014, the age-adjusted suicide rate for all ages in the United States increased 24 percent from 10.5 to 13.0 per 100,000 with much of the increase driven by suicides in mid-life (ages 35-64), the age range in which the majority of all suicides in the United States occurred in 2014. However, suicide was the second leading cause of death for young people ages 10-14, 15 to 24, and 25 to 34. The highest rates of suicides (suicides per 100,000) occurred among men aged 75 and up and among women aged 45 to 54.

Suicidal thoughts and attempts are also significant concerns. Having serious thoughts of suicide increases the risk of a person making an actual suicide attempt. There are more than 25 attempted suicides for each suicide death. A 2014 report on Suicidal Thoughts and Behaviors Among Adults from the 2014 National Survey on Drug Use and Health (NSDUH) report indicated that an estimated 9.4 million adults (3.9 percent) aged 18 or older had serious thoughts of suicide in the past year. The percentage was highest among people aged 18 to 25, followed by people aged 26 to 49, then by people aged 50 or older. Additionally, 1.1 million adults made a suicide attempt. According to the CDC's Youth Risk Behavior Survey in 2015, among high school students, in 2015, 17.7 percent (approximately 2.5 million ninth through twelfth graders) have seriously considered suicide, 14.6 percent have made a suicide plan, and 8.6 percent attempted suicide in the previous 12 months.

The most critical risk factors for suicide are prior suicide attempts, mood disorders (such as depression), alcohol and drug use, and access to lethal means. In 2013, among suicide decedents tested in 17 states (n=2,720, 38.2 percent), blood alcohol content was over the legal limit in more than 70 percent of cases.⁴⁴

The National Institute of Mental Health (NIMH) funded the [Emergency Department Safety Assessment and Follow-up Evaluation](#) (ED-SAFE) which aimed to increase suicide detection and prevention efforts among patients who present with suicide risk factors in hospital emergency departments (ED). Findings showed that universal screening for suicidal ideation among patients was beneficial in identifying individuals at high risk for suicide. A subsequent study is underway

to develop and test a suicide risk screening tool in adolescents admitted to EDs thought the [Emergency Department Screen for Teens at Risk for Suicide](#) (ED-STARs) study.^{45,46}

Recognizing that some families use EDs as their sole health care service, researchers from the NIMH Intramural Research Program developed a brief, four-question suicide prevention screening tool, the [Ask Suicide-Screening Questions](#) (ASQ), that takes emergency department nurses or physicians less than 2 minutes to administer. Based on results from the ASQ where it was utilized, 18.7 percent of the ED patients screened positive for suicide risk, most of whom had come to the ED with psychiatric concerns. Elevated suicide risk was detected in 4.1 percent of the ED patients with medical/surgical concerns. Absent the new screening tool, the suicide risk in these patients may have gone undetected.^{47,48}

Suicide touches all ages and backgrounds, all racial and ethnic groups, in all parts of the country. However, some populations are at higher risk for suicidal behavior. Suicide is a complex human behavior, with no single determining cause. The following groups have demonstrated a higher risk for suicide or suicide attempts than the general population:

- American Indians and Alaska Natives
- People bereaved by suicide
- People in justice and child welfare settings
- People who intentionally hurt themselves (non-suicidal self-injury)
- People who have previously attempted suicide
- People with medical conditions
- People with mental and/or substance use disorders
- People who are lesbian, gay, bisexual, or transgender
- Members of the military and veterans
- Men in midlife 35-64 and older men 75+

Below, we describe in greater detail suicide prevention efforts among American Indian and Alaska Natives, people who are lesbian, gay, bisexual, or transgender, national initiatives, and initiatives for our nation's veterans.

Preventing Suicide among American Indian and Alaska Native Populations

Despite the strengths of American Indian and Alaska Native (AI/AN) families and communities, suicide remains a devastating and all too frequent event. The suicide rate among American Indian/Alaska Native adolescents and young adults age 15-34 (19.5 per 100,000) is 1.5 times

higher than the national average for that age group (12.9 per 100,000).⁴⁹ Suicide was the second leading cause of death in American Indians/Alaska Natives age 10-35 – the highest suicide rate of any cultural or ethnic group in the United States – and the eighth leading cause of death among Native Americans of all ages in 2014.^{50,51}

In September 2015, building from the 2009-2015 demonstration project phase, the Indian Health Service (IHS) Division of Behavioral Health (DBH) announced the new Methamphetamine and Suicide Prevention Initiative (MSPI) five-year funding cycle to support Tribal, Tribal organization, Urban Indian Organizations (UIO), and IHS Federal facilities in their efforts to address methamphetamine, substance use, and suicide in Indian Country. Initial awards totaled more than \$13 million. In Fiscal Year (FY) 2016, IHS received additional funding to focus on building positive youth development and resiliency, promoting family engagement, and increasing the number of behavioral health providers who focus on American Indian/Alaska Native (AI/AN) youth. In April 2016, 10 additional projects were awarded, totaling more than \$14 million. The MSPI currently funds 129 innovative projects supporting the use and development of evidence-based and practice-based models: culturally appropriate prevention and treatment approaches to methamphetamine abuse and suicide in a community driven context. From 2009 to 2015, the MSPI pilot resulted in:

- Over 12,200 individuals entering treatment for methamphetamine abuse;
- More than 16,560 substance use and mental health disorder encounters via telehealth;
- Over 16,250 professionals and community members trained in suicide crisis response; and,
- More than 690,590 encounters with youth provided as part of prevention and positive youth development activities, and early intervention.

In fall 2016, IHS will announce 42 additional MSPI awards to Tribes, Tribal organizations, UIOs, and IHS Federal facilities, totaling more than \$7 million per year, and bringing the total number of MSPI program awards to 156. Awardees will focus on fostering resiliency and promoting family engagement among Native youth up to age 24. These awards will also help increase access to health services by increasing the number of behavioral health providers who specialize in working with children, adolescents, and families.⁵²

In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA), released, *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*, that helps address the problem of suicide and promote mental health among Native young people. The guide is organized to help readers understand the important and complex process of developing suicide prevention plans within a cultural context. The publication is for tribal leaders, elders, healers, youth activists, community organizers, school administrators, and others in the community. As one of SAMHSA's 10 Strategic Initiatives,

“Prevention of Substance Abuse and Mental Illness” encompasses more than a focus on those who may be at risk for suicide. In 2014, SAMHSA awarded grants to 20 tribes to prevent and reduce suicidal behavior and substance abuse, and promote mental health among American Indian and Alaska Native young people up to and including age 24. Prevention also includes programs to promote youth mental health, as well as actions that a community can take in response to a suicide, to help the community heal and to prevent related suicidal behaviors. Specifically, this guide explores cultural issues around prevention, describes approaches that respectfully address these issues as part of prevention planning, and provides practical tools and resources for assessment, program selection, coalition-building, and strategies used as part of a comprehensive plan.⁵³

Through its Native Connections program, in 2014 SAMHSA provided grants to the first 20 tribal communities to prevent and reduce suicidal behavior and substance abuse and promote mental health among American Indian/Alaska Native young people up to age 24. The agency will fund an additional 70 tribes and villages—a total of 90—to do this life-saving work in their own communities.

NIMH also supports suicide prevention research in special populations through an initiative guided by the U.S. chairmanship of the Arctic Council, [Reducing the Incidence of Suicide in Indigenous Groups](#) (RISING SUN). RISING SUN is an international collaborative effort designed to identify a toolkit of common outcomes and measures for Arctic indigenous peoples to evaluate suicide prevention efforts, and assess key correlates associated with suicide prevention across Arctic states.⁵⁴

Preventing Suicide among the Lesbian, Gay, Bisexual, and Transgender Communities

In April 2010, President Barack Obama asked the Secretary of Health and Human Services to identify steps the Department could take to improve the health and well-being of lesbian, gay, bisexual, and transgender (“LGBT”) individuals, families, and communities. LGBTQ health has become a fundamental part of the President’s initiatives to help improve access to health care and mental health services in the country.

In 2015, the CDC’s Youth Risk Behavior Surveillance System found that nationwide, 17.7 percent of all students; 14.8 percent of heterosexual students; 42.8 percent of gay, lesbian, or bisexual students; and 31.9 percent of not sure students had seriously considered attempting suicide during the 12 months before the survey. Also that nationwide, 8.6 percent of all students; 6.4 percent of heterosexual students; 29.4 percent of gay, lesbian, and bisexual students; and 13.7

percent of not sure students had attempted suicide one or more times during the 12 months before the survey.⁵⁵ As in the overall population, there is some evidence that the frequency of suicide attempts may decrease as LGB adolescents move into adulthood. LGB youth report rates of suicide attempts from 20 to 40 percent and lifetime prevalence suicide attempt rates ranging from 7 to 20 percent in adults.⁵⁶ Suicidal behaviors in LGBT populations appear to be related to minority stress, which stems from the cultural and social prejudice attached to minority sexual orientation and gender identity. This stress includes individual experiences of prejudice or discrimination, such as family rejection, harassment, bullying, violence, and victimization.

Collaboration between suicide prevention and LGBT organizations is needed to ensure the development of culturally appropriate suicide prevention programs, services, and materials, and to facilitate access to care for at-risk individuals. Another critical need is closing knowledge gaps through additional research and improved surveillance. Efforts are underway to expand the inclusion of sexual orientation and gender identity measures in federal mental health and mental health surveys.⁵⁷

Preventing Suicides Nationwide

Fortunately, there is strong evidence that a comprehensive public health approach is effective in reducing suicide rates. Released by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention in 2012, the National Strategy for Suicide Prevention is intended to guide suicide prevention actions in the United States over the next decade. The strategy provides guidance for schools, businesses, health systems, clinicians, and others, and emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide.

Each year, more than 20,000 Americans who die by suicide use a firearm. In January 2016, President Obama outlined a number of new, commonsense steps that his Administration is taking to protect our communities from gun violence. The President also has called for a new \$500 million investment to increase access to mental health care and has underscored the increased mental health coverage that the Affordable Care Act has made possible.

The Federal government provides funding and other resources to support suicide prevention and efforts to assist those contemplating suicide, including multiple efforts to raise awareness about mental health:

- In 2013, President Obama hosted the White House National Conference on Mental Health as part of the Administration's effort to initiate a national conversation to increase understanding and awareness about mental health. The White House hosted a day-long conference with individuals and families of those with mental health

conditions, health care experts, psychologists, faith leaders, advocates for veterans, and a host of administration officials to kick off a national conversation about mental health, including suicide prevention, in the United States.

- In addition, the Administration launched the website -- MentalHealth.gov -- aimed at providing resources for those suffering from mental illness.
- The White House Initiative on Asian Americans and Pacific Islanders and the White House Office of Public Engagement hosted a briefing on mental health issues and suicide prevention for the Asian American and Pacific Islander (AAPI) community. The briefing also highlighted AAPI-serving community mental health programs, suicide prevention initiatives such as the [National Suicide Prevention Lifeline](#) and the [National Strategy for Suicide Prevention](#) and government resources. Also featured was the [California Reducing Disparities Project Asian Pacific Islander report](#) “In Our Own Words,” which outlined effective strategies for reducing AAPI behavioral health disparities and provided specific program examples.⁵⁸ SAMHSA’s National Suicide Prevention Lifeline, a 24-hour toll-free, confidential hotline, has helped more than 6 million people since its inception in January 2005. People from anywhere in the United States can call 1-800-273-TALK (8255) to be routed to the closest crisis center within Lifeline’s network of more than 160 crisis centers. Users also have the option to text or live chat with a crisis counselor. Evaluations of the SAMHSA-funded network show that most callers report decreased feelings of distress and hopelessness and fewer thoughts about suicide as a result of their calls.
- Suicide Safe, SAMHSA’s suicide prevention app for mobile devices and optimized for tablets, helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients.
- Through a SAMHSA/Department of Veterans Affairs (VA) collaboration that began in 2007, more than 1,400 veterans, service members, and their families call the Lifeline number each day, press “1” at the prompt, and are connected to professional VA counselors. The “Veterans Crisis Line” includes the “Military Crisis Line” when promoted to active duty service members, National Guard members, and reservists, so that they and their families .
- SAMHSA launched Cooperative Agreements for the National Suicide Prevention Lifeline Crisis Center Follow-Up in 2008 to support crisis centers within SAMHSA’s Suicide Prevention Lifeline network in reconnecting with callers to offer emotional support and ensure that they follow up with treatment referrals. In 2013, the program expanded to include follow-up with people at risk for suicide who have been discharged from emergency rooms and inpatient hospital units. SAMHSA awarded grants to four states in 2014 to support their efforts to implement the 2012 National Strategy for Suicide

Prevention (NSSP) goals and objectives focused on preventing suicide and suicide attempts among working age adults 25 to 64 years old.

- SAMHSA also administers the Garrett Lee Smith State/Tribal Suicide Prevention Program. SAMHSA's largest suicide prevention grant program funded in part by the Prevention and Public Health Fund established by the Affordable Care Act, it is focused on reducing suicide and suicide attempts among youth ages 10 to 24. Since 2005, SAMHSA has awarded 196 of these grants: all 50 states, Guam, Washington, D.C., and 49 tribes have received at least one such grant.
 - Two recent analyses compared counties conducting activities through the Garrett Lee Smith (GLS) program to matched counties (without GLS funding) that were not implementing activities. Results showed that the GLS counties had significantly fewer youth suicides and suicide attempts. Furthermore, results suggest that approximately 427 deaths were avoided between 2007 and 2010 and that more than 79,000 attempts were avoided between 2008 and 2011 following GLS implementation.
- SAMHSA supports the National Action Alliance for Suicide Prevention, a public-private partnership with more than 200 participating organizations, which is advancing the National Strategy for Suicide Prevention. The Action Alliance has set a goal of saving 20,000 lives over the course of 5 years. To help meet this goal, SAMHSA is funding the Suicide Prevention Resource Center to act as Executive Secretariat, and is active on the Executive Committee and many Action Alliance task forces. For example, the Action Alliance's Faith. Hope. Life. campaign gives faith communities of every tradition, philosophy, sect, or denomination an opportunity to dedicate one Sabbath each year, preferably corresponding to World Suicide Prevention Day, to celebrate life, hope, and reasons to live.
- Another successful Action Alliance initiative is Zero Suicide, through which health and behavioral health care systems can commit to making suicide prevention a core priority within their systems, and implement processes and strategies that prevent suicide and significantly improve their care of patients at risk for suicide. As of June 30, 2016, 178 health and behavioral health care systems were implementing Zero Suicide.⁵⁹
- In 2015, NIMH, the National Institute of Health (NIH) Office of Behavioral and Social Sciences Research, and the National Institute of Justice (NIJ) announced a significant collaboration on a 4-year, \$6.8 million study called [Suicide Prevention for at-Risk Individuals in Transition](#) or "SPIRIT." The study will address a critical gap in evidence-based suicide prevention and focus on the high-risk individuals who are transitioning from jail to community. The study is NIMH's largest major investment in suicide prevention in the justice system.⁶⁰

- In June 2014, the SAMHSA Administrator and OPM Director co-wrote materials that were sent to every Federal employee intended to promote positive mental health in the workplace and to support employees who may be facing health or substance abuse challenges.
- CDC has supported cooperative agreements examining connectedness as a focus of suicide prevention programs. The projects included two different age groups: one focused on adolescents and young adults, the other focused on older adults aged 50 years and older.
- CDC also supported two cooperative agreements that focus on suicide prevention among middle-aged males. These projects will use innovative approaches to reach this population who are underserved regarding suicide prevention activities.
- CDC supports the National Violent Death Reporting System (NVDRS). NVDRS is the only state-based surveillance (reporting) system that pools data on violent deaths from multiple sources into a usable, anonymous database. These sources include state and local medical examiner, coroner, law enforcement, toxicology, and vital statistics records. The National Violent Death Reporting System (NVDRS) provides states and communities with a clearer understanding of violent deaths to guide local decisions about efforts to prevent violence and track progress over time. The NVDRS currently includes 42 states and has been used in partnership with the Department of Defense and Department of Veterans Affairs to examine suicide in those populations.
- Approximately 70 percent of HRSA-supported health centers provide mental health treatment or counseling services, and there were more than 7 million mental health visits made to health centers in FY 2015.⁶¹

Preventing Suicide Among Veterans

Marshalling efforts across government and partnering with communities to ensure Servicemembers, Veterans, and families get the mental health care they need and have earned.

Since day one of his Administration, the President has worked to ensure that the brave men and women who serve our country receive the care, services, and benefits they have earned and deserve. This includes caring not only for their physical health, but just as importantly, for their mental health. For Servicemembers, Veterans, and their families that experience mental health challenges, we must ensure that they are aware of and have the opportunity to utilize the resources and supports that are available to them. The Administration has made tremendous strides in this regard since the beginning of 2009, but more work is needed so that every Servicemember, Veteran, and family has the support they need.

Last fiscal year alone, the Department of Veterans Affairs (VA) provided mental health treatment to more than 1.6 million veterans, with VA completing – on average – more than 500,000 mental health appointments every month. In that same period, the Department of Defense (DoD) provided mental health treatment to more than 670,000 Servicemembers and their families, averaging approximately 700,000 completed visits with a provider every month at Military Treatment and civilian medical facilities. And in order to ensure that urgent services are offered in a timely fashion, VA has announced the goal of providing Veterans with same-day evaluations and access to mental health care by the end of calendar year.

Addressing mental health issues is not only about the number of people treated and how quickly they are treated, but about ensuring that individuals facing mental health challenges and their families know that help is available and treatment is possible. For that reason, DoD, VA, and the Department of Health and Human Services (HHS) are working together to:

1. Strengthen mental health and suicide prevention services;
2. Work with community partners to foster a better understanding of mental illness and build networks to support Servicemembers and veterans in the community; and
3. Improve public awareness of mental health.

In 2012, the President signed an Executive Order (EO) directing greater coordination between Federal agencies on this issue, including through the creation of the Interagency Task Force on Military and Veterans Mental Health (ITF) and a subsequent Cross-Agency Priority Goal setting out ambitious targets and milestones for this work. To further support these efforts, in August 2014, the President also announced a series of 19 Executive Actions to further our work on supporting the mental health of Servicemembers and Veterans. In February 2015, he signed into law the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, designed to further reduce the tragedy of Veteran suicide and improve access to mental health care. And thanks to the Affordable Care Act, we seen an historic expansion of health coverage that has helped more people get treatment for substance use and mental health conditions.

While important progress has been made, this work is not done. Moving forward, and building on the lessons learned at the February 2016 summit, “Preventing Veterans Suicide – A Call to Action,” the Administration will continue its work to ensure that Servicemembers and Veterans have access to the mental health care that they need and have earned. And we will continue to embed and institutionalize the arrangements among VA, DoD and HHS so that these agencies continue to work together to advance mental health policies and programs for the benefit of the brave men and women who serve our country.

Strengthening Mental Health and Suicide Prevention Services

The Administration continues to strengthen Federal mental health services and suicide prevention efforts for Servicemembers and Veterans by sharing resources and identifying new opportunities for early intervention.

- [The Veterans Crisis Line / Military Crisis Line](#) is a partnership in which responders are specially trained to help military Servicemembers and Veterans of all ages and circumstances. From its inception in 2007, the crisis line has received over 2.2 million calls and dispatched emergency responders to callers in crisis over 58,000 times. Since adding an anonymous online chat service in 2009, responders have engaged in more than 280,000 chats and after adding a text messaging service in November 2011, have responded to 51,000 texts. VA is also working to add capacity to the crisis line to keep up with demand, increasing staffing to 310 employees and adding new training for responders. As a result, the crisis line continues to have a strong record of success, demonstrating a 97 percent satisfaction rating from Veterans that call in.
- In response to the President's 2012 Executive Order, VA hired additional personnel to provide mental health care, bringing onboard approximately 5,300 new clinical and non-clinical mental health staff since 2012, as well as 932 peer specialists.

The "[Power of One](#)" is a VA-led public outreach campaign that conveys the power that one person, one conversation, or one small act can have towards preventing suicide. The recent "Power of One" television public service announcement ranked in the top 2 percent of PSAs nationally, achieving over 700 million media impressions.

- New connections are being made across DoD and VA to ensure more seamless support as individuals transition from military service to civilian life. For example:
 - Medical records are consistently shared across the DoD and VA health care systems through the Joint Legacy Viewer to ensure that health care providers have a seamless, comprehensive view of a patient's mental health history.
 - In response to an Executive Action announced by the President in 2014, transitioning Servicemembers are now automatically enrolled into DoD's *inTransition* program, which pairs behavioral health professionals with Servicemembers to provide a smooth and stable transition to VA or civilian behavioral health services.
 - Similarly, in response to the President's Executive Actions, VA's policy is now for mental health medications initiated by DoD authorized providers to be continued when a patient moves to the VA, ensuring that Veterans are able maintain their mental health medications when they transition.
- To reduce the risk of overdose and suicide, we are facilitating the return of medications that are no longer necessary. VA offers take back options to Veterans at all VA facilities and to-date over 30,4000 pounds of unwanted/unneeded medications have been returned and destroyed in an environmentally responsible manner. VA engages Veterans in these efforts through flyers at the facility level, as well as online resources which provide information on safe storage and medication safety in the home. In

addition, DoD has published a new policy requiring a drug take-back program across all Military Treatment Facilities and accompanying operational procedures, to make these programs more effective and ensure beneficiaries receive consistent service across DoD.

- On February 2, VA in cooperation with DoD and other stakeholders hosted a summit, “Preventing Veterans Suicide – A Call to Action,” to bring together Veterans, families, Federal agencies, community providers, subject matter experts, and other key partners to enhance suicide prevention efforts. The summit generated a series of 9 key initiatives and goals that will guide our efforts moving forward, focused on individually-tailored care, new access standards, research and partnerships designed to engage and serve all 22 million of our nation’s Veterans.

Working with Community Partners

Servicemembers, Veterans, and their families often seek care and support in their communities. That is why we continue to look for opportunities to partner with community entities to ensure all who touch the lives of Veterans and Servicemembers will be more effective in their efforts.

- We have created the [Community Provider Toolkit](#), a one-stop web-based repository of DoD, VA and HHS tools, which provides community organizations and clinicians with access to information and resources to support their work with Veterans.
- The understanding of military culture is essential to providing patient-centered care and services. That is why DoD and VA have developed [military cultural training](#) for health care professionals interested in improving their understanding of Servicemember and Veteran experiences. This is an online course offering free continuing education to health care providers in the community as well as to those in Federal agencies.
- VA’s Community Mental Health Summits began in 2013 in response to the President’s call to action at the White House’s National Conference on Mental Health, and are held annually at all VA medical centers in partnership with local community and military organizations. These summits have improved community partners’ understanding of VA services and willingness to work with VA to improve care for Veterans and their families.
 - As Peer Specialists increasingly play important roles on mental health care teams, DoD, VA and HHS have been working together to determine best practices for developing the skills of peers, peer services, and their role in supporting prevention, treatment and recovery. Peers have a common understanding of the experience of Servicemembers and Veterans and have been recruited to implement programs that reach Servicemembers and Veterans who may otherwise not seek treatment.
- Building on a requirement in the Clay Hunt SAV Act, the VA is standing up a pilot program to use community outreach and peer support to engage Veterans in care.

Improving Public Awareness of Mental Health

We continue our shared efforts to improve our understanding of mental health and interventions that work.

- The [National Research Action Plan](#) (NRAP) fosters interagency collaboration on research related to the diagnosis, prevention, and treatment of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), and to improve suicide prevention efforts.
- In addition to coordinating interagency research goals, DoD, VA, and HHS are working to implement common clinical and treatment outcome measures in order to deliver services which are measurement-based.
- Negative attitudes, stereotypes, and prejudice against those with mental health conditions are barriers to care for those who may need help. Robust outreach to combat the negative perceptions associated with mental health services is essential for raising awareness and educating Servicemembers, Veterans, and their families about mental health and the resources that are available to them. VA's [Make the Connection](#), DoD's [Real Warriors campaign](#), and the HHS/Substance Abuse and Mental Health Services Administration (SAMHSA) [Recovery Month campaign](#) are all examples of initiatives intended to address prejudice and discrimination against those with a mental disorder.
- VA is working to create a pilot program, in response to the Clay Hunt SAV Act, to repay education loans for medical training in psychiatry for individuals who serve in the VA and provide psychiatric care for Veterans.

Resources and Assistance Available

Servicemembers, Veterans, and families that are struggling with mental health issues, as well as community partners seeking to help, can look to the following resources to get care and assistance or reach out to their local DoD or VA health care facility:

Veterans Crisis Line / Military Crisis Line

<https://www.veteranscrisisline.net/>

1-800-273-8255

Text 838255

Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org/>

1-800-273-8255

Military Cultural Competence for Health Care Professionals

<http://deploymentpsych.org/military-culture>

Make the Connection

<http://maketheconnection.net/>

Real Warriors

<http://www.realwarriors.net/>

Recovery Month

www.recoverymonth.gov

VA MedSafe

<http://www.pbm.va.gov/PBM/vacenterformedicationsafety/vacenterformedicationsafetyprescriptionsafety.asp>

Community Provider Toolkit Interagency Page

<http://www.mentalhealth.va.gov/communityproviders/itf.asp>

Military OneSource

<http://www.militaryonesource.mil/>

1-800-342-9647

Our Work Continues

The Obama Administration is deeply committed to helping people contemplating or at risk of suicide get the help they need. Yet, work remains to bring the number of deaths by suicide to zero. Together with communities, individuals with mental health conditions, their families, health care professionals, and researchers, the Federal government will continue its efforts to prevent suicide – to help countless individuals live the healthy, productive lives they deserve.

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