Appendix I

WHAT YOU CAN DO

Now that you have read *A Common Struggle*, you might be wondering what you can do to improve care and coverage for mental illness and addiction, and end discrimination. I've been hearing this question for decades as a politician, and even longer as someone struggling with the illnesses and the stigma. We sometimes get too caught up in what we are hoping will happen in the future, with new discoveries, and forget just how many options and opportunities are available to us *right now*. So let's focus first on what you and I can do immediately, together.

First, don't be alone with your illness and your struggle. And don't be afraid to demand the best diagnosis, the best care, the best coverage, and the best way of staying current with the medicine and treatment. The illnesses are challenging enough, even when you do have all the information, caregivers you trust, and coverage that is equal to that for all other illnesses. You have to take the best possible care of yourself—or the person you are caring for—in order to be strong enough to advocate. If you or those close to you don't feel they understand the illnesses and treatments well enough, good basic resources include *Understanding Mental Disorders*, the consumer version of the *Diagnostic and Statistical Manual* used by all caregivers, the "Mental Health First Aid" training (www.mentalhealth-firstaid.org) offered nationwide by the National Council on Behavioral Health as well as the in-depth

information on the websites from NAMI (https://www.nami.org/Find-Support), Mental Health America (which offers a help guide and very good basic online screening tools at http://www.mentalhealthamerica.net/mental-health-screening-tools), the National Council on Alcoholism and Drug Dependence (which offers an excellent guide on balancing medication-assisted treatment with abstinence and twelve-step peer support at https://ncadd.org/images/stories/PDF/Consumer-Guide-Medication-Assisted-Recovery.pdf) and the American Foundation for Suicide Prevention (http://afsp.org/find-support/). To make sure your treatment wishes are understood if your symptoms worsen, make an "advance directive" for your care choices with the help of the National Resource Center on Psychiatric Advance Directives (www.nrc-pad.org). If you and your caregiver feel your treatment is not being adequately covered by your insurance, explore your rights at ParityTrack.org, our online, state-by-state parity implementation watchdog, which we've created in partnership with the Thomas Scattergood Behavioral Health Foundation. There you can find our Parity Resource Guide (https://www.paritytrack.org/get-support/parity-resource-guide) and even register a complaint about denial of coverage at (www.parityquest.org). For a medical emergency with a mental illness or substance use disorder, dial 911 immediately; if it's an opiate overdose situation make sure you request naloxone. If you are having suicidal thoughts, call the National Suicide Hotline (800-273-8255).

Second, it is time to become educated about the political issues surrounding your illness, so you can vote and advocate effectively. The issues go far beyond just more funding for research for your individual disease—we also need to focus more strongly on larger goals that will help treat and cure all brain diseases. This is a big part of the reason why I wrote *A Common Struggle*—and created two nonprofits that are broadly inclusive of all mental illnesses and addictions (in the case of the Kennedy Forum www.thekennedyforum.org) and all brain diseases (in the case of One Mind www.onemind.org). I'm trying to provide and encourage leadership to bring together groups that sometimes compete for research dollars and public awareness in their own national and state lobbying. I'm also trying to help level some of the advocacy playing fields because, for a variety of reasons, the ad-

vocacy for some illnesses is heard above others—even if many more Americans suffer from illnesses with fewer or quieter advocates—and in some cases the advocacy for certain treatment approaches to illnesses are heard above others. For example, because of the historic anonymity in twelve-step recovery, there has not been as much public leadership for alcoholism and addiction advocacy as there has been for other mental illnesses. There is still an artificial divide in substance use disorders between those using medication-assisted treatment and some form of cognitive behavioral therapy (CBT) to detox and remain sober and those relying primarily on abstinence and twelve-step peer support—even though we know that the gold standard of treatment requires access to all of these together, based on your needs and symptoms at any given time. And with all these treatments, there are shortages of caregivers all around the country, as well as shortages of available appointments for in-network care. That is why we are working to create stronger advocacy on behalf of **all mental health**—including all mental illnesses and addictions, and all evidence-based treatments.

What I am trying to do is bring together as many stakeholders as possible—and their best ideas—to create an omnibus **National Behavioral Health Platform** which can offer an integrated and nonpartisan political agenda for the future of mental illness and substance use disorder care that is "secular" of guilds, political frictions and silos. It is also a platform that attempts to learn from the setbacks of the past, and takes advantage of the newest understandings of how to legally attack discrimination using state and federal parity acts, the protections inherent in the Affordable Care Act, and other laws in novel ways. It can help us get beyond assessing elected officials only on whether or not they voted for research funding for the exact illness we or our family members struggle with, and will help everyone see the big picture.

Starting on page 387, you can read through the entire National Behavioral Health Platform, which has been put together by the Kennedy Forum and the Scattergood Foundation—with input from many stakeholders—for use through the 2016 election and beyond, and will be periodically updated.

But, if you want to know what you should be demanding first—of your candidates and elected officials—**here is the lowest hanging fruit**:

1. **Every medical examination must include a mental illness and substance use disorder evaluation—one that is automatically connected, when indicated, to an aggressive plan of early diagnosis and intervention.** At every age, we need to be getting a simple "checkup from the neck up" every time we see a healthcare provider, starting with the depression screen that, though it is now fully covered under the Affordable Care Act, many doctors still aren't using. If you have any history of mental illness or addiction and your primary care physician isn't asking you, at each visit, the status of your illnesses, talk to them about it. To ensure our clinical workforce is better prepared to deliver these screenings, all healthcare providers should be required to take additional Continuing Medical Education classes on current brain health issues to keep their licenses to practice; similar continuing education is needed for attorneys, judges, and law enforcement officials. Further, the Centers for Medicare & Medicaid Services (CMS) and all private insurers should not only encourage these screenings through reimbursement but require that providers consistently use standardized outcomes measures to track patient progress. (Thanks to the Mood Disorders Association of Ontario, which coined "checkup from the neck up" and allows me to use it.)
2. **The Centers for Disease Control and Prevention (CDC) should establish a broad mental health surveillance system** so that we have accurate, regularly updated information and statistics on all aspects of the epidemics of mental illness and substance use disorder, including prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses CDC already covers. The work that CDC already does on incidence of suicide and some other discreet areas of mental health and addiction, the National Survey on Drug Use and Health done by SAMHSA, and other smaller efforts are simply not sufficient for public officials, or the public, to understand and track the burdens of these diseases. Parity is about more than insurance; we also need parity in epidemiology.
3. **In order for research on brain diseases to catch up with basic science and medical research on the rest of the body, we call for a one-time five-year tripling of the budgets for the National Institutes of Health that**

cover the brain: NIMH, NIDA, NIAAA, and NINDS. Right now all the brain institutes combined receive less than 15 percent of the NIH's budget. This boost in funding should be used to integrate the institutes within a clinical research network that will study the brain and brain illnesses, develop new treatments, and conduct research on the dissemination of evidence-based therapies. The current segregation of the institutes into four separate bodies inhibits the ability of research at one institute from benefitting from findings produced at another. To make sure this extra funding is used to break down artificial barriers and silos between these medical areas, we propose an umbrella entity, the National Institutes of Brain and Behavior Disease, to coordinate the use of these extra funds, and the budget of SAMHSA. But this five-year period should also be used to slowly and logically phase out SAMHSA, because much of what it now accomplishes with grants—as part of an outdated "carve-out" way of approaching mental illness and substance use disorder—must be incorporated into a more structural approach to coverage that includes mental health along with all other health. Any areas in brain health requiring specialized grants and programs should be integrated into the appropriate section of HHS, including HRSA, AHRQ, CMS, and CDC.

4. **We must take immediate steps to dramatically increase our capacity for mental health and addiction care, which means aggressive action to increase the number of inpatient beds and coordinated outpatient stepdown services in this country, as well as incentivizing the training of more MDs, PhDs, MSWs, psychiatric nurses, and certified peers.** We support revising or further reinterpreting the IMD exclusion—a law from the 1960s meant to prevent dilapidated facilities from refilling their beds when Medicare/Medicaid was passed that has instead become the single largest impediment to quality inpatient mental health care, by preventing many facilities from getting Medicaid reimbursement for patients between the ages of twenty-two and sixty-four. While CMS recently changed the rule slightly, it still dramatically limits the number of inpatient beds available to anybody. Congress must also eliminate the arbitrary 190-day lifetime limit on inpatient psychiatric hospital care in Medicare—a

restriction that does not exist for any other inpatient Medicare service. To increase the number of caregivers, we must provide additional funding to the National Health Service Corps and create training grants for fellowships for mental health and addiction continuing education programs. These programs incentivize providers to enter into and stay in behavioral health care. We must also support the development of the Behavioral Health Minimum Data Set, a project sponsored by SAMHSA and HRSA, that tracks and studies the national mental health and addiction workforce.

5. **We must make an impact on the nation's rising suicide rate.** We support the important work of the JED Foundation in schools, the American Foundation for Suicide Prevention, the National Action Alliance for Suicide Prevention, and the Suicide Prevention Resource Center. The last two groups have also developed a unique effort called **Zero Suicide** (http://zerosuicide.sprc.org) that brings the most modern tools and ideas to a special at-risk group: patients in hospital settings, whose suicides are considered the most clearly preventable of all. Zero Suicide began as an aspirational concept in the Air Force in the 1990s and was later used as an experimental benchmark in the Perfect Depression Care Initiative of the Henry Ford Health System. This new Zero Suicide for healthcare initiative employs a unique systems approach involving everyone who interacts with patients, and not just their clinicians, and a tool kit that allows much closer study of the processes leading to suicide attempts than previously possible. But it is time to make "zero suicide" our national standard of care, by accepting that most suicides represent a tragic course of illness for a brain disease and the only real way to prevent them is to improve brain health screening, diagnosis, and treatment. We need to better integrate means reduction, traditional hotlines and online media tools, and work to reduce the stigma associated with being open about suicidal ideation, suicide attempts, and completed suicides.
6. **Records for mental health and substance use disorder treatment must be integrated into electronic health-record systems so providers have the information needed to treat the whole person—while still protecting patient privacy.** HHS must finalize the update of federal regulation

"42 CFR part 2" so substance use disorder information can be incorporated into health records. Congress must amend the HITECH Act and CMS must update its final rule so that mental health professionals and facilities are eligible for financial incentives and reimbursement associated with electronic health records.

7. **Every county in the country should be implementing a system of diverting individuals with serious mental illnesses or co-occurring substance use disorders into community-based treatment and support services instead of putting them in jail.** The groundbreaking Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) from Miami-Dade has been an incubator for programs, large and small, that can be emulated by counties nationwide. And for those already incarcerated with mental illnesses, states should adopt a version of the Mentally Ill Offender Community Transition Program in Washington State, a collaboration between the Department of Corrections and the Department of Mental Health that made a large impact on recidivism rates.
8. **We need to stop talking about "collaborative care" that is "outcomes driven" and actually start providing it.** There are programs around the country that are already doing this right, and can be replicated in every primary care setting. One is the Mental Health Integration Program (MHIP) in the state of Washington, sponsored by the Community Health Plan of Washington, and Seattle and King County Public Health. It provides excellent collaborative care for all mental illnesses and substance use disorders by bringing together primary care and community mental health centers; and it uses a unique payment system tied to quality improvement metrics, and a patient registry that tracks and measures patient goals and clinical outcomes, facilitating treatment adjustments if patients aren't improving. Another program is the chronic condition Healthcare Home initiative run by Missouri Healthnet, the state's Medicaid authority, for Medicaid recipients with severe mental illness. It combines many of the latest ideas about diverting "high utilizers" from emergency room care into more long-term coordinated care, but is among the first in the country to include a focus on high utilizers whose primary medical problem is

severe mental illness. Their cases are overseen by what are called "health homes" that combine aspects of primary care and community mental health, with cases actively overseen by nurse liaisons and case managers. For integration of care in emergency rooms and across socio-economic groups, an excellent model is the work done at Grady Health System in Atlanta with the Morehouse School of Medicine's Satcher Health Leadership Institute and the Georgia Department of Behavioral Health and Developmental Disabilities.

9. **Mental wellness programs should be required in all public and private schools.** Programs for social and emotional learning (SEL), executive function training, neurofeedback, mindfulness, and brain literacy help young people improve their traditional educations, but also allow development of better processing skills, promote emotional resilience, and help mitigate stress. They can also attack some of the underlying environmental triggers of mental illness—and the systems created by the interventions often help schools and parents identify at-risk students. These programs are easy to integrate into school curricula and don't take a lot of time every day. For SEL, we recommend the Responsive Classroom from the Center for Responsive Schools in northern Massachusetts (as does the Collaborative for Academic, Social, and Emotional Learning in Chicago, which has been evaluating these interventions for over twenty years); for executive function training, the ACTIVATE program from Yale's Dr. Bruce Wexler and C8 Sciences, which improves brain fitness with twenty-to-thirty-minute interactive game-like sessions several times a week, and also has healthcare applications for students with attention and autism spectrum disorders. One of the best combined interventions is Mind UP, developed with educators and neuroscientists by The Hawn Foundation.
10. **All American employers should reconsider their health insurance and employee assistance programs (EAPs) to see how they can improve diagnosis and treatment of mental illnesses and substance use disorders among their employees and executives—not only because it is the right thing to do and it is the law but because it is the single best way to save money on medical spending, absenteeism and presenteeism,**

and recruitment. It is crucial that companies and large organizations prioritize overall program quality over initial costs in improving their EAPs, which need to establish and maintain close contact with health insurance plans and available community resources, by following models like the Tufts Employee Assistance Program (http://hr.tufts.edu/benefits/employee-assistance-program). Since employees are often reluctant to seek help because of stigma, employers should implement evidence-based internal stigma-reduction programs, such as those featured in the Working Minds Project of the Mental Health Commission of Canada (http://www.mentalhealthcommission.ca/English/initiatives/11893/working-mind).

11. **We must respond to the epidemic of opioid addiction in a way that broadens diagnosis and treatment for all substance use disorders, and guarantee that insurers provide full coverage for these diseases. This must include a comprehensive range of evidence-based treatments such as residential care, intensive outpatient programs, cognitive behavioral therapy, and medication assisted treatment (MAT)—buprenorphine, methadone, and naltrexone.** Congress must amend the Drug Addiction Treatment Act of 2000 so that there is no longer any arbitrary limit to the number of patients to whom a specialty-trained physician can prescribe buprenorphine. State lawmakers should pass legislation that requires all pharmacies to carry naloxone, a life-saving drug that immediately reverses the effects of an opioid overdose. To address prevention, all physicians, nurse practitioners and physician assistants that prescribe opioid medications should follow the CDC Guideline for Prescribing Opioids for Chronic Pain.
12. **It is time for the Department of Health and Human Services, the Department of Labor, and state regulatory agencies to end the managed care secrecy that allows all American medical insurers (including the federal government) to discriminate against those with mental illness and addictions.** These departments must use the legal power they *already have* to demand detailed disclosures of how insurers make their decisions to approve or deny coverage for all medical, surgical, and mental health care. The departments have issued guidance about

disclosure, but it is still not sufficient. Making this information transparent is the only way to assure that the standards used for decisions on medical/surgical cases and mental health cases can be properly compared. The law has required this disclosure since the parity act was passed in 2008 and insurers still haven't complied (although some state agencies have begun to audit and fine health plans not in compliance). And we're not singling out the private insurance companies. We also call on the major public insurers—the Centers for Medicare and Medicaid Services (CMS) and its various entities, as well as the Office of Personnel Management (OPM), which oversees medical benefits for federal employees, the Departments of Defense (DOD) and Veterans Affairs (VA), the Indian Health Service (IHS) and others—to disclose the same criteria and protocols for their coverage decisions. This could be done in the form of blinded real-life scenarios and court decisions that can be used to guide decisions and clarify what violates the law, the way that the Internal Revenue Service often explains the ramifications of new tax regulations. Once these criteria and protocols have been shared, it would be essential for DOL and HHS to begin detailed random audits of health plans to determine compliance. We also call on the Department of Justice (and state Attorneys General) to get involved in enforcing such disclosures and transparency, since their investigations and consent decrees now often take the place of traditional regulation.

In the meantime, here is what you can do to immediately help the parity cause. Go to www.paritytrack.org. Do the quick online registration, and make your voice heard with the political outreach app and the national appeal/denial registry. From the site you can **send an email directly to your state insurance commissioner and regional office of the Department of Labor**, urging them to conduct random audits of health insurers practices concerning behavioral health, and to check all healthcare complaints for evidence of non-compliance with parity laws. (Many complaints are filed that don't mention the actual word "parity" so regulators need to look harder at whether feedback from consumers and caregivers represent non-compliance

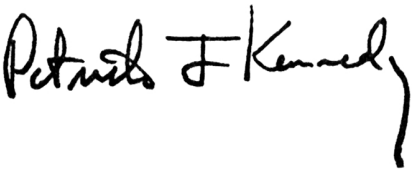
with parity laws.) You can also **email your state legislators and members of Congress to urge them to pass even stronger laws to protect you from discriminatory insurance practices**. And, if your doctor has ordered behavioral health care which your insurance company has denied, **you can immediately file an appeal** (and, if it's an emergency, an expedited appeal.)

This is just the beginning. There is a lot of work to do and, frankly, it is going to take contributions from everyone. The good news is that we already have many evidence-based programs ready to implement across our country, and smart public policies awaiting approval, passage or, in some cases, refunding. And I'm pleased to say there has been some notable progress since we put this kind of political agenda together for the hardcover edition of *A Common Struggle* in 2015. The President announced a large proposed budget increase in the fight against the rising epidemic of opiate addiction, overdose and suicide. He also finally created an interagency Mental Health and Substance Use Disorder Parity Task Force, which is scheduled to make its first recommendations just before the 2016 election.

The Centers for Medicare and Medicaid Services announced a new final rule that will strengthen access to mental health and substance use disorder services for children in the CHIP program and those with low incomes receiving Medicaid. The US Preventive Services Task Force made new recommendations that doubled down on screenings for depression, especially for pregnant women. But there is still so much to do.

On the pages that follow, you'll find our National Behavioral Health Platform, as well as more information on how to connect with our organizations, including the Kennedy Forum, ParityTrack, and One Mind.

Thank you for joining me in the common struggle.



www.acommonstruggle.com

Appendix II

THE NATIONAL BEHAVIORAL HEALTH PLATFORM
A NONPARTISAN APPROACH TO MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Since I left Congress in 2010 and starting working more broadly on the politics of mental health and addiction, my staff and I have been gathering, deconstructing, editing, and re-editing lists of programs and policies that we know already work—yet they haven't been fully adopted across the country. Below you'll find our expanded working list of these programs and policy needs in a variety of areas. It is meant to be understandable and useful to everyday medical consumers and their families, as well as to caregivers and policymakers. And I hope it serves as a reminder that even though we have much to learn about the brain, how it works, and what to do when it doesn't work as well as we like, we really have not yet tried, on a national scale, much of what we already have proven can be successful.

For the 2016 elections and beyond, we hope this platform will prove useful in helping you decide which candidates and causes to support, and what specific bills and programs to advocate for in your area of strongest personal interest and commitment.

The goal of our ongoing platform project is to use an interdisciplinary public health approach to target six key areas: **access to services, prevention and early intervention, vulnerable populations, the behavioral health workforce, social determinants, and research**.

I. Access to services for behavioral health care is woefully inadequate, there is little continuum of care, and treatment for mental illness and substance use disorders remains medically and economically segregated from general health care. Furthermore, mental health care is often left out of programs targeting the rapid raise in opioid use and suicide. The recommendations below address this lack of access to behavioral health services and unfair medical management.

Parity

- HHS and DOL should strongly enforce the federal parity law by conducting no fewer than twelve random audits of health plans on an annual basis for compliance
- Federal and state regulators, and accreditation agencies, must require all health plans to disclose medical management criteria and protocols and how they are applied for both behavioral health care and medical/surgical care
- DOL, state insurance departments, and other applicable regulatory agencies should conduct audits or market conduct exams of any plan with three or more behavioral health complaints of the same type
- Congress must extend the federal parity law to Medicare and Medicaid fee-for-service
- Congress must amend the federal parity law so that it clearly states that mental health and substance use disorder benefits include residential treatment and that residential treatment is comparable to sub-acute inpatient medical/surgical treatment such as hospice care or care in a skilled nursing facility
- Congress must amend the federal parity law so that mental health conditions and substance use disorders are defined as any listed in the ICD-10 or found in the DSM-5.

- The federal government should release further regulations on non-quantitative treatment limitation compliance with examples of appropriate and inappropriate use. These regulations must clearly define the terms processes, strategies, evidentiary standards, or other factors.
- State insurance departments and other applicable state agencies should develop, implement and enforce strong requirements that health plans have an adequate number of behavioral health providers in their networks.
- DOL and state insurance departments should scrutinize all consumer complaints regarding prior authorization, fail first protocols, and concurrent medical necessity reviews for non-quantitative treatment limitation compliance under the federal parity law
- An online resource for consumer and provider reports of potential non-compliance with the federal parity law should be developed (this tool can consolidate complaints from other registries, such as www.parityquest.org)
- State legislatures throughout the country should introduce and pass legislation that increases parity protections, requires insurer transparency, and demands regulatory agency accountability (a model legislation is available at www.paritytrack.org/model-legislation)
- Attorney Generals with jurisdiction should investigate the actions of insurance plans if they receive numerous complaints regarding inadequate compliance with state or federal parity laws
- Insurers must approve of in-plan exceptions when the insurer's network does not have any provider accessible, available, or qualified capable of providing a medically necessary service. This information must be made publically accessible on the website that lists network providers and be communicated when a beneficiary calls to inquire about network providers
- Medical necessity determinations for eating disorder treatment should be based upon the overall medical and mental health needs of the patient—and not solely on body weight or body mass index. States should consider legislation similar to the recent Missouri law guaranteeing this: http://www.senate.mo.gov/15info/pdf-bill/tat/SB145.pdf

Integrated Care

- CMS should remove payment obstacles to facilitate the integration of behavioral health care into all other medical settings, including primary care, emergency rooms, and Federally Qualified Health Centers
- States should revise their Medicaid payment policies to allow for the billing of behavioral health and primary care services provided the same day
- States should implement integrated managed care programs for dual eligible enrollees in Medicare and Medicaid
- Congress should extend Medicare and Medicaid reimbursement for electronic health care use to mental health professionals and facilities
- Behavioral health providers must take advantage of incentives in the Physical Quality Reporting System program
- Federal and state governments, the National Quality Forum, accreditation agencies, purchasers of insurance and other stakeholders should continue to integrate behavioral health metrics into their core set of health care quality measures
- All health care plans should adopt value-based payment models based on measurement systems that integrate behavioral and physical health metrics
- Research on behavioral health integration through collaborative care, such as studies conducted by the Advancing Integrated Mental Health Solutions Center at the University of Washington, should be disseminated nation-wide

Substance Use Disorder Special Issues

- Insurers must cover residential treatment for substance use disorders as a first course of treatment rather than requiring patients to fail first at outpatient treatment
- Insurers should develop a reimbursement system for certified peer specialists in alcoholism and addiction treatment
- Congress should strengthen prescription drug monitoring programs, encourage training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports
- Needle exchange programs should incorporate treatment motivation and

incentive programs, such as those pioneered by the Baltimore Syringe Exchanged Program (http://health.baltimorecity.gov/hiv-std-services/community-risk-reduction)
- Communities should establish Family Treatment Drug Courts, an alternative to regular dependency courts, which aim to improve the safety and well-being of children in the welfare system by providing parents access to drug and alcohol treatment, judicial monitoring, and individualized services that integrate the needs of the entire family
- Policymakers and health care providers should rely on resources produced by the National Center on Addiction and Substance Abuse, a national nonprofit research and policy organization, in developing policies and programs addressing addiction (http://www.centeronaddiction.org/about)
- Federally funded pain research studies should incorporate recommendations made by the Interagency Pain Research Coordinating Committee so that pain management is less reliant upon the use of prescription opioids
- States should allow partial fills of schedule II controlled substances so long as the total quantity for all partial fillings does not exceed the total quantity prescribed
- The FDA should issue guidance as to how approved labeling on opioid prescriptions may include statements that deter misuse
- States should revise their Essential Health Benefit benchmark plans to comply with the ACA regarding SUD coverage so that addiction treatment is accessible and affordable
- Congress should amend the Drug Addiction Treatment Act of 2000 and the Controlled Substances Act so that nurse practitioners and physician assistants are allowed to be certified to prescribe medication-assisted treatment
- HHS must expand access to medication assisted treatment by increasing the highest limit on the number of patients eligible providers can treat from 100 to 500

International Recommendations

- All countries should use tools developed through the WHO Mental Health Gap Action Program to address the severe lack of resources for

mental, neurological, and substance use disorders and help implement evidence-based and low cost interventions
- Countries that recently created or are in the process of implementing universal health coverage must incorporate mental health care into their national benefits plans upon initiation of the program in order to avoid the siloing of mental health and addiction from other health disorders
- Non-profits and international organizations must support programs that train community health workers in how to treat individuals with mental health and substance use disorders, such as Partners In Health MESH-Mental Health program
- All countries should develop and maintain a National Mental Health Plan with clear indicators that align with the WHO mental health action plan 2013-2020
- All countries should release data to and support the International Association for Suicide Prevention's efforts to conduct cross-national comparisons of suicide aimed at providing insight into the growing clustering and contagion of suicidal behavior
- All national disaster and emergency response initiatives must include a mental health component based on the WHO mental health and emergency resources (http://www.who.int/mediacentre/factsheets/fs383/en/)
- The International Narcotics Control Board should make fentanyl a regulated substance

II. <u>Prevention and Early Intervention</u> can decrease the chronic and debilitating outcomes associated with mental illness and addiction. Yet the United States' health system continues to rely on expensive interventions implemented only long after the onset of disease. The following recommendations prioritize prevention in an attempt to avoid adverse health outcomes and curb costs.

Community-Based Services

- Congress should expand the Medicaid home and community-based services waiver to include youth who are in need of services provided in a psychiatric residential facility, including Coordinated Specialty Care for First Episode Psychosis

- Congress should extend Section 223 of the Protecting Access to Medicare Act to facilitate the development of certified community behavioral health clinics
- Congress should pass the Expand Excellence in Mental Health Act and implement alternative payment models that incentivize coordination between community-based services
- States should take advantage of the Medicaid home and community based services HCBS waiver
- State insurance commissioners should require healthcare plans cover evidence-based home visiting programs, such as the Nurse Family Partnership, and encourage their integration into managed care plans and integrated care models
- The SAMHSA Substance Abuse Prevention and Treatment and the Community Mental Health Services Block Grants should be integrated into funding structures used to deliver grants for other medical care to eliminate the siloing of behavioral health from other medical grants
- All programs operated or supported by SAMHSA should incorporate the best available science, use evidence-based practices, and measure their effectiveness and efficiency through the adherence to clearly identified goals

Law Enforcement

- All law enforcement personnel should complete a 40-hour Crisis Intervention Team program based on the Memphis Model, an internationally-recognized best practice for pre-arrest jail diversion for those in a mental illness crisis, which can be accessed at www.cit.memphis.edu
- All law enforcement agencies and first responders should be required to carry naloxone in either the injection or intranasal form
- All states should enact Good Samaritan or 911 drug immunity laws that provide immunity from supervision violations, low-level drug possession, and use offenses when an individual experiencing or witnessing an opiate-related overdose calls 911 for assistance or seeks medical attention

Schools and Universities

- All colleges and universities must increase behavioral health resources to be sufficient to address the long wait times frequent on campuses

- The Department of Education, in collaboration with the HHS and other agencies, should develop social and emotional learning standards for elementary and secondary schools aimed at improving mental wellness
- The Department of Education, in coordination with the NIMH, should develop and disseminate evidence based brain-building interventions for schools
- The Department of Education should develop and disseminate guidance on the implementation of multitier systems of supports for behavioral health services in school systems
- Colleges and universities should create and implement strategic plans for mental illness and substance use disorder prevention based on The Jed Foundation's Campus Program Framework (https://www.jedfoundation.org/professionals/programs-and-research/CampusProgram)

Screening

- All disciplinary actions in schools should be accompanied by a mental health screening
- The Department of Education should require mental health screening as a component of annual school physicals that include recommendations for considering family member mental health when necessary
- State health insurance commissioners should require healthcare plans reimburse for Screening, Brief Intervention, and Referral to Treatment, an approach where primary care staff assess patients' substance use risk and refer to appropriate treatment
- Screening pregnant women for perinatal mood disorders, anxiety disorders, and substance use disorders should become the standard of care
- Congress should enact legislation requiring all health plans to reimburse for evidence-based mental health screening during annual well-child exams and adult annual physical exams. They should include an adverse childhood experience (ACE) component, as higher ACE scores are associated with a greater likelihood of numerous medical and behavioral conditions
- CMS should enforce the federal Medicaid law requiring states provide early and periodic screening, diagnosis, and treatment for Medicaid eligible children and adolescents

Suicide

- States should increase funding for and assist in the implementation and evaluation of state suicide prevention plans that focus on suicides across the lifespan
- Congress should pass the Garrett Lee Smith Memorial Act Reauthorization of 2015, which funds several research, training, prevention, and technical assistance programs aimed at decreasing suicide, including the Youth Suicide Early Intervention and Prevention Strategies, and Mental Health and Substance Use Disorder Services on Campuses programs
- All colleges and universities should develop evidence-based suicide prevention plans to respond to the high incidence of suicide in young adults
- All secondary schools, and even elementary schools, should also have evidence-based suicide awareness plans, based on the Model School District Policy on Suicide Prevention (https://afsp.org/wp-content/uploads/2016/01/Model-Policy_FINAL.pdf), to respond to the growing problem of suicide in younger children

Emergency Response

- All hospitals should create behavioral emergency response teams (BERT) to assist staff in non-behavioral health units treating patients with acute psychiatric disorders experiencing violent behaviors
- All offices of emergency management should develop a comprehensive mental health disaster plan using PsySTART Rapid Mental Health Triage and Incident Management System (http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf)
- All states should pass legislation requiring school districts to develop evidence-based plans detailing how they will handle emotional and behavioral distress, including suicidal thinking and behavior, and threats of violence, during the school year

III. <u>Vulnerable Populations</u> are more severely impacted by behavioral health disorders than the general population. Individuals in the criminal justice system, veterans and active members of the military, marginalized populations, and pregnant women are among the groups that will benefit from targeted efforts to achieve health equity and improve health outcomes.

- Congress should require that all programs and treatments receiving federal funding are culturally and linguistically sensitive, age appropriate and trauma-informed
- HHS should create the Inter-Departmental Serious Mental Illness Coordinating Committee, which will evaluate the effect on public health of federal programs related to serious mental illness that includes data about health outcomes and other social outcomes such as employment, homelessness, and incarceration rates

Criminal Justice System

- States and counties should implement evidence-based pre-arrest, pre- and post-booking, pretrial, and presenting diversion programs for offenders with a serious mental illness or substance use disorder and connect individuals with appropriate services
- Federal and state legislatures should provide financial incentives for prosecutors and attorney generals who demonstrate a commitment to evidence-based alternatives to incarceration
- Federal, state and other correctional authorities should replace solitary confinement with evidence-based and cost-saving mental health care, such as crisis intervention training for correctional officers and mental health step-down units
- States should increase enrollment of the criminal justice population in Medicaid or private insurance to ensure that individuals with mental health and substance use disorders receive appropriate treatment and support services while incarcerated and are connected with appropriate community services upon release
- Congress should appropriate full funding for the Justice and Mental Health Collaboration Act
- Post-secondary educational institutions should adopt admissions policies that do not unfairly discriminate against individuals with a criminal record

Veterans and Active Members of the Military

- In cases where the VA is incapable of meeting care demands, reimbursement for licensed mental health providers external to the agency should be made available

- Congress should appropriate additional funding to the Department of Veterans Affairs to increase the number of behavioral health professionals in the Veterans Health Administration available to veterans and their family members
- Congress should consider extending the National Health Service Corps to include Veteran's Administration Hospitals
- States and counties must collect and publish data on the number of veterans incarcerated in the criminal justice system

Individuals with Developmental Disability Comorbid with Mental Illness or Substance Use Disorder

- States must prioritize mental health diagnosis and treatment for individuals with co-occurring developmental disability, mental illness, and substance use disorder by taking advantage of federal programs, such as Medicaid waivers, Money Follows the Person, and the Balancing Incentive Payment program
- Insurers should reimburse for day rehabilitation treatment programs for adults with dual diagnoses of intellectual disabilities and mental illness that promote independence and focus on transitional planning, similar to the Harris County ADAPT program, www.mhmraharris.org/idd/Brochure%20ADAPT.pdf
- Individuals and facilities treating children and adults with co-occurring disabilities must meet qualifications standards, such as the NADD Accreditation and Staffing Certification Guidelines (http://thenadd.org/products/accreditation-and-certification-programs/)
- State legislatures should amend their laws about insurance coverage of pervasive developmental disorder so that all developmental disabilities are included

Marginalized Populations

- Training and continuing-education programs must incorporate cultural competency elements focused on under-served populations, including racial, ethnic, and sexual minorities, and be based on evidence-based standards
- The Indian Health Services, a division of the HHS, must develop a strategy to address the high incidence of suicide and untreated substance use disorders in Native American communities

- The Model Adolescent Suicide Prevention Program, originally developed for a small tribe in New Mexico, should be disseminated to other Native American tribes (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=251)

Pregnant Women

- Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth
- Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor fetal alcohol syndrome disorder practice and implementation centers in every region

IV. <u>The Behavioral Health Workforce</u> is unable to meet the needs of the growing population requiring mental health and addiction services. Mental health professional shortage areas exist throughout the country. Training programs do not reflect the diverse needs of patients. Many facilities offering behavioral health treatments do not meet accreditation standards. The following recommendations combat the growing workforce crisis in mental health and addiction care.

- Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals
- Federal and state governments should create training grants for fellowships and stipends for advanced education programs in behavioral health care
- Medical training programs must include discussions of safe-prescribing practices, including the use of opioid treatment alternatives when appropriate
- Behavioral health provider organizations should conduct annual cultural competence self-assessments
- Congress should create a Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations (http://www.samhsa.gov/minority-fellowship-program)

- Public and private health systems should incentivize the effective use of telehealth
- Continuing Medical Education for state medical licensure should include training in evidence-based care coordination and valued-based payment systems
- All health care plans that offer behavioral health benefits must meet accreditation standards developed by URAC or the National Committee for Quality Assurance
- National peer credentialing standards for individuals in clinical settings must be developed to encourage peer specialist reimbursement
- All facilities and programs serving persons with mental illness, including, hospitals, community mental health centers, clinics, nursing homes, rehabilitation programs, correctional institutions, and networks, should seek accreditation

V. <u>Social Determinants</u> which are known to trigger and exacerbate mental illness and substance use disorders must be addressed in combination with policies aimed at service access.

Education

- Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development in mental wellness programs, such as social and emotional learning, early warning sign identification, and trauma-informed approaches
- Federal Title I education funds and other congressional funds should be used to replace zero tolerance policies with programs that consider behavioral health, such as trauma-informed programs and positive behavioral support
- Congress should amend the Head Start Act to require that in providing and allocating resources for training and technical assistance the Department of Health and Human Services must give priority to the implementation of evidence-based trauma-informed programs, age-appropriate positive behavioral interventions and supports, early childhood mental health consultation, and prevention of suspension and expulsion

Workplace

- Employers should ensure that they are fully compliant with the Americans with Disabilities Act regarding current and prospective employees with mental illnesses and substance use disorders. They must offer them the same accommodation they would any other medically disabled person.
- The Occupational Safety and Health Administration should develop a national psychological health and safety in the workplace standard—similar to physical health and safety standards—to help organizations achieve measurable improvement in the psychological health of employees
- Employers should ask employees to complete health risk appraisals that include questions relating to behavioral health. Individuals who screen positive should be connected with relevant employee assistant programs
- Employers should design their health insurance benefits in accordance with the Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act (http://www.workplacementalhealth.org/ParityGuide15) published by Milliman, Inc. and the Partnership for Workplace Mental Health
- Employers should adhere to the guidelines of Employee Assistance Professionals Association (http://www.eapassn.org/Portals/11/Docs/EAPAStandards10.pdf) and measure the performance of EAPs with validated tools, such as those provided within the Workplace Office Suite (http://chestnutglobalpartners.org/wos)
- Employers should create an easily accessible summary of behavioral health benefits to help consumers navigate the healthcare system
- Employers should implement workplace wellness programs similar to Wellness Works, a California workplace education and training program (http://www.wellnessworksmentalhealth.org/)
- Employers should pledge to avoid using language in advertisements and organizational documents that perpetuates negative and inaccurate stereotypes about people with mental illnesses and substance use disorders

Employment

- CMS should revise Medicaid regulations to extend the Medicaid Rehabilitation Option to cover vocational and employment support services

- Federal and state entities should track unemployment rates among individuals identified as living with a behavioral health disorder
- Titles I and II of the Americans with Disabilities Act must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness
- Expand eligibility for supplemental security income and supplemental security disability income to include people with substance use disorders
- The VA should have authority to provide supportive-employment services to veterans

Housing

- States should increase funding and fully implement evidence-based housing programs, such as Housing First (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=365), to reduce homelessness among individuals with mental illness and addiction
- CMS should revise Medicaid regulations to extend the Medicaid Rehabilitation Option to cover housing support services
- Federal and state entities should track homelessness rates among people identified as living with a behavioral health disorder

VI. Research is needed to better understand the etiology of brain diseases and to create a proper evidence base for treatment development and implementation. The recommendations below encourage sustained and sufficient funding for both public and private mental health and addiction research.

- No brain health research should be funded unless it employs the open science principles required to make its results shareable across disciplines and around the world. All funders and researchers should incorporate the One Mind Open Science Principles into their protocols, so that informed consents for medical information collection allow de-identified data to be shared to study a broad range of conditions, research employs the most widely accepted common data elements, and data can be made available

to the research community as early as possible (http://onemind.org/Our-Solutions/Open-Science)

- The NIH should appropriate equitable funding to the NIMH, NIDA, and NIAA that is comparable to funding for the other institutes. This funding would support research on the etiology of brain diseases, treatment development, the evaluation of clinical practices, and outcomes monitoring
- Congress should continue to appropriate funding to the NIMH Research Domain Criteria (RDoC) initiative
- Research institutes focused on mental illness and substance use disorders should follow the model of the National Network of Depression Centers, based off of the National Comprehensive Cancer Network, which facilitates collaboration between different centers to reach the critical mass necessary for large clinical trials and data registries
- Congress should appropriate funding to the NIMH for research on the determinants of self-directed violence
- State should amend existing state laws to include brain donation within existing organ donation policies
- Congress should incentivize pharmaceutical companies in the development of new medications targeting the central nervous system by creating a regulatory pathway to hasten the conditional approval of beneficial CNS drugs
- Federal research grants for behavioral health treatments should include a translational research component on the financial, ethical, logistic, and regulatory aspects impacting dissemination of therapies into clinical and community settings
- Congress should increase funding to the CMS to expand the National Violent Death Reporting System nationally and to facilitate coordination between the states
- National and/or state standards protecting psychiatric research participants must include stronger provisions on informed consent, advanced directives, and right to withdraw

FOR MORE INFORMATION ABOUT OUR PROGRAMS

- Policy incubator and convener for the entire community of mental health and addiction
- Gathers experts from across the spectrum of behavioral health to discuss and promote best practices and policy solutions in areas requiring collaborative leadership, including parity implementation, outcomes-based care, integration, technology, and mental wellness
- Launching a global brain health leadership enterprise with One Mind and Johnson & Johnson—One Mind Initiative at Work—which will provide a forum for select visionary corporate leaders and thought leaders committed to improving behavioral health through the workplace
- Holds conferences and meetings, including the annual "State of the Union in Mental Health and Addiction"
- Works closely with the Kennedy Center for Mental Health Policy and Research, Satcher Health Leadership Institute, Morehouse School of Medicine and the Kennedy Forum Illinois
- To join the Kennedy Forum and get regular updates on legal, medical and scientific news, go to www.thekennedyforum.org

ParityTrack.org

- Collaboration between the Kennedy Forum and the Thomas Scattergood Behavioral Health Foundation that provides live, interactive resources, on a state-by-state basis, to improve implementation and enforcement of the Mental Health Parity and Addiction Equity Act of 2008, the additional behavioral health protections of the Affordable Care Act, and any new legislation or regulations.
- Provides technical assistance to legislators, regulatory agencies and advocates, develops model state parity legislation, and aggressively aggregates legal cases and decisions that impact implementation and enforcement of parity laws.
- For consumers, family members and caregivers, ParityTrack also provides critical information, on a state-by-state basis, to explain relevant legislation, regulations, and litigation so everyone understands their rights under the law. Explains common parity violations, to help better educate consumers on a host of issues that might arise when seeking or accessing treatment.
- Provides contact information for consumers and family members to reach out to state insurance commissioners, insurance companies and other local resources.
- ParityTrack also has debuted an app that allows any complaints you file concerning denials of care to become part of a national database at www.parityquest.org.
- For more information, visit www.paritytrack.org.

- International forum for open science, sharing of big data, and advanced collaboration in brain research, which will accelerate replication and vali-

dation of results, allow increased data integration and power for statistical analysis, and accelerate the translation of basic research to clinical use so patients receive improved diagnostics and treatments
- Built open data portal with open science principles that will greatly accelerate the discovery of better diagnostics, treatments and, some- day, cures for diseases and injuries of the brain
- Creates global public-private partnerships among governmental, corporate, scientific, and philanthropic communities
- Holds annual summit of international brain research community to share innovation and best practices, and take on new research challenges that will benefit a broad range of brain diseases
- To join the One Mind effort and get regular updates on its brain science efforts, go to www.onemind.org.

SAM Smart Approaches to Marijuana
preventing another big tobacco

- Champions smart policies that promote getting the science out to the public about today's high-potency marijuana and encourage decreasing marijuana use—without harming marijuana users with arrest records that stigmatize them for life
- Works to stop the commercialization of marijuana and marijuana-edible products by fighting Big Marijuana—the Big Tobacco of our time
- Promotes research on marijuana's medical potential and helps to assure that medicines made from marijuana's active ingredients can be dispensed by board-certified physicians to appropriate patients in pharmacies like any other medicine
- For more information, visit www.learnaboutsam.org.