



MENTAL HEALTH & SUBSTANCE USE DISORDERS

tool kit

a women in government publication







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Women In Government's National Task Force on Mental Health and Substance Use Disorders' Policy Toolkit

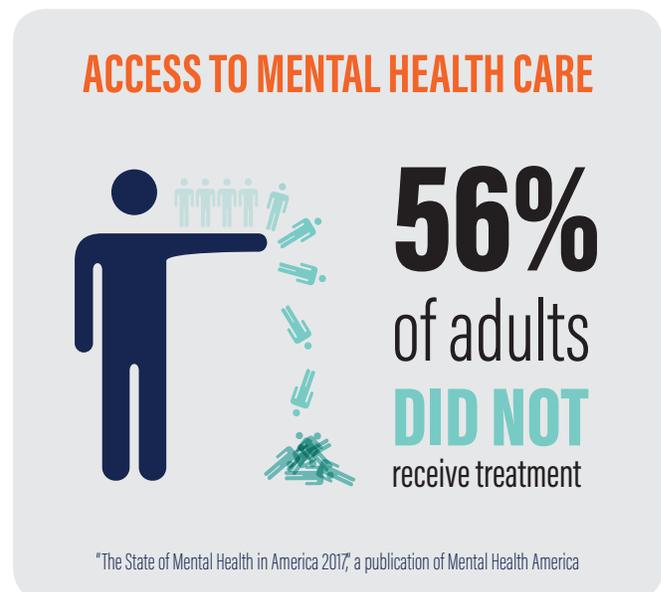
Building Greater Awareness and Making Meaningful Change Around Mental Health and Substance Use Disorders —A State Policymaker's Guide

More than 40 million American adults—one in five people—have a mental health condition, and half of all Americans will have a mental health condition in their lifetimes.¹ But for a number of reasons, a majority of those people will not receive treatment. Lack of access to insurance or to a mental health professional—or even an effort to avoid the stigma attached to admission of a mental illness—often block the patient from needed care. “The State of Mental Health in America 2017,” a publication of Mental Health America, found that 56 percent of adults with mental illness across the country did not receive treatment because of a lack of access to mental health care.²

Likewise, the number of people with a substance use disorder is high. More than 27 million people reported current use of illicit drugs or misuse of prescription drugs, according to a new Surgeon General's report, “Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health,” released in November 2016. One in seven people will develop a substance use disorder at some point in their lives.³

A growing recognition of the detrimental impact to the individual and to society when mental health issues and substance use disorders are not treated has sparked a wave of action across the country by states and the federal government. In addition to the societal costs, government officials have recognized the financial costs to state budgets and the future financial independence of those individuals.

2016 saw Congress pass the 21st Century Cures Act, which included a package of mental health care and addiction treatment reforms. The Cures Act, which passed on a



bipartisan basis, includes a requirement for states to use at least 10 percent of their mental health block grants on early intervention for psychosis and establishes a grant program for community treatment to help people with serious mental illnesses.⁴ The bill also allows flexibility for communities in the use of federal grants. Funding for the programs must be approved by future Congresses.

While mental health advocates lauded the support at the federal level, they recognize much of the action to address the many challenges of mental health and substance use issues occurs on the state level.



“States are where all the actions happen for mental health and substance abuse. It’s at the state level where services are delivered, where policies are set and where behavioral health issues have a disproportionately large effect on state budgets.”

—Debbie Plotnick, MSS, MLSP
vice president,
Mental Health and Systems Advocacy
Mental Health America

“States are where all the actions happen for mental health and substance abuse,” said Debbie Plotnick, MSS, MLSP, vice president for Mental Health and Systems Advocacy at Mental Health America. “It’s at the state level where services are delivered, where policies are set and where behavioral health issues have a disproportionately large effect on state budgets.”⁵

That’s evident in states like California, which adopted the Mental Health Services Act in 2004 to revamp the state’s mental health system. The action followed a damning report from California’s Little Hoover Commission, which deemed the state’s mental health system “woefully inadequate” to address the needs of Californians who were experiencing mental health issues.⁶ Following a yearlong study, the Little Hoover Commission, an independent oversight agency created by the state legislature, emphasized the need for essential services, such as housing, drug treatment, psychiatric care and job assistance to better address those issues.⁷

Toby Ewing, executive director of the Mental Health Services Oversight and Accountability Commission, said at the time, the system was broken because clinicians dealing with mental health patients might know what those patients needed to address their mental health needs, but the way programs were funded, they were only able to meet two or three of the needs.⁸ Patients with co-occurring mental health and substance use disorders might get mental health services, but not drug treatment, for instance.

“(The system was) broken in the sense that there was a mismatch between the kinds of services that we pay for, that we can deliver and the needs of the population,” Ewing said.⁹

Four years after the Little Hoover Commission study, the

state’s voters approved Proposition 63, the Mental Health Services Act, aimed at reforming the system. The proposition directed a new tax on people making more than \$1 million annually be spent on mental health services provided by California’s 58 counties. The Mental Health Services Oversight and Accountability Commission was formed to oversee programs developed as a result of the Mental Health Services Act.¹⁰

The Act was just the beginning of the transformation of California’s mental health system, an ongoing transformation that is mirrored at the state and federal level throughout the U.S.

Women In Government in 2016 seated a National Task Force on Mental Health and Substance Use Disorders after hearing from members about the growing epidemic in their states. The panel met throughout the year to collaborate, develop state policy responses and fresh ideas, and create effective partnerships. The task force, which includes state legislators, mental health professionals and advocates, targeted several policy areas that affect mental health and substance use disorders. Those areas are:

- » Providing access to coordinated, quality care;
- » Training professionals on mental health and substance use disorder issues;
- » Addressing housing instability for people with mental health and substance use issues;
- » Effectively collecting and utilizing data to better serve those with mental health and substance use disorder issues;
- » Providing adequate care in all stages of recovery;
- » Reforming sentencing guidelines and prison programming for those with mental health and substance use issues; and
- » Fostering awareness and a better understanding of mental health and substance use issues in educational settings and with the community at large.

While many of these issues are addressed in silos through state government policy, the task force and mental health stakeholders see each of them as integral to improving behavioral health care across the country. “Without taking a look at the housing, the education ... all of these issues and recognizing how integrated they are, we really are not going to resolve this problem by tackling one or just a few,” said Minnesota Rep. Cindy Pugh, a member of the task force and WIG state director. “It’s a very complex issue. It’s going to take time to resolve.”¹¹

The Problem

Mental health and substance use disorder issues cross more public policy areas than just health care. They increase the caseloads in the courts and the number of people in jails and prisons. They create discipline issues and distractions in the classroom for the student impacted by the mental illness and for his or her classmates. They create the need for more social

service interventions, from counseling to housing. Perhaps most importantly, they steal the ability of the affected individuals to lead a productive life where they can contribute to society.

A majority of mental disorders first occur in childhood or adolescence, but many of them are not treated until years later.¹² Mental health experts say the absence of prevention efforts, or even early intervention, lends to the complexity of the problem down the road. Anna Hasselblad, director of public policy for the Steinberg Institute in Sacramento, which is focused on mental health care in California, said 50 percent of all lifetime mental illnesses have occurred by age 14, and 75 percent have occurred by age 24.¹³

“The bulk of issues are identified in adolescence, but they occur pre-adolescence,” said Collette Lueck, chair of the Illinois Children’s Mental Health Partnership, a statewide, public/private partnership of policymakers and advocates in Illinois committed to improving the scope, quality and access of mental health programs, services and supports for children. She said teachers of students as young as second grade can identify the children who will likely face a mental illness in the future. “The severity of the symptoms don’t become problematic enough that they can be addressed. It’s kind of on a low level simmer in the early ages, but the issues are there,” Lueck said.¹⁴

In many cases, though, the students are left to flounder in a system that is ill-equipped to address their needs because of a lack of funding, expertise or resources. Illinois sought to change that dynamic in 2003 with the passage of the Illinois Children’s Mental Health Act, which created the public/private partnership of which Lueck is the chair. Even with that granular focus, Illinois serves as an example of just how difficult it is to address the needs of people with mental health issues and substance use disorders. The state ranks 19th on prevalence of mental health issues among youth and 30th in overall access to care in “The State of Mental Health” report.¹⁵

Like several other states, Illinois is working to find ways to increase resources for early intervention. Before the act, Lueck said, “almost all of the resources were going to the kids at the top of the triangle, with virtually nothing spent on prevention and early intervention.”¹⁶

Ignoring prevention and early intervention—things such as screening, education, family needs and housing—comes with a cost to states, according to Plotnick. “The earlier we get in, the better outcomes (for patients) and the more fiscally sound it is for states,” she said.¹⁷

“If you identify a problem early, you do a brief intervention. There are many effective evidence-based interventions that have a return on investment that is many, many fold,” she said. “That can make a huge difference and states can facilitate getting screening, intervention and treatment all along the way.”¹⁸

Plotnick said patients in the later stages of mental illness and substance abuse end up costing a state more than the early intervention services would have cost.¹⁹ For instance, the Surgeon General’s “Facing Addiction in America” cites studies that show a \$4 savings in health care costs for every dollar spent on treatment for substance use disorder.²⁰ In addition, many people with mental health or substance use disorder issues have a co-occurring chronic condition that adds to the cost of caring for their physical health.²¹

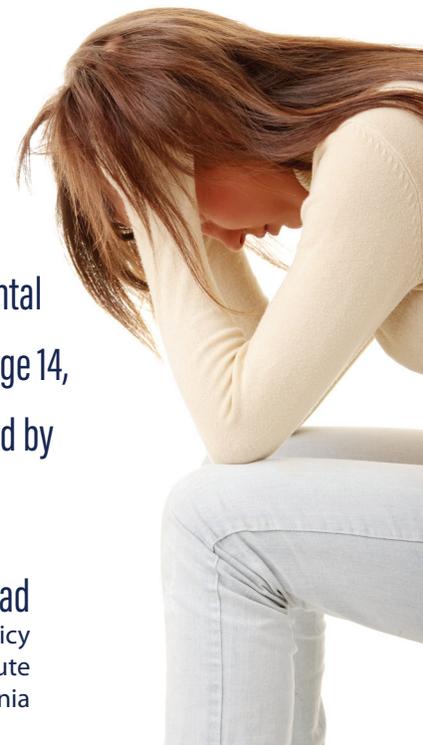
It’s better, Plotnick and others say, to provide those wrap-around services to treat mental health and substance use disorder issues early than to allow them to develop to a point where treatment is more expensive and, often, less effective.²² For that reason, Women In Government’s MHSUD National Task Force has developed this tool kit to look at policy options for state government leaders in several key areas.

Task force co-chair Sen. Jennifer Flanagan of Massachusetts said the need is too great for states to delay creating a coordinated action on mental health and substance use disorders.

“The communities we represent have been drastically affected and it is imperative that we work together to take action for both immediate and long-term to curb this crisis and turn the tide for our citizens,” she said. States, she said, need to “remain vigilant and active in the fight against substance use disorder, and to work to enhance mental health services that are desperately needed by many families across the country.”²³

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—Anna Hasselblad
director of public policy
Steinberg Institute
Sacramento, California



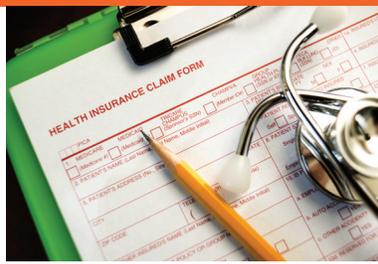
With that in mind, the task force developed a problem statement and a set of recommendations by looking at what has worked in the states and promising legislation related to mental health and substance use disorders in the seven policy areas they targeted. In many cases, actions in one policy area will reverberate through the other areas and affect the success. Task force members developed these problem statements for the policy areas.

- » Access to coordinated, quality care: Finding quality, coordinated and appropriate care is difficult in many areas. Some states don't have a full range of MHSUD programs.
- » Housing: Housing instability fails to present successful prevention, treatment and recovery for people living with mental health and substance use issues.
- » Training Professionals: There is a lack of adequate training on awareness, prevention and treatment of MHSUD.
- » Education: There is a lack of public education, awareness and understanding of MHSUD, as well as of prevention, early intervention and recovery, by the community at large.
- » Judicial: People living with MHSUD are inappropriately housed in jails and prisons with inadequate programming. Sentencing reform and prison programming is lacking across the country and policymakers need to develop standardized, evidence-based assessments for appropriate placements and ensure that treatment programs are evidence-based and person-centered.
- » Recovery: There are multi-faceted challenges to all stages of recovery and maintaining sobriety and treatment.
- » Data: Data collected on mental health and substance use disorders needs to be effectively collected/utilized to better serve individuals with these conditions. The data that is being collected is not being shared and there is a lack of understanding of what is being spent for data collection.

Access to Coordinated Quality Care

Finding quality, coordinated and appropriate care is difficult in many areas. Some states don't have a full range of MHSUD programs.

More than half—56 percent—of American adults with a mental illness didn't receive the treatment they needed in 2012. Of the youth with a major depression episode, 64.1 percent did not receive mental health treatment, and many of those who did received inconsistent treatment.²⁴ Less than



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“The State of Mental Health in America 2017”
Mental Health America

one-fourth—21.7 percent—of youth with severe depression received consistent treatment.²⁵ Even with the states with the best access to care—Vermont for adults and New Hampshire and Iowa for youth—more than 40 percent of individuals in need of care failed to receive services.²⁶ While some of that unmet need can be attributed to a lack of recognition that they have a mental illness, part of it also is due to a lack of support.²⁷ Other factors include a lack of insurance, lack of providers, lack of treatment types and a lack of money to cover such things as copays, uncovered treatment or providers who don't take insurance.²⁸

The growth in the number of people who are insured because of the Affordable Care Act helped to alleviate part of the issue, according to Sita Diehl, director of Policy and State Outreach, National Alliance on Mental Illness, but even then, there are issues. “We're making significant strides currently in getting people

insured although we have a long way to go on parity,” Diehl said. “Also Medicaid expansion has been a real boon to our population because it provides a safety net whereby people who have been uninsured or unable to get services can now get the services they need to get back on their feet.”²⁹

Mental Health America's “The State of Mental Health in America 2017” found that 19 percent of adults with mental health conditions remained uninsured in states that did not expand Medicaid and 13 percent remained uninsured in states that expanded Medicaid.³⁰ Diehl and others fear changes in the Affordable Care Act and a rollback of Medicaid expansion in states that took advantage of the federal offer could hamper the progress that has been made in improving access to care.³¹ “The next few years are going to be very telling of whether we go backward,” said Kentucky Rep. Joni Jenkins.³²

Untreated mental illness, especially in the early stages, leads to more severe problems later on, experts say. “You can literally prevent an episode of psychosis if you provide (patients) with the right kinds of treatment,” said Anna Hasselblad of the Steinberg Institute. “A lot of those individuals are going to be those high need chronic users later on if they don't get treatment.”³³

The Mental Health Parity Act of 2008 requires coverage of behavioral health issues at the same level as physical health. But some states go beyond that. Arkansas, for example, requires broad coverage for all mental illnesses.³⁴ Other states, however, allow insurers to offer coverage but also charge a higher premium—the insured person can reject that coverage.³⁵

Diehl said even with the law, there's still some ambiguity for mental health coverage. "We are really looking to the future for insurers to come on board not just with things you can count—the number of visits, limits in the hospital—but also the softer pieces, such as utilization management techniques used to contain costs, such as step therapy where you have to try one drug or service first. There's overstringent interpretations of medical necessity criteria. We find that for mental health and substance use services, those criteria are often interpreted more strictly."³⁶ She'd like to see some clarification on how plans should uphold parity for nonquantitative treatment limits.

But it's not just the ability to cover the costs of treatments, it's also the ability for the individual seeking help to find a health care professional to provide the treatment. "The State of Mental Health" report found some states have one mental health professional for every 1,000 patients—that includes psychiatrists, psychologists, social workers and psychiatric nurses.³⁷ The ratio for individuals to mental health provider nationally is 529-to-1. It's highest in Alabama, at 1,200-to-1, Texas at 990-to-1 and West Virginia at 910-to-1; it's lowest in Massachusetts at 200-to-1, the District of Columbia at 230-to-1 and Maine at 240-to-1.³⁸

"There's a critical nationwide shortage of mental health providers. It's hard work. The pay is not high and administrative requirements are high and liability is high," said Diehl.³⁹ She said loan forgiveness programs at the federal and state levels for mental health professionals could work to draw people to underserved areas.⁴⁰

Texas in 2016 started a loan forgiveness program for mental health professionals and included more than \$2 million to fund the program through 2017.⁴¹ Sen. Charles Schwertner, chair of the Senate Health and Human Services Committee, said the need is growing for mental health providers in the state. "Without an adequate number of mental health professionals, we will continue to see those experiencing mental illness cycle through our jails and emergency rooms at great expense to the taxpayer," Schwertner said.⁴² The loan forgiveness program covers psychiatrists, psychologists, advanced practice nurses who are board certified in psychiatric or mental health nursing, licensed professional counselors and licensed clinical social workers.⁴³

In Kentucky, the legislature increased from certification to licensure as the highest level for professionals providing drug and alcohol counseling and for those providing peer education support, according to Jenkins. That made them eligible for Medicaid reimbursement. "We saw more people go into drug and alcohol counseling and more people seeking help



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director, Policy and State Outreach
National Alliance on Mental Illness

because there was a payer source," she said.⁴⁴ Jenkins said it's important to have a professional available for individuals when they are seeking help. "When someone is suffering from mental illness or substance abuse, when they decide they're ready for treatment, a month later they may not be."⁴⁵

Minnesota Rep. Cindy Pugh said people who live in metropolitan areas in Minnesota have better access to care. But that leaves a lot of people out. She believes telemedicine services could serve some of those rural areas and says that might be a good avenue to explore. "I see opportunity there given the advancements in technology to work collaboratively with mental health professionals where they are in conjunction with providers (in rural areas)," Pugh said.⁴⁶

Diehl said another strategy is to allow allied health professionals to practice in that mental health care space. Advance practice nurse practitioners and physician assistants can work with a psychiatrist to provide services. Most states allow certified peer support specialists—those people who have "gained wisdom through lived experience of mental illness and have recovered to a degree where they can help others," said Diehl.⁴⁷

Eight states—Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon and Pennsylvania—were selected at the end of December, 2016, to participate in Certified Community Behavioral Health Clinic two-year demonstration projects under the Excellence in Mental Health Act. Clinics in those states will receive enhanced Medicaid payments for providing expanded mental health and substance use disorder treatment along with basic primary care services.⁴⁸

The Women In Government Task Force offers these recommendations with regard to the access to care:

- » Mandate insurance coverage and access, without prior action, for detox, stabilization and outpatient substance use disorder treatment services;
- » Provide community-based MHSUD services to remove barriers to access;

- » Simplify and streamline access to child and adult services such as a single point of entry;
- » Provide telehealth MHSUD services for all geographical areas, especially underserved areas;
- » Provide more financial incentives to MHSUD providers to locate in underserved areas, such as loan reimbursement, loan forgiveness and increased reimbursement;
- » Legislatively require public and private insurance coverage for MHSUD care;
- » Recognize licensure for MHSUD providers across state lines;
- » Increase affordable transportation options—volunteer or paid—with a particular emphasis on those living in rural areas in need of care/access to medical appointments;
- » Support MHSUD facility diversion programs.

Housing

Housing instability fails to present successful prevention, treatment and recovery for people living with mental health and substance use issues.

Anna Hasselblad could think of no better way to illustrate the severity of the plight of homeless Californians than to show key legislative leaders how those people live.

“We took them on reality tours so they could see, hear, smell what homelessness looks like in their districts,” she said.⁴⁹

Hasselblad, of the Steinberg Institute in Sacramento, Calif., took Senate President pro Tempore Kevin de León on a tour of Skid Row in Los Angeles. She took Sen. Mark Leno, chair of the Senate Committee on Budget and Fiscal Review, to see Veterans’ Housing Services in San Francisco. The goal, she said, was to illustrate “that really dramatic need” for help for the homeless population in California.⁵⁰

The effort paid off. California legislators in 2016 passed the No Place Like Home Act championed by the Steinberg Institute, which was founded in January 2015 by former state Senate leader Darrell Steinberg to advance sound public policy on mental health issues. Steinberg spearheaded efforts to improve mental health services when he was state Senate President pro Tempore.

The Steinberg Institute, Hasselblad said, supports the “Housing First” approach; it calls for providing shelter for people before work to addressing addiction and other issues. The No Place Like Home Act addresses chronic homelessness of people with mental illness in California. “Once you get somebody into housing, they are going to be more receptive to treatment,” Hasselblad said.⁵¹

She explains it using Maslow’s hierarchy of needs. The base is formed by basic physiological needs—including food, water, clothing and shelter. Hasselblad said the principal of that theory is that your brain can’t focus on anything else until

the most basic needs are met. As late as 2013, nearly half of people who were experiencing chronic homelessness across the country suffered from a severe mental illness or a chronic substance use disorder.⁵² The U.S. Department of Housing and Urban Development in its 2010 Annual Homeless Assessment Report to Congress found 26 percent of homeless adults in shelters live with serious mental illness and 46 percent live with severe mental illness and/or substance use disorders.⁵³

The No Place Like Home Act, signed into law by Gov. Jerry Brown in July 2016, addresses both permanent and transitional housing for homeless persons with mental illness. It includes up to \$2 billion in bonds for permanent supportive housing for chronically homeless people with mental illness and \$45 million in 2016–17 for rent subsidies while permanent housing is constructed or rehabilitated.⁵⁴ Revenues generated from California’s Mental Health Services Act will be used to fund the projects. Hasselblad said the move will save money in the long run. “There are individuals that are living on the streets and their average annual cost is about \$100,000 a year,” she said. “If we got them into permanent supportive housing ... you can cut those costs in half.”⁵⁵

For Debbie Plotnick, the number one issue in addressing mental health and substance use disorder issues is housing. But she said, if your mind immediately jumps to homelessness, that’s a mistake. “We’re starting to pay attention to people on the street and the people we step over,” said Plotnick, of Mental Health America.⁵⁶

Plotnick said many states require people to get treatment before they can qualify for housing services. Like Hasselblad, she believes that outlook is a mistake for many reasons. “Homelessness costs a huge amount of money. We need to look at preservation of people in housing. One of the biggest ways to keep people housed is to provide them with services, not wait until they’re homeless,” Plotnick said. “When they are housed, they can engage in treatment, whether mental health treatment or substance use disorder treatment. ... It is far more cost-effective to have a person housed than to have them on the street.”⁵⁷

More than 90 percent of the people who gain housing and engage in treatment remain housed, she said, decreasing not only their time on the streets but also the costs to treat them. Housing support, case management and peer support programs, Plotnick said, are ways to help keep MHSUD patients housed. “Keeping them housed is more effective in people’s life outcomes. They don’t lose the ability to be members of the community,” she said.⁵⁸

Sita Diehl, of NAMI, said decent, safe, affordable housing is “foundational” to recovery for those with mental illness. “Without it, it’s almost impossible,” she said. “That’s the cornerstone.”⁵⁹

Several states have developed models that have been successful in reducing chronic homelessness among those

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people with mental illness or substance use disorders, Diehl said.⁶⁰

For example, in 2000, Tennessee developed the Creating Homes Initiative “to assertively and strategically partner with local communities to educate, inform, and expand quality, safe, affordable, and permanent housing options for people with mental illness and co-occurring disorders.” The state allocates \$2.5 million annually for the program.⁶¹

Diehl said the program “takes HUD funding and leverages it with state funds and private investment to create or renovate homes” for individuals with mental illness. Since its inception, the program has created more than 10,000 housing units. “They have created lots and lots of housing across the spectrum ... from supervised housing to home ownership,” said Diehl.⁶²

Several states, including Arizona and Washington, passed legislation recently to help fund housing. Arizona legislators in 2015 created a housing trust fund for those with serious mental illness through passage of House Bill 2488.⁶³ Likewise, in 2015, Washington state legislators passed House Bill 2263, which included, among other things, a provision that allows local governments to impose a sales and use tax to fund housing and related services for individuals with mental illness, developmental disabilities and other vulnerable populations.⁶⁴

Other states have long had programs to aid the development of housing for various groups of people with need, including those with mental illness and substance use disorders. Illinois in 1990 established the Affordable Housing Trust Fund, which uses portions of a fee the state collects on transfer of real estate to finance rental housing and small home units for low-income recipients with needs, including

MHSUDs.⁶⁵ Florida in 1992 passed the Sadowski Affordable Housing Act, which established a documentary stamp tax to fund affordable housing for those with needs, including MHSUDs.⁶⁶

The Women In Government Task Force offers these recommendations with regard to housing:

- » Provide tax incentives to private property owners to transform existing properties into MHSUD-supportive homes;
- » Allow public-private partnerships, such as NAMI and local government, to create homes to serve individuals with MHSUD;
- » Create “new” college campus “common space” model with individual locked bedrooms and shared common space;
- » Ensure inpatient treatment facilities provide a discharge planning process that links consumers to appropriate housing options;
- » Create prison-aftercare services to support housing and employment services;
- » Address low-level criminal offenses that keep people from securing affordable housing;
- » Ensure solid and consistent funding for programs;
- » Create public-private partnerships to increase access to stable housing; and
- » Educate target agencies on federal and state grants to fund housing and create a portfolio of affordable housing options for the population.

Training Professionals

There is a lack of adequate training on awareness, prevention and treatment of MHSUD.

Deaths from drug overdoses reached a peak in 2014; 60 percent of the deaths involved an opioid.⁶⁷ In the first six months of 2015, one-fourth of people who were shot and killed by police nationwide—124 of 462 total—suffered from mental illness and were currently in crisis, according to a *Washington Post* analysis.⁶⁸ These numbers illustrate the challenges professionals face in dealing with mental health and substance use disorder issues.

“It is crucial to invest in training of those who are on the front lines of this fight,” said Massachusetts Sen. Jennifer Flanagan. “Lack of understanding and training leads to inadequate services.”⁶⁹

Massachusetts in 2016 took action to address the training aspect in its efforts to combat an opioid epidemic it is facing, along with other states around the country. The STEP Act—for Substance Use Treatment, Education and Prevention—included provisions aimed at education of medical personnel and first responders about substance abuse. But it goes beyond that. It also expands opioid addiction education into athletic and driver’s education programs at schools.⁷⁰ A key provision of the law, according to Flanagan, is improved training guidelines for medical personnel capable of prescribing opioids and other controlled substance. “There needs to be an understanding of the consequences of our pharmaceutical driven society,” she said.⁷¹

In fact, several states require participation in prescription drug monitoring programs and training for physicians on prescribing practices. South Carolina, for instance, has expanded its continuing education requirements for physicians on opioids, abuse and addiction, according to Rep. Phyllis Henderson, a member of the WIG task force. The change didn’t apply to other medical professionals, such as dentists or pharmacists.

“We’re working on expanding the education requirement to health care professionals who either prescribe or pharmacists

who fill prescriptions,” she said. While other members of the WIG Task Force discussed expanding training for teachers and first responders, Henderson said she was thinking about the basics. “I’ve still got people writing prescriptions that don’t have continuing education requirements,” she said.⁷²

That illustrates the disparate levels of training required in states across the country. Some of it has to do with funding, while political viewpoints also play a role. In a red state like South Carolina, Henderson said, government mandates and government funding are problematic. “I’ve got to be able to work within those parameters,” she said. “Red states have more problems with government mandates and we are further behind in this whole topical area.”⁷³ Still, she’s hopeful. “I think those would be some natural partnerships in states like mine that have to be done outside of the government funding path,” she said.⁷⁴

On the federal level, the U.S. House of Representatives passed the Mental Health First Aid Act in September. That legislation would provide grants for mental health and substance use training to law enforcement and other first responders, teachers and others who work with youth.⁷⁵ The National Council for Behavioral Health said in a press release “police have become the de facto first responders to mental health crises. The eight-hour Mental Health First Aid training provides officers with tools to help de-escalate incidents and avoid tragic outcomes.”⁷⁶ The federal legislation would provide grants to help first responders de-escalate crisis situations and recognize signs of mental illness, which could get individuals with mental illness services more quickly.⁷⁷

The National Council offered success stories for those police officers who have received Mental Health First Aid training. In Rhode Island, for example, the training has improved officers’ understanding of mental illness. New Mexico started training in 2016, which led to a decrease in police-involved shootings with people suffering from mental health issues. Training at the Pennsylvania Department of Corrections led to policy changes and better interactions in the state’s prisons.⁷⁸

Texas lawmakers in 2015 passed legislation requiring universities to provide information on mental health and suicide prevention. Legislators also passed a bill requiring universities to create a single web page to include contact information for health care authority in their community.⁷⁹ Rep. Four Price said it’s often difficult for college students to seek help. “There is a stigma associated with mental health issues and seeking out help, resources and treatment,” he said.⁸⁰

In 2013, President Barack Obama launched the “Now is the Time” initiative to increase access to mental health services. Part of that initiative was a grant program to expand the workforce addressing the needs of children, adolescents and transitional age youth facing mental health and substance abuse disorder issues. The grants cover education and



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“The Illinois Children’s Mental Health Partnership invested in early intervention and prevention services, establishing partnerships between schools and community mental health agencies to create an intervention plan. They train teachers on management of classroom behavior and set up a system to identify the children who are truly at risk “as opposed to who is the teacher struggling with that day.”

—Collette Lueck
chair
Illinois Children’s mental Health Partnership



clinical training for professionals and paraprofessionals in the behavioral health fields who focus on work with those at risk of developing mental or substance use disorders. Prevention and clinical intervention and treatment are cornerstones of the program, and it stresses family involvement in activities serving the youth.⁸¹

“Now is the Time” also includes “Project AWARE” (Advancing Wellness and Resilience Education), which focuses on state and local educational agencies’ efforts to educate students about mental health and substance abuse issues. It also stresses training for school personnel in detection of mental health issues among students and connecting families in need with appropriate behavioral health services. Twenty states received funding in the first round of grants in 2014.⁸² Among the ways the program recommends accomplishing those tasks is providing training in Mental Health First Aid, working with systems serving youth in local communities and in the state, and including families in the planning process.⁸³

The Women In Government Task Force offers these recommendations with regard to training professionals:

- » Establish incentives for professional training in comprehensive, evidence-based integrated prevention and treatment models;
- » Encourage nonprofit community groups to add MHSUD awareness and training for staff and professionals;
- » Provide sensitivity training for all state agencies in charge of employment services, which focus on improving interactions between the agencies and those with mental health conditions;
- » Develop core curricula for educators, health care providers, law enforcement, first responders, the judiciary, social

workers and other professionals aimed at getting appropriate preparation and familiarity with mental health and substance use;

- » Provide incentives for new behavioral health providers to ensure that all providers are adequately trained in evidence-based integrated prevention/treatment models. Consumers of mental health and substance use services should be included in the decision-making process regarding services for MHSUDs and co-occurring interactive disorders;
- » Encourage state agencies across the board to implement a comprehensive set of evidence-based prevention programs and policies that include universal, selective and indicated interventions;
- » Ensure adequate training on MHSUD is provided to all health clinicians through continuing education credits;
- » Encourage nonprofit organizations such as Boys and Girls Clubs, Boy Scouts, Girls Scouts, etc., to add mental health awareness, recognition and training to their programs for both staff and program participants;
- » Initiate statewide programs such as Zero Suicide – legislatively, although nonprofits or private organizations could independently add programs.

Education

There is a lack of public education, awareness and understanding of MHSUD, as well as of prevention, early intervention and recovery, by the community at large.

More than a decade ago, mental health dollars targeting children were spent on the kids at the top of the funding

triangle—those with critical mental health needs.⁸⁴ There was little money for prevention and intervention. A group of people from Chicago public schools and the Illinois chapter of Mental Health America thought the state could do better through better coordination across the multiple systems of funding mental health care.⁸⁵ The group issued a report, built up momentum and worked to get legislators on board in an effort to reform the system. The result, the Illinois Children’s Mental Health Act of 2003, created the Illinois Children’s Mental Health Partnership, which convenes the child-serving state agencies, parents, youth, policymakers, providers and advocates to better serve children with mental health issues.⁸⁶

Collette Lueck, chair of the partnership, said the state closed the children’s state hospital and diverted money through Medicaid to serve the needs of those children through private hospitals.⁸⁷ But it also invested in early intervention and prevention services, establishing partnerships between schools and community mental health agencies to create an intervention plan.⁸⁸ They train teachers on management of classroom behavior and set up a system to identify the children who are truly at risk “as opposed to who is the teacher struggling with that day,” Lueck said.⁸⁹

Those at risk children get early intervention services to prevent more serious—and more costly—problems down the line. “You have kids who are using high end services who could have been treated earlier and you have kids who aren’t getting services at all,” Lueck said.⁹⁰ The creation of the partnership, and the changes to state policy, helped to spend the mental health dollars more effectively.

The state mandated social and emotional learning standards be taught in schools. While teachers were talking about social and emotional behavior, the standards weren’t consistent across the state. The mandated standards changed that. Lueck said the standards could range from teaching preschoolers how to wait in line to working with high school students who might be struggling with suicide. “If you actively teach kids how to build good social and emotional skills, you are building good mental health,” Lueck said.⁹¹

Illinois is just one state working to integrate mental health services into schools and communities, taking a public health

approach to addressing those issues. Sieta Diehl of NAMI said Minnesota was the pioneer in providing school-based services. “It’s a relatively simple concept—they provide clinic space at schools for mental health providers,” she said. That expert, she said, can help the faculty with any mental health concerns in children.⁹² In addition, the school-based services offers convenience for parents, who won’t have to take their child out of school for mental health care.⁹³

The school-based mental health services has reached children who had not been able to access mental health care before.⁹⁴ The program identified many children with serious mental health needs, including 12,289 children who met the criteria for Serious Emotional Disturbance classification.⁹⁵ A

survey of Minnesota students in 2010 illustrated the mental health needs of students. The National Alliance on Mental Illness reported that more than 2,800 sixth grade girls and more than 5,000 high school freshman girls had thought about killing themselves, and 950 freshmen girls said they had tried to commit suicide in 2010.⁹⁶

Diehl said the success of these services can help in the long-run. They can help prevent first episode psychosis. “If you intervene early with an array of services, most of them are not rocket science, but you do them in a coordinated way you can nip psychosis in the bud,” she said. Much of it is framing the treatment in a way that the young person feels attached. “The idea is to change the

culture of care ... to take that

moment of engagement and actually deeply listen to the person coming for care and stand in their shoes and help them achieve what they want to achieve in a respectful dignified way that makes all the difference.”⁹⁷

Minnesota Rep. Cindy Pugh said some of Minnesota’s 87 counties are more affected than others. She said the school-based services also help to heighten community awareness of the prevalence of mental health issues in schools. “I believe that’s the start to making a difference,” she said. “The more we talk about it, the less stigma will be attached.”⁹⁸

The ability to keep kids in school is critical to their care and their future, Debbie Plotnick, of Mental Health America, said.⁹⁹ “When you have untreated mental illness in kids, that is a major factor in the school to prison pipeline,” she said.



“The idea is to change the culture of care ... to take that moment of engagement and actually deeply listen to the person coming for care and stand in their shoes and help them achieve what they want to achieve in a respectful dignified way that makes all the difference.”

—Sieta Diehl

director, Policy and State Outreach
National Alliance on Mental Illness

“They have very diminished learning outcome and a very high probability of substance use disorders and ending up in the criminal justice system.”¹⁰⁰

Plotnick cited the California program that U.S. Rep. Grace Napolitano would like to see replicated across the country. Napolitano, who represents California’s Third District, sponsored the Mental Health in Schools Act to provide funding for schools across the country. She’s proposing \$200 million in competitive grants of up to \$1 million to expand the scope of the Safe Schools/Healthy Students Program to provide school-based mental health professionals.¹⁰¹ Napolitano’s website cites a SAMHSA report that found success with such programs. Among the successes:

- » 31 percent of youth with mental health issues had fewer behavior and emotional problems after six months;
- » Attendance by students with mental health issues rose from 75 percent to 81 percent; and 66 percent received passing grades, up from 55 percent before mental health care;
- » Schools saw a 15 percent drop in the number of students involved in violent incidents within three years of implementation of the program;
- » Students reported lower depression and lower anxiety rates, as well as better behavior.¹⁰²

Plotnick said states could leverage Medicaid dollars to address these issues under the “free care” rule.¹⁰³ California uses that rule to provide school health services.¹⁰⁴ Beyond bringing services into schools, Plotnick said there are other steps states can take to improve behavioral health care in schools and other settings. Pennsylvania, she said, is examining at the state level the kinds of practices that are detrimental to all students, but especially those with behavioral health issues.¹⁰⁵

Kentucky Rep. Joni Jenkins would like to see evidence-based programs to also target education about substance abuse in middle and high schools. She plans to sponsor legislation that could start as early as elementary school.¹⁰⁶ “The disease of addiction goes across all economic classes, although we do see it tied in some ways to poverty,” she said. “When you have folks that are living with no hope of life ever getting better, it’s very easy to turn to substances whether it be alcohol or other drugs.”¹⁰⁷

She’d like to see the stigma of dealing with MHSUD issues erased, and believes educational settings are a good place to start. “I think we’ve really turned the corner that we understand that addiction and mental illness are a health care issue, a public health issue,” she said.¹⁰⁸

At the federal level, the Helping Families in Mental Health Crisis Act would address the needs of families of people facing a serious mental illness like schizophrenia and bipolar disorder. Among other things, it would increase the number of psychiatric hospital beds and boost treatment for young people with mental health issues. It would also create an assistant secretary in the U.S. Department for Health and

Human Services specifically focused on mental health and substance use disorders.¹⁰⁹

The Women In Government Task Force offers these recommendations with regard to education:

- » Develop and provide school-based, evidence-based training/awareness programs for students, parents and staff;
- » Train educators on warning signs of MHSUD in students;
- » Implement social emotional training programs for educational staff, school-based administrators and parents;
- » Take a public health approach to addressing MHSUD;
- » Establish statewide 24/7 helpline for public and private services to those in need;
- » Evaluate current state laws in terms of human and civil rights discrimination;
- » Establish statewide zero suicide model;
- » Work in collaboration with veterans groups in each state and county and consider a zero suicide model by county and for each school district.

Judicial

People living with MHSUD are inappropriately housed in jails and prisons with inadequate programming. Sentencing reform and prison programming is lacking across the country and policymakers need to develop standardized, evidence-based assessments for appropriate placements and ensure that treatment programs are evidence-based and person-centered.

Victor Carrion, M.D., chair of the Mental Health Services Oversight and Accountability Commission in California, calls the Los Angeles jail system “the biggest mental health institution in the world.”¹¹⁰ That’s because a large portion of the jails’ inmates suffer from some form of mental illness or substance use disorder. In fact, from 2013 to mid-2016, the number of L.A. jail inmates jumped 34 percent, from 3,081 to 4,139, even as the total number of inmates dropped.¹¹¹ A California Department of Corrections spokesman said 37 percent of prison inmates in the state suffered from some sort of mental illness.¹¹²

“There are many challenges in the jail system because the population is so heterogeneous that it’s very difficult to give appropriate treatment,” Carrion said.¹¹³

While people were getting treatment, Toby Ewing, executive director of the commission, said the prison environment is not conducive to recovery. “People with mental illness make very bad prisoners,” Ewing said. People need to get help to leave the system better. “That’s a really tall order for jailers who were not trained, who do not have the resources and the physical environment” to provide the necessary treatment.¹¹⁴

The Council of State Governments’ Justice Center, the National Association of Counties and the American Psychi-



Victor Carrion, M.D., chair of the Mental Health Services Oversight and Accountability Commission in California, calls the Los Angeles jail system “the biggest mental health institution in the world.” That’s because a large portion of the jails’ inmates suffer from some form of mental illness or substance use disorder.

atric Association Foundation in 2015 launched Stepping Up, an initiative aimed at reducing the number of inmates with mental illness in jails and prisons around the country.¹¹⁵

“We need significant reforms so we can get people with serious mental illness out of our prisons and jails and into treatment,” said American Psychiatric Association President Renée Binder, M.D. “Once incarcerated, people with mental illness struggle to access the appropriate care and treatment options they desperately need.”¹¹⁶

In 1997, four jurisdictions developed mental health courts as a way to divert people with mental illness from the court system; today, more than 300 mental health courts are operating in nearly every state.¹¹⁷ The CSG Justice Center defines a mental health court as “a courtroom-based program that brings together members of criminal justice and behavioral health systems, among others, to work with people with mental illnesses who face criminal charges.”¹¹⁸ These courts modify traditional court process and target participants’ needs with a “therapeutically oriented path of court supervision and behavioral health treatment.”¹¹⁹

When Congress passed the 21st Century Cures Act in 2016, it included provisions of two bipartisan bills aimed at serving people with mental illness in the criminal justice system. Michael D. Thompson, director of the Justice Center, blogged in December that the act reauthorizes millions of dollars for innovation at the state and local level to reduce the number of people with mental illness in jails and prison, supports efforts to help people recognize signs of untreated mental illness, and expands treatment and transitional

services for people with mental illnesses and substance use disorders leaving jails and prison.¹²⁰

“Each of these measures alone might not be as eye-popping as something like the ‘cancer moonshot,’ but they collectively propel upgrades to state criminal justice policy and stimulate innovation in rural and urban counties alike,” Thompson wrote.¹²¹

But Debbie Plotnick, of Mental Health America, calls mental health courts “the stage four approach,” meaning participants have long had the problems that place them in the judicial process.¹²²

“The problem with them is they don’t help people until they get involved with the justice system,” she said. “Once they get involved with the justice system, it messes up other things in their lives.”¹²³ She’d like to see more money spent on early intervention or prevention, if possible. That, she believes, will cut the need for the higher cost funding of the stage our programs, like mental health and substance abuse courts.

But she acknowledges the need is there for mental health courts, and Mental Health America generally supports the specialty courts for reducing the number of people with mental illnesses in the criminal justice system or facing the stigma by a criminal conviction. The organization also supports the courts’ intent to improve mental health services and provide diversion as early as possible. But it opposes courts that are intended to or result in bringing more people with mental illnesses into the criminal justice system.¹²⁴

Kentucky state Rep. Joni Jenkins said the Bluegrass State has worked to walk that fine line of available funding versus mounting needs. “We’ve done a lot of work in Kentucky on a limited budget trying to fund more treatment and looking at these issues not as a criminal justice issue, but as a public health issue,” she said.¹²⁵

In 2016, Kentucky lawmakers considered legislation that would allow a judge to order outpatient medical treatment for some mentally ill Kentuckians, Jenkins said. “It’s so hard on families because very often the person affected doesn’t realize how much they need treatment,” she said. Oftentimes, those individuals end up in the criminal justice system. “We’ve seen in Kentucky so many folks who really have mental illness and they filter in and out of the criminal justice system. It’s not the proper place for them to get treatment.”¹²⁶

Once people with mental health and substance use disorders are in the jails and prisons, they need assistance transitioning to the outside world once they are released. The 21st Century Cures Act expands the amount of money to help with that, but some states are looking at other avenues. Sita Diehl of NAMI said the Stepping Up initiative has a set of principles and procedures to help communities get people into services. But it’s important, she said, for jails and prisons to connect individuals with mental illness and substance use

disorders to services throughout the transition process. “If they can get those services to kick in before the person gets out the door, they can link the person to services outside,” Diehl said. Some of those transition services are dependent on Medicaid, which will likely face changes with the new administration in Washington, D.C. “If Medicaid goes away or if Medicaid gets block granted, it’s going to be difficult to connect these people with services,” she said.¹²⁷

The Stepping Up initiative is gathering best practices in interventions with individuals with mental illness throughout the process. Law enforcement officers get intensive training specifically on intervening and de-escalating situations, Diehl said.¹²⁸

Some states are investing in better mental health care and transition services for people in the criminal justice system with mental health and substance use disorder issues. Utah in 2014, for example, included in its Justice Reinvestment Initiative \$3.35 million to expand access to behavioral health treatment and \$2.08 million to develop the Division of Adult Probation and Parole to help transition inmates back into society. It also included nearly \$5 million to the Division of Substance Abuse and Mental Health to expand treatment and provide training on addressing the needs of individuals with MHSUD issues.¹²⁹

The Women In Government Task Force offers these recommendations with regard to the judicial system:

- » Increase funding for diversion and specialty courts, re-entry and exit programs so that treatment is first action versus incarceration;
- » Develop appropriate sentencing for low level, nonviolent drug use and abuse – lower or eliminate mandatory minimum sentencing;
- » Evaluate current prison and jail populations for alternative placement for treatment and provide appropriate treatment programs and education;
- » Provide guidelines and training on the appropriate use of solitary confinement;
- » Prioritize funding for community support programs over diversion programs;
- » Focus criminal justice reforms on individual patient needs with a particular focus on addressing drug trafficking;
- » Make mental health and drug courts available in all geographical areas;
- » Focus on inappropriate prescribing of controlled substances and e-prescribing by providers and clinicians.

Recovery

There are multi-faceted challenges to all stages of recovery and maintaining sobriety and treatment.

Recovery for people with mental health and substance abuse disorder issues is often a long-term process that



“It’s not a question of bad people. It’s a question of people who have a disease and want very much to be very healthy again.” That stigma of being associated with having mental health or substance use disorder issues could delay or prevent people who need help to reach out “because it changes the way you are seen in the community.”

—Rep. Joni Jenkins
Kentucky

requires a multi-pronged approach that requires a circle of care from health care professionals, family and friends. It’s important that those people affected by MHSUDs recognize their condition is like those who have physical ailments, and that will require elimination of stigma associated with these disorders, experts say.

“It’s not a question of bad people,” said Kentucky Rep. Joni Jenkins. “It’s a question of people who have a disease and want very much to be very healthy again.”¹³⁰ She said that stigma of being associated with having mental health or substance use disorder issues could delay or prevent people who need help to reach out “because it changes the way you are seen in the community.”¹³¹

While awareness about mental health and substance use disorder is growing, stigma surrounding the issues is slow to fall. Toby Ewing, executive director of the Mental Health Services Oversight and Accountability Commission in California, said that’s a “foundational issue” that must be addressed.¹³² He stresses a need for understanding that “mental health is real and it isn’t about a character flaw that there are real physiological, emotional and social challenges out there.”¹³³

Victor Carrion, M.D., chair of the Mental Health Services Oversight and Accountability Commission, suggested a need to integrate physical and mental health to improve care and recovery. “When I started my work in the commission I wanted to really emphasize that there is no barrier between physical health and mental health,” he said. But, he added, it’s necessary to maintain independent recognition of mental health issues so they don’t lose funding to other health areas. “So it’s still important to continue to use the term mental health and to emphasize that work but the reality is that we know that stress and trauma and adversity affects not only mental health but it has direct correlations with how individuals do physically,” he said.¹³⁴

In fact, substance use disorder is associated with several physical ailments, including heart and liver disease, cancer, HIV/AIDS and problems that occur when women use alcohol or drugs during pregnancy.¹³⁵ And substance misuse is often connected to mental health disorders.¹³⁶

“This is one of the big topics on the agenda nationally is that whole person care,” said Ewing. “How do we really meet people where they are and understand what’s driving some of their health needs, whether it’s mental health or physical health, and see that connection? The service delivery systems are fairly separate at this point. We’re looking forward to opportunity to work with counties and other partners to figure out how to rethink that delivery system so that we’re not separating those.”¹³⁷

While treatment is available for MHSUD, these conditions¹³⁸ are often chronic conditions and require long-term treatment during the recovery process. Many of the strategies used in other policy areas—such as providing education in schools, utilizing intervention programs for youth and mandated MHSUD treatment in the court system—are valuable efforts to the recovery process. The U.S. Surgeon General’s report, “Facing Addiction in America,” recommends the use of recovery supports, including peer recovery services, for people recovering from substance use disorder.¹³⁹ The report also supports the use of medications for treating substance use disorders, along with behavioral therapies, where appropriate.¹⁴⁰

States can ensure the services individuals in recovery for substance use disorders are getting quality treatment. A 2012 report from the National Association of State Alcohol and Drug Abuse Directors found a variety of requirements for both inpatient and outpatient services. For instance, only 21 states required distinct licensure for inpatient treatment of substance use disorders.¹⁴¹ Thirty-five states required specific licensure for inpatient care—both long-term and short-term—and 36 states have licensure requirements for outpatient care.¹⁴²

Debbie Plotnick of Mental Health America stresses the need for a comprehensive look at the problem from a state policy perspective. That, she says, will bring better results for the patient and for the state budget.

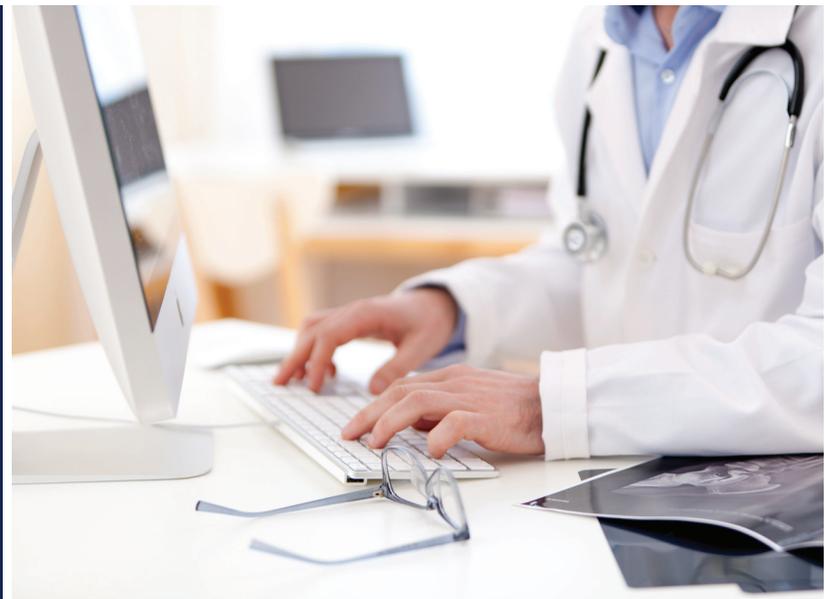
“One of the things states legislatures do regularly is look at individual pieces of state budgets that cost so much that are related to behavioral health. They often look at Medicaid formulary costs and mental health medications cost a great deal of money,” she said. “One of the things not looked at because state budgets are in silos and have individual budget lines: Cutting one thing has ripple effects. When you cut the medication budget people can stop taking medications. People go off medications because they can’t access medications then they end up in the more expensive systems”—emergency rooms, county jails or state prisons.¹⁴³ That, she said, also inhibits their recovery efforts.¹⁴⁴

The Women In Government Task Force offers these recommendations with regard to recovery:

- » Establish state credentialing standard of care for recovery services;
- » Develop court-mandated mental health/substance use disorder treatment
- » Authorize pilots of utilization and reimbursement of long-acting injectables for MHSUDs;
- » Encourage/incentivize community-based coalitions;
- » Develop ACES screening and appropriate interventions for children and youth;
- » Adopt mental health parity and addiction equity act;
- » Consider substance use disorders as chronic so treatment will include both episodic and long-term management;
- » Create peer support intervention at ER and criminal justice locations to educate and encourage treatment of MHSUDs;
- » Establish alternatives to court-ordered mandate—voluntary mental health and substance use court (like drug court, veteran’s court, etc.) and offer a roadmap to recovery;
- » Encourage the department of health to integrate mental health/substance use recovery services with general health services for those with co-occurring interactive disorders regardless of the location of service delivery;
Encourage individual treatment plans that cater to the changing needs for those with serious mental illnesses. These plans should include such things as health care, education, housing, rehabilitation and community support services;
- » Have state Medicaid agencies investigate potential opportunities to be more invested in comprehensive programs such as housing, employment, parenting skills, etc.;
- » Include treatment providers and specialists, local prevention coalitions, family members of patients in recovery planning;
- » Provide education and support activities for family, friends and peers to assist those living with MHSUDs;
- » Implement a public education campaign to reduce the stigma associated with MHSUD;
- » Integrate recovery strategies with holistic health strategies so it’s not seen as a separate disorder.

“Today, opioid overdose deaths are more common than deaths from car crashes. Our study provides support that prescription drug monitoring programs are part of what needs to be a comprehensive approach to the prescription opioid epidemic.”

—Stephen Patrick, M.D., MPH, M.S.
assistant professor
Pediatrics and Health Policy
Monroe Carell Jr. Children’s Hospital
Vanderbilt University



Data

Data collected on mental health and substance use disorders needs to be effectively collected/utilized to better serve individuals with these conditions. The data that is being collected is not being shared and there is a lack of understanding of what is being spent for data collection.

When Massachusetts created the Center for Health Information and Analysis, or CHIA, in 2012, the goal was to ensure the commonwealth was contain the increases in health care costs. But Massachusetts Rep. Jennifer Benson, a WIG state director, believes it can be targeted to see the trends in how mental health and substance use disorder issues are treated.

The data currently are used to analyze cost trends and the consumption of various services. “They could be looking at mental health issues and trends around pharmaceutical use and prescribing practices and looking at those things in tandem,” she said. “We could take it a step further and look at historic trends between prescribing and increases in mental health and substance use issues.”¹⁴⁵

The data are so robust that researchers could look at cohorts of people and determine, for instance, whether there is an increase in depression in elderly adults. That analysis could then be shared with the Department of Mental Health, she said.¹⁴⁶

The Women In Government National Task Force on Mental Health and Substance Use Disorders found data sharing was one area in which states could improve their efforts. In fact, some members of the task force found the dearth of data collected hampers efforts to improve care.

“Data is severely lacking in many areas,” said Massachusetts Sen. Jennifer Flanagan. “Massachusetts has made collecting data a priority.”¹⁴⁷

In fact, the Bay State was one of the first states to adopt a prescription drug monitoring program. These electronic databases track the prescribing and dispensing of controlled substances to look for possible abuse or diversion.¹⁴⁸ The Centers for Disease Control and Prevention call the PDMPs “among the most promising state-level interventions to improve opioid prescribing, inform clinical practice and protect patients at risk.”¹⁴⁹

Flanagan lauded the success of the Massachusetts program. “PMP has greatly increased the oversight in the amount of doctor shopping and pill prescribing taking place,” she said. “I am pleased to say that PMP was recently updated in Massachusetts and is being used frequently by our doctors.”¹⁵⁰

The fiscal impact of substance misuse and substance use disorders on states and communities is huge. “Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs and Health” puts the annual economic impact of substance misuse and substance use disorders on states and communities at \$442 billion—\$249 billion for alcohol misuse and \$193 billion on illicit drug use.¹⁵¹ Beyond the fiscal impact are the societal consequences including increased alcohol- and drug-related crime and violence and motor vehicle accidents, as well as the increase in health care costs.¹⁵²

State prescription drug monitoring programs provide the data to help contain some of those economic and societal effects. Researchers at Vanderbilt University found prescription drug monitoring programs were associated with a decrease in deaths from opioid overdoses.¹⁵³ Specifically, researchers found, “States with the most robust programs saw the greatest reduction in overdose deaths: these states monitored and tracked a greater number of substances with abuse potential and updated their data more frequently (at least weekly).”¹⁵⁴

“Today, opioid overdose deaths are more common than

deaths from car crashes. Our study provides support that prescription drug monitoring programs are part of what needs to be a comprehensive approach to the prescription opioid epidemic,” said lead author Stephen Patrick, M.D., MPH, M.S., assistant professor of Pediatrics and Health Policy in the Division of Neonatology at Monroe Carell Jr. Children’s Hospital at Vanderbilt.¹⁵⁵

“This work is important not only because it demonstrates that prescription drug monitoring programs can save lives, but also because it shows that there are specific actions that states can take to strengthen their programs,” said Melinda Buntin, Ph.D., professor and chair of the Department of Health Policy at Vanderbilt and senior author of the study.¹⁵⁶

Missouri is the only state lacking a prescription drug monitoring program, but in some states, like South Carolina, participation in the database is voluntary. South Carolina Rep. Phyllis Henderson hopes to change that. She is working on legislation that would require physicians to register in the database. Now, only about a quarter of doctors are actually registered, she said.¹⁵⁷

“The good news for us is that Medicaid last year implemented a mandatory use of the database,” she said. “If you’re a doctor and you want to get reimbursed by Medicaid, you have to use the database.” Blue Cross/Blue Shield, the largest insurer in the state, also enacted that requirement in 2015, Henderson said.¹⁵⁸

Benson said the prescription monitoring programs offer real-time information on prescribing practices by individual doctors. That’s good data to have, but she thinks more information could lead to better policy surrounding MHSUD issues. She believes CHIA can help Massachusetts, and other states that adopt a similar system, paint a better picture of the long-term trends around these issues. “It gives you the opportunity—along with prescription monitoring, along with anecdotal data—it gives you that data set to look at larger and long-term trends,” Benson said.¹⁵⁹

The Women In Government Task Force offers these recommendations with regard to the data on mental health and substance use disorder issues:

- » Provide a centralized data hub for MHSUD data and have a separate entity to monitor data hub;
- » Expand Massachusetts/CHIA-like programs to include MHSUD data from corrections, health plans and first responders;
- » Mandate prescription monitoring programs to include aggregate data from schools with special category to include “emotional disturbance”;
- » Abolish silos by combining data from major state agencies and ensure state keeps a comprehensive master list of public, private and nonprofit service providers;
- » Allow data to be shared across state lines. Use prescription monitoring data to monitor physician practice patterns;

- » Coordinate insurance claim data to ascertain level of MH-SUD treatment and provision of care;
- » Conduct a survey of providers to determine total dollars spent and percentage of administrative expenses versus direct services to consumers;
- » Measure outcomes by number serviced and rate of recidivism;
- » Reallocate funds from incarceration to community-based programs.

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MENTAL HEALTH & SUBSTANCE USE DISORDERS

legislation

US HR 6

21st Century Cures Act

- » Will authorize the Minority Fellowship Program to train culturally competent minority mental health professionals, reauthorize the Graduate Psychology Education Program and include health service psychology programs and internships in a new demonstration grant program for academic programs to improve the diagnosis and treatment of mental health and substance use disorders and provide services in underserved and community-based settings.
- » Eliminate the Medicaid “same day” exclusion, which prohibits separate payment for mental health and primary care services provided to a Medicaid enrollee on the same day. This change will especially benefit individuals in rural areas.
- » Strengthen the enforcement of mental health parity requirements by directing the Department of Health and Human Services to produce, in coordination with stakeholders, an action plan for improved federal and state coordination, and to issue new guidance to health plans to assist them in complying with existing requirements.
- » Enhance mental health and substance use treatment for children and families, including reauthorizing the National Child Traumatic Stress Network to support children recovering from trauma, and support for screening and treatment of maternal depression.
- » Include provisions that address mental health issues in the criminal justice system, such as increased funding and new authority for the Justice and Mental Health Collaboration Program, law enforcement training and alternatives to incarceration.
- » Primary Sponsor
 - US Representative Fred Upton (R-MI)

- » Latest Action
 - Signed into law on December 13th 2016

IL SB 320

Mental Health Opportunities for Youth Diversion Task Force

- » Creates a task force to develop an action plan for State and local law enforcement and other agencies to increase the number of youth diverted into community-based mental health treatment rather than further engagement with the juvenile justice system.
- » Primary Sponsors
 - Sen. Donne Trotter (D)
 - Rep. Sara Feigenholtz (D)
- » Latest Action
 - Enacted on August 26, 2016

CA AB 1618

Mental Health Services Act

- » This measure establishes a ‘No Place Like Home’ Program through the California Department of Housing and Community Development. The program creates a competitive atmosphere for counties to finance capital costs, including, but not limited to, acquisition, design, construction, rehabilitation, or preservation, and to capitalize operating reserves, of permanent supportive housing for targeted populations.
- » Primary Sponsor
 - Assembly Committee on Budget- Committee Chair Rep. Philip Ting (D)
- » Latest Action
 - Enacted on July 1, 2016.

AK HB 234

An Act relating to insurance coverage for mental health benefits provided through telehealth

- » Amends Alaska insurance statutes to require that insurance providers in the state who, either by group plan or individual market, provide mental health benefits should provide coverage for this care through telemedicine.
- » Primary Sponsor
 - Rep. Elizabeth Vazquez (R)
- » Latest Action
 - Enacted on June 14, 2016

CO SB 16-147

Suicide Prevention Through Zero Suicide Model

- » Establishes a Colorado Suicide Prevention Plan to reduce the number of deaths by suicide. The Colorado plan will be based on components of the “zero suicide” model. The “zero suicide” model is built on goal that suicide deaths of individuals who are under the care of our health care systems, including mental and behavioral health systems, are frequently preventable. The “zero suicide” model includes valuable components, such as leadership, training, patient engagement, transition, and quality improvement.
- » Primary Sponsors
 - Sen. Linda Newell (D)
 - Sen. Beth Martinez Humenik (R)
 - Rep. Brittany Pettersen (D)
- » Latest Action
 - Enacted on June 10, 2016

CO HB 16-1103

License Pathways for Mental Health Workforce

- » Clarifies that graduates must “have completed” their degrees (rather than “hold”) in order to fulfill the educational requirements for licensure. This change will expedite the licensure process significantly; clarifies the recommended pathway a student should take for licensure in Colorado.
- » Primary Sponsors
 - Rep. Lois Landgraf (R)
 - Sen. Beth Martinez Humenik (R)
 - Sen. Nancy Todd (D)
 - Rep. Tracy Kraft-Tharp (D)
- » Latest Action
 - Enacted on April 15, 2016

FL SB 1534

Housing Assistance

- » Florida State Apartment Incentive Loan Program so that non-profit organizations are included in projects that provide mortgage loans for affordable housing to very low income people.
- » Primary Sponsors
 - Sen. David Simmons (R)
 - Senate Committee on Appropriations
- » Latest Action
 - Enacted on April 8, 2016

MN SF 2753

Mental Health Crisis Response Peace Officer Training

- » Established a list of training courses to instruct peace officers (who hold a license) techniques for responding to a mental health crisis. The course must include instruction on, (1) techniques related to individuals with mental illness and their families, (2) crisis de-escalation, (3) diverse communities and education of mental health diversity, (4) mental illness and the criminal justice system, (5) education on community resources and supports for individuals experiencing a mental health crisis, (6) education of psychotropic medications and their side effects, (7) education on co-occurring mental illness and substance use disorders, (8) education on suicide prevention, (9) education on mental illness and their symptoms. The course must also provide information on mental health crisis teams in the officer’s jurisdiction and a summary of services offered by the team as well as contact information to help both an individual and their children and family. This training will be part of a continuing education model.
- » Primary Sponsor
 - Sen. John Marty (D)
- » Latest Action
 - March 2016; House to pass as amended and re-refer to Finance Committee

FL HB 439

Mental Health Services in the Criminal Justice System (based on Miami-Dade/Judge Leifman model)

- » Authorizes the creation of treatment-based mental health court programs; creates the Forensic Hospital Diversion Pilot Program; authorizes courts to order certain offenders on probation or community control to post adjudicatory mental health court programs.

- » Primary Sponsor
 - Rep. Charles McBurney (R)
- » Latest Action
 - Enacted March 28, 2016
- » Similar Bills
 - FL HB 604

IN HB 1102

Criminal Justice Matters

- » Directs the department of correction to make grants to county jails to provide evidence based mental health and addiction forensic treatment services from funds appropriated to the department. Requires the commissioner of correction to coordinate with the division of mental health and addiction when issuing community corrections and court supervised recidivism reduction program grants. Requires collaboration among: (1) the probation department; (2) the community corrections program; and (3) any other local criminal justice agency that receives funding from the department; when creating a community corrections plan.
- » Primary Sponsors
 - Rep. Gregory Steuerwald (R)
 - Sen. Brent Steele (R)
 - Sen. R. Michael Young (R)
 - Sen. Lonnie Randolph (D)
- » Latest Action
 - Enacted March 21, 2016

WI AB 766

Prescription Drug Monitoring Program

- » This bill creates program review and reporting requirements for the Prescription Drug Monitoring Program (PDMP) administered by the Controlled Substances Board. Beginning in 2017, the bill requires the board to conduct an annual review of the PDMP to evaluate the actual program outcomes compared with projected outcomes. That review must include an evaluation of the satisfaction with the PDMP of pharmacists, pharmacies, practitioners, and other users of the PDMP and the PDMP's impact on referrals of pharmacists, pharmacies, and practitioners to relevant boards for discipline and to law enforcement agencies for investigation and prosecution.
- » Primary Sponsors
 - Rep. John Nygren (R)
 - Rep. Gary Tauchen (R)
 - Rep. John Spiros (R)
 - Rep. Kevin Petersen (R)

- Rep. Tom Larson (R)
 - Rep. Romaine Quinn (R)
 - Rep. Michael Rohrkaste (R)
 - Rep. Mary Czaja (R)
 - Rep. Warren Petryk (R)
 - Rep. Joe Sanfelippo (R)
 - Rep. Terry Katsma (R)
 - Rep. Dan Knodl (R)
 - Rep. Alvin Ott (R)
 - Rep. Joel Kitchens (R)
 - Rep. Todd Novak (R)
 - Rep. Jesse Kremer (R)
 - Rep. James Edming (R)
 - Rep. Cindi Duchow (R)
 - Rep. Travis Tranel (R)
 - Rep. Robb Kahl (D)
 - Rep. Jill Billings (D)
 - Rep. Debra Kolste (D)
 - Rep. Evan Goyke (D)
 - Rep. Tod Ohnstad (D)
 - Rep. David Considine (D)
 - Rep. Gordon Hintz (D)
- » Last Action
 - Enacted March 17, 2016

VA HB 197

Mental Health First Aid Program

- » Establishes a Mental Health First Aid Program in VA to provide training by certified trainers of individuals residing or working in the Commonwealth on how to identify and assist individuals who have or may be developing a mental health or substance use disorder or who may be experiencing a mental health or substance abuse crisis. The program will include, (1) training on building mental health and substance abuse literacy to help the public identify, understand, and respond to signs of mental illness and substance abuse; (2) assist individuals who have or may be developing a mental health or substance use disorder or who may be experiencing a mental health or substance abuse crisis by (i) recognizing the symptoms of a mental health or substance use disorder; (ii) providing initial assistance to those experiencing a mental health crisis; (iii) guiding individuals requiring assistance, including individuals who may be experiencing a mental health or substance abuse crisis, toward appropriate professional assistance; (iv) providing comfort to an individual experiencing a mental health or substance abuse crisis; (v) helping an individual with a mental health or substance use disorder avoid a mental health or substance abuse crisis that may

lead to more costly interventions and treatments; and (vi) promoting healing, recovery, and good mental health.

- » Primary Sponsor
 - Del. L. Scott Lingamfelter (R)
- » Latest Action
 - Enacted March 11, 2016

AZ HB 2107

Substance Abuse Recovery Homes

- » Allows cities and towns to adopt ordinances regarding health and safety standards and enforcement mechanisms for structured sober living homes.
- » Primary Sponsors
 - Rep. Noel Campbell (R)
 - Rep. Sonny Borrelli (R)
- » Latest Action
 - Enacted on May 17, 2016

MA SB 2133 (2014)

An Act To Increase Opportunities For Long-Term Substance Abuse Recovery

- » Requires insurers to reimburse patients for addiction treatment from licensed counselors, which will improve access to treatment for those struggling with addiction.
- » Removes prior-authorization requirements for outpatient substance abuse treatment and provides for coverage of up to 14 days in an inpatient setting, if deemed medically appropriate. This provision will remove barriers to treatment that some patients have experienced and gives patients and clinicians discretion over a patient's treatment plans.
- » Gives the Department of Public Health (DPH) new regulatory authorities to reduce abuse of opioids and provides emergency scheduling powers to temporarily ban dangerous substances like bath salts and K2, when circumstances warrant. This will stem the tide of dangerous substances that are fueling the addiction epidemic.
- » Requires chief medical examiners to report overdose deaths to DPH and the U.S. Food and Drug Administration, improving the ability of public health agencies to quickly identify and implement measures to reduce the risk of further overdoses.
- » Primary Sponsor
 - Senate Committee on Ways and Means
- » Latest Action
 - Enacted on August 6, 2014

MA HB 4056

An Act Relative To Substance Use, Treatment, Education And Prevention

- » A comprehensive bill touching on practitioner training, reporting, opiate alternatives, insurance coverage, prevention education, and data collection.
- » Primary Sponsors
 - Sen. Jennifer Flanagan (D)
 - Rep. Brian Dempsey (D)
 - Rep. Elizabeth Malia (D)
 - Rep. Randy Hunt (R)
 - Sen. Karen Spilka (D)
 - Sen. Viriato Manuel deMacedo (R)
- » Latest Action
 - Enacted on March 14, 2016

WI AB 446 (2014)

- » This bill amends existing statutes to include training and agreements for administering the drug naloxone, requiring emergency medical technicians to carry naloxone, and immunity for certain individuals who administer naloxone.
- » Latest Action
 - Enacted on April 4, 2014

WI AB 447 (2014)

- » This bill provides immunity from certain criminal prosecutions for a person (aider) who brings another person to an emergency room or other health facility, who summons police or emergency medical assistance, or who administers aid to another person because the aider believes the other person is suffering from an overdose or other adverse reaction to a controlled substance or a controlled substance analog.
- » Latest Action
 - Enacted on April 7, 2014

WI AB 448 (2014)

- » Under this bill, the Department of Justice (DOJ) may authorize the operation of drug disposal programs in this state to receive, for destruction, drugs, including prescription drugs, controlled substances and controlled substance analogs, and certain medical and drug delivery devices (collectively, pharmaceutical items).
- » Latest Action
 - Enacted on April 7, 2014

WI AB 701 (2014)

- » This bill requires the Department of Health Services (DHS) to create two or three regional comprehensive opioid treatment programs to provide treatment for opiate addiction in rural and underserved, high-need areas
- » Latest Action
 - Enacted on April 7, 2014

WI AB 364

- » States that when law enforcement encounters an inappropriate use or an infraction of the law concerning scheduled drugs, they upload that information into the PDMP and have the PDMP notify the physician. There are exceptions for on-going investigations.
- » Latest Action
 - Enacted on March 17, 2016

WI AB 367

- » Requires methadone clinics to gather data such as staffing ratios, the number of patients receiving behavioral health services with the medication, and average mileage an individual is traveling to come to a clinic. This information will then be reported to DHS on an annual basis to give public health and treatment professionals a chance to analyze outcome data.
- » Latest Action
 - Enacted on March 17, 2016

WI AB 658

- » Criminalizes the use, possession, manufacture, distribution, and advertisement of any substance or device that is intended to defraud, circumvent, interfere with, or provide a substitute for a bodily fluid in conjunction with a lawfully administered drug test.
- » Given that many employers subject their employees to lawfully administered drug tests, this bill will help ensure that people are not defrauding or interfering with the test results.
- » Latest Action
 - Enacted on March 17, 2016

WI AB 660

- » Allows a number of medical-affiliated boards under the Department of Safety and Professional Services (DSPS) to issue guidelines regarding best practices in prescribing controlled substances. These best practices will help reduce

instances of overprescribing and, in turn, lessen prescription opioid misuse, abuse, and addiction.

- » Latest Action
 - o Enacted on March 17, 2016

WI AB 766

- » Creates reporting requirements for the Prescription Drug Monitoring Program (PDMP). The data collected will be reviewed and evaluated by the Controlled Substances Board (CSB) to determine the effectiveness of the PDMP and to compare actual outcomes with projected outcomes.
- » Latest Action
 - Enacted on March 17, 2016

Holmes Youthful Training Act Revisions (MI): New approach to prevent certain young offenders from having a criminal record.

- » Original Bill: The Department of Corrections describes the Holmes Youthful Trainee Act as a state law that allows a judge to place a youth between 17 and 20 who is alleged to have committed a crime and who has pleaded guilty to that crime to be placed in prison or on probation without a conviction to avoid a criminal record. Excluded from this program are youth who are charged with a felony for which the maximum punishment is life imprisonment, a major controlled substance offense or a traffic offense. This action protects the privacy of the offender while on trainee status. If the youth successfully completes the program, there is no criminal record. Imprisonment or probation cannot exceed three years.

HB 4069

- » Expands age of offenders eligible for trainee status under HYTA to include 21-23 year olds
- » Requires consent of prosecutor for assignment of youths 21-23
- » Allows court to require trainee to work, attend school, or wear an electronic monitor at any time during probationary period
- » Primary Sponsor
 - Rep. Harvey Santana (D)

HB 4135

- » Requires court to revoke trainee status if individual convicted of certain crimes during assignment to trainee status
- » Primary Sponsor
 - Rep. Kurt Heise (R)

HB 4169

- » Revises original option to send trainee to prison
- » Prohibits assignment to prison for certain underlying charges
- » Creates alternative of prison/jail with community service
- » Each provision applies to cases on or after bill's effective date
- » Primary Sponsor
 - Rep. Marcia Hovey-Wright (D)
- » All three bills took effect on 8/18/2015
- » Presumptive Parole (MI)

HB 4138

- » Amends Michigan's Corrections Code's parole guidelines aligned with statutory requirements that carries a high degree of discretion among members of the parole board
- » Specifies no inherent entitlement to parole
- » Presumes (absent substantial reasoning to the contrary) that offenders designated with "high probability of parole" score will not be menace to society and released after serving minimum sentence ("presumptive parole")
- » Apply presumptive parole only to prisoners transferred to DOC on or after bill's effective date and will not be applied to any serving a life sentence
- » Require parole eligibility report to include result on any validated risk assessment
- » Defer prisoner's parole to allow time to finish treatment program
- » Primary Sponsor
 - Rep. Kurt Heise (R)
- » Passed Michigan House 10/01/2015
- » Alternative Custody (CA)

SB 219

- » Existing California law authorizes Secretary of Corrections and Rehabilitation to offer a program in which female inmates committed to state prison may be allowed to participate in an alternative form of custody
- » These alternative forms include confinement to residency, drug treatment program, or transitional care facility
- » Female inmates serving determinate sentences and meet certain criteria shall be eligible
- » Existing law also requires suspension of certain medical benefits to those in prison/jail and state to retain respon-

- sibility for medical needs (medical, mental, and dental) of those enrolled in alternative custody program
- » Provides that an inmate's existing mental or psychiatric condition requiring ongoing care and attention is not a basis of exclusion for program's eligibility
- » Prescribes specific timeframes for application review, notifying applicants of their status, development of individualized treatment plan, and release into program
- » Requires notice of denial to specify reasons for denial and allows opportunities to reapply or appeal
- » Requires assistance of those participating in alternative custody program in obtaining health care coverage; the state would be responsible for all outstanding coverage of participants
- » Primary Sponsor
 - Sen. Carol Liu (D)
- » Bill Approved by Governor 10/10/2015
- » Helping Families in Mental Health Crisis (Fed)

HR 2646

- » Creates the position of Assistant Secretary for Mental Health and Substance Use Disorders to take over from Administrator of Substance Abuse and Mental Health Services Administration (SAMHSA)
- » SAMHSA must establish National Mental Health Policy Laboratory and Interagency Serious Mental Illness Coordinating Committee
- » Amends Public Health Service Act to require National Institute of Mental Health to translate evidence-based interventions into systems of care
- » Pediatric mental health specialists are eligible for National Health Service Corps programs
- » An underserved population of children can be designated as health professional shortage area
- » Protected health information of those with a serious mental illness may be disclosed to caregivers under conditions
- » Amends Title XIX (Medicaid) of Social Security Act to conditionally expand coverage of mental health services
- » Part D (Voluntary Prescription Drug Benefit Program) of Title XVIII (Medicare of Social Security Act amended to require coverage of antidepressants and antipsychotics
- » Primary Sponsor
 - Rep. Tim Murphy (R-PA)
- » Passed U.S. House 07/06/2016



Bank of Tweets and Facebook Posts for Mental Health & Substance Use Disorders

Twitter

1 in 5 people have a **#mentalhealth** condition, but most won't receive **#treatment**, **@MentalHealthAm** says. **#WIGToolkit**

Report from **@Surgeon_General**: 1 in 7 people will develop substance use disorder in their lifetime. States need to focus on **#addiction**. **#WIGToolkit**

Toolkit from **@WomeninGovt** offers smart suggestions for state policy on **#mentalhealth** and substance use disorder. **#WIGToolkit**

Debbie Plotnick from **@MentalHealthAm** says "states are where all the actions happen for **#mentalhealth** and substance abuse."

National task force offers solutions for addressing **#mentalhealth** and substance use disorders. **#WIGToolkit**

#Housing, **#education**, **#healthcare**, **#judicial** play a role in addressing **#mentalhealth** & substance use disorder issues facing states. **#WIGToolkit**

Addressing **#mentalhealth** needs could help states deal with **#homelessness**. **#WIGToolkit**

Steinberg Institute's **@Anna4Health** told **@WomeninGovt** people with **#mentalillness** are more receptive to treatment if they have **#housing**. **#WIGToolkit**

Report from **@MentalHealthAm** found 19 percent of adults with **#mentalhealth** conditions lack **#access** to **#healthcare**. **#WIGToolkit**

Access to **#healthcare** sometimes blocked by lack of providers. Nationally, rate is 529-to-1. **#WIGToolkit**

#Alabama has highest rate of patients to **#mentalhealth** providers at 1,200-to-1; **#Massachusetts** has lowest at 200-to-1. **#WIGToolkit**

States must do more to attract **#mentalhealth** providers. **#MHSUD #WIGToolkit**

#FirstResponders must be trained on **#mentalhealth** and substance use disorder issues to prevent tragedies. **#WIGToolkit**

@JenFlanaganMA says states must invest in training on **#mentalhealth** & substance use disorders for **#firstresponders**. **#WIGToolkit**

States should provide education on **#mentalhealth** and substance use disorders to eliminate **#stigma**. **#MHSUD #WIGToolkit**

@WomeninGovt task force recommends training **#educators** on warning signs of **#MHSUD** in students. **#WIGToolkit**

The national **#CuresAct** gives states opportunities for innovation to help people with **#mentalillness** in **#judicial system**. **#WIGToolkit**

Economic impact of **#addiction** costs states \$193 billion yearly, **@Surgeon_General** report says. **#WIGToolkit #MHSUD**

States must address **#mentalillness** issues early to prevent problems from getting worse. **#WIGToolkit #MHSUD**

Facebook

A new toolkit from Women In Government offers states smart solutions for addressing problems that arise from mental health and substance use disorders. The report is the result of a yearlong study by members of a national task force of women in state government and other stakeholders interested in mental health and substance use disorder issues.

Massachusetts Sen. Jennifer Flanagan, co-chair of the Women In Government National Task Force on Mental Health and Substance Use Disorders, says states must "remain vigilant and active in the fight against substance use disorder, and to work to enhance mental health services that are desperately needed by many families across the country."

States must address the entire scope of the issues surrounding mental health and substance use disorders to better serve people with those problems. That includes access to coordinated, quality care, housing opportunities, training for professionals, education about the issues, better policies to care for people with **MHSUD** in the judicial system, access to recovery, and data to track the problem and successes in addressing the problem.



ABOUT WOMEN IN GOVERNMENT

Mission

Women In Government (WIG) is a national nonprofit, nonpartisan organization of women state legislators providing leadership opportunities, expert forums, educational resources and collegial networking, to address and resolve complex public policy issues. WIG serves as a member-informed, policy-driven organization leading the nation with a bold, courageous and passionate vision to empower and mobilize all women state legislators to drive sound policy.

Leadership

Women In Government's Board of Directors is composed of 13 female state legislators who guide the organizational activities, help recruit new members and provide support to implement WIG's strategic action plan. The Board is made up of both Democrats and Republicans, reflecting Women In Government's non-partisan nature.

Vision

Women In Government leads the nation with a bold, courageous and passionate vision that empowers and mobilizes all women legislators to effect sound policy.

History

Women In Government is soon to enter its 29th year. Since its founding, WIG has successfully implemented leadership and educational activities to support informed policy decisions at the state level. With over 28 years of experience working with state legislators, state agency representatives and the public, Women In Government proudly hosts educational conferences, state briefings, and other policy events annually to address the nation's public policy issues.

Women In Government ensures that members and partners are provided with up-to-date publications and resource materials on cutting-edge policy topics. Beginning in 2004, Women In Government launched Policy Resource Centers that provide educational materials and resource tools, including legislative toolkits, while identifying important policy issues and supporting state legislative activity.

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Through the support of sponsors, including corporations, foundations, and state and federal grants, Women In Government provides its members with legislative scholarships. These scholarships provide conference participants with opportunities to hear presentations from nationally noted expert speakers, receive comprehensive issue-based information and network with fellow policymakers, sharing best practices and developing policy solutions.





www.womeningovernment.org

1319 F Street, NW | Suite 402 | Washington, DC 20004
P (202) 333-0825 | F (202) 333-0875