HEALING THE NATION

Advancing Mental Health and Addiction Policy

WELL BEING TRUST

January 2020 (Version 1.0)

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FOREWORD

Whether you are a federal policymaker or an advocate fighting for change, you play an important role in the health and well-being of the American people. Thank you for taking the time to read this informative report, Healing the Nation, which details the depth and breadth of our country's mental health crisis, as well as important policy steps we must take to adequately address it.

It is no secret that those with mental health and addiction challenges continue to face a separate and unequal system of care of this country.

During my time in Congress, I was the lead sponsor of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), which requires most insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer.

Unfortunately, the legislation was never properly implemented or enforced—a reality that has undoubtedly contributed to the dire circumstances we see today in the form of skyrocketing rates of overdoses and suicides.

Many who seek care using private health insurance still face enormous roadblocks. A 2019 report by the actuarial firm Milliman found huge—and growing—out-of-network utilization disparities between mental health/addiction and medical/surgical care for inpatient facilities, outpatient facilities, and office visits. This means insured individuals are paying more out-of-pocket for mental health/addiction care than they are for medical care—largely because health plans continue to reimburse mental health/addiction providers far less than their primary care/specialist counterparts, causing those providers to stop accepting insurance altogether.

Consequently, people are depleting retirement accounts and taking out second mortgages to cover costs on their own. Frustrated families are often forced to give up when the money runs out and just hope for the best.

The Milliman report also found that in 2017, despite the rising rates of overdoses and suicides, only $1 out of every $100 spent on health care was for addiction treatment and only $1 out of every $25 was for mental health and substance use disorders combined.

This is unacceptable. And, sadly, it is just the tip of the iceberg.

As Healing the Nation points out, the cause of our mental health crisis is multifaceted and complex. To save lives, we have to unpack many important underlying factors—from separate and unequal mental health and addiction treatment systems to poverty, inequitable distribution of resources, and the loss of hope in communities.

As we begin a new decade, it is time to address the crisis with the same focus and urgency we would any other public health crisis.

The advocacy community has worked tirelessly to shine a spotlight on the deaths of despair that dominate national headlines but garner little federal policy action. Most recently, Mental Health for US, a nonpartisan educational initiative designed to elevate mental health and addiction in policy conversations during the 2020 election cycle, successfully united 90 organizations—representing tens of thousands of people from all walks of life—to speak with one powerful voice about the need for systemic change. I am proud to serve as co-chair of this initiative, along with former U.S. Sen. Gordon H. Smith.

It is my hope that all member organizations of Mental Health for US will take advantage of the policy framework identified within Healing the Nation so we can coordinate advocacy efforts moving forward and maximize results.

True progress will require a comprehensive approach to federal policy that connects the dots between health care, the judicial system, educators, employers, and community supports with clear, tangible action items. Efforts must be customized to meet the diverse needs of state and communities across this country—there is no one-size-fits-all solution.

True progress will also require an emphasis on innovation to break down existing silos and propel best practices. Game-changing technological advances must be fully embraced and funded in order to expand our reach for treating and preventing mental health and substance use disorders, especially in rural areas. And we must dramatically increase investments in research to create more effective treatments and improve patient outcomes.

Status quo is no longer acceptable.

I hope you will find Healing the Nation helpful in fighting for the people you serve. According to SAMHSA, one in five U.S. adults experienced mental illness in 2018 and one in 14 people aged 12 or older had a substance use disorder. Time is of the essence. Too many families have suffered due to federal inaction on this critical issue. Now is the time to stand up and demand better for our ourselves, our loved ones, our neighbors, and our friends.

Not only are the lives of millions of Americans currently at risk, but the well-being of future generations is on the line. We must set the standard now—there is no health without mental health—and declare 2020 the decade of integration, empowerment, and support.

Patrick J. Kennedy

Former U.S. Representative
Founder of The Kennedy Forum


OUR NATION
IS HURTING.

THE CAUSE OF OUR PAIN IS MULTIFACETED AND COMPLEX.

Increases in economic disparities, declines in social connectivity, increased discrimination based on race, gender, gender identity, country of origin and more, and the ever-challenging cost of health care coverage and access all play a role. Understanding these root causes matters if we are serious about preventing our current crisis from ever happening again. For our country to make a meaningful impact on what matters to people and their health, we are going to have to address their needs in comprehensive, culturally relevant, and community focused manner. While our country has made tremendous innovations in health care, it's our health and well-being that seems to be suffering the most.

For most of the past century, despite persistent disparities based on class and race, most Americans enjoyed an increase in average life expectancy due to advances in medicine, nutrition, and science. But in 2015, this trend changed. In fact, 2018 marked the longest sustained decline in lifespan since 1920. For the past three years, Americans have died younger and younger, primarily due to deaths from drugs, alcohol, and suicide. More lives were lost to these "deaths of despair" in 2017 than ever before, demanding a comprehensive, systemic response to battle the complex, multilevel causes of this epidemic. So, how do we bring healing to the people of our nation?

Policy makers at all levels have an opportunity to address these issues. However, to accomplish this in a meaningful way, we must develop a comprehensive approach that is bound in a tight framework supported by robust policy.

The goal of this document is to provide meaningful and actionable solutions to help advance mental health and addiction policy in this country. Using a systems framework, we outline specific ways that policy makers can take action to advance mental health in this country, and structure the solutions in an integrated fashion to have maximum impact for all of America.

What makes it so hard for people to get mental health care in America?

>33%
wait more than a week to access a mental health clinician

~50%
drive more than one-hour round trip to mental health treatment locations[1]

50%
of counties with no psychiatrist

111 million
people live in areas with mental health professional shortages[2]

10%
with an identified substance use disorder (SUD) received care

A mental health office visit with a therapist is
5x as likely to be out-of-network
when compared to a non-mental health office visit[3]

A Framework that Begins in Community

The audience for this document is federal policy makers. This is a living guide and additional versions of this work will be created for state policy makers and community leaders.

Before getting into the specifics of the policy, let's lay out the framework. When healthy community conditions, good coverage, and inclusive policies are in place, we can achieve positive outcomes that improve the mental health and well-being of all Americans. Accomplishing this goal requires a comprehensive framework that sees mental health as existing on a continuum that begins in community and extends into health care. If we are serious about tackling mental health and addiction in our country, we must leverage all the places and spaces people present with needs and provide support accordingly. We must also see "needs" as including risk factors as well as mental health conditions and focus on "upstream" factors that can prevent or mitigate later problems.

The underlying causes that fuel the "deaths of despair" are multiple and deeply rooted, including:

- **Individual-level factors like loneliness, isolation, and a lack of belonging;**
- **Systemic elements such as fragmented care delivery, lack of culturally effective care, and limited affordable access to care; and**
- **Social and community conditions like economic exclusion, housing and food insecurity, systemic racism and intergenerational trauma, and inequitable divisions of resources.**

Issues like social isolation, loneliness, hopelessness, trauma, and shame intersect. These are exacerbated by a lack of economic opportunity, toxic stress, stigma, and a blend of opportunity-limiting cultural and environmental factors in our communities that ultimately thwart human flourishing. The multilevel factors compound in especially negative ways for racial and ethnic minority populations, people who are low-income, or people who live in rural areas, driving health disparities. African Americans, Latinx, American Indian/Alaska Native, and Asian American populations have higher rates of mental health and substance use conditions. Additionally, minorities may experience symptoms that are undiagnosed, under-diagnosed, or misdiagnosed for cultural, linguistic, or historical reasons. Non-Hispanic whites with mental illness are 17% more likely to receive treatment than African Americans or Hispanics and over twice as likely to receive treatments as Asian Americans.[4] Often, these dynamics present intergenerational risks, with risk factors present prenatally and continuing through early childhood for families lacking access to the factors and conditions needed to support healthy human development.

Communities of color are also the most likely to be impacted by climate change and related issues. Studies show climate change and climate disasters cause anxiety-related responses as well as chronic and severe mental health disorders.[126] Flooding and prolonged droughts have been associated with elevated levels of anxiety, depression, and post-traumatic stress disorders.[127] The trauma and losses from a disaster, such as losing a home or job and being disconnected from neighborhood and community, can contribute to depression and anxiety. The need for mental health services increases in the aftermath of a climate-related disaster. At the same time, there is often a disruption in services or a decrease in the availability or accessibility of services.[128]

Leveraging Opportunities at Each Entry Point

Our guiding principle for this framework is that our health policies and solutions must be inclusive enough to ensure that all places and spaces effectively promote mental health, from creating positive dynamics that prevent conditions from developing, providing access to culturally appropriate services when needs arise, defining outcomes and collecting data to ensure equitable positive outcomes, and supporting recovery in whatever form it takes for that individual. This also exists on a continuum whereby some people have more severe needs than others.

This framework focuses on multiple places for engagement with a specific emphasis on five main entry points for policy:

HEALTH SYSTEMS

The most obvious place people present with a mental health or substance use service needs are in health care settings. We highlight three doors for health care, which include primary care (ambulatory care), hospitals, and specialty mental health settings.

JUDICIAL SYSTEMS

For many, our prisons and jails have become the "de facto" mental health system. The guide offers specific examples of ways we can better help prevent this while also providing more robust support to those incarcerated who have mental health and addiction needs.

EDUCATION SYSTEM

Childhood is a critical developmental time for mental health, and schools, universities, and early care and education (ECE) systems all present opportunities to improve the mental health trajectory for children.

WORKPLACE & UNEMPLOYMENT

Work, unemployment, and disability all have serious implications for mental health, and this guide offers ways to maximize mental health outcomes across all of these situations.

WHOLE COMMUNITY

Effective change to promote mental health needs to span sectors and ultimately engage whole communities. The guide breaks down this complex concept in a series of concrete steps for policy makers.

FOCUS POPULATIONS

A sixth section. Specific populations are impacted differently by the mental health and addiction crisis and there are existing systems and institutions in place that seek to address this reality.

No matter where you start on this framework —with a target population, access point, or intervention strategy—there is a way to create a more comprehensive policy to improve and evaluate mental health outcomes. The guide identifies specific federal legislative and/or regulatory actions that policy makers can choose from in order to improve different aspects of our nation's approach to mental health.

This framework provides a portfolio of solutions that should be considered when advancing a comprehensive mental health and addiction policy platform or if seeking policy targeting a specific population or entry point. The key role for government in creating better mental health is eliminating policies that artificially carve out or separate mental health and addiction benefits, delivery services, or financing from overall healthcare. These policy priorities presented in this guide should be considered as an integrated strategy alongside robust quality measures to assess and assure that standards are being met within all populations and people are getting healthier.

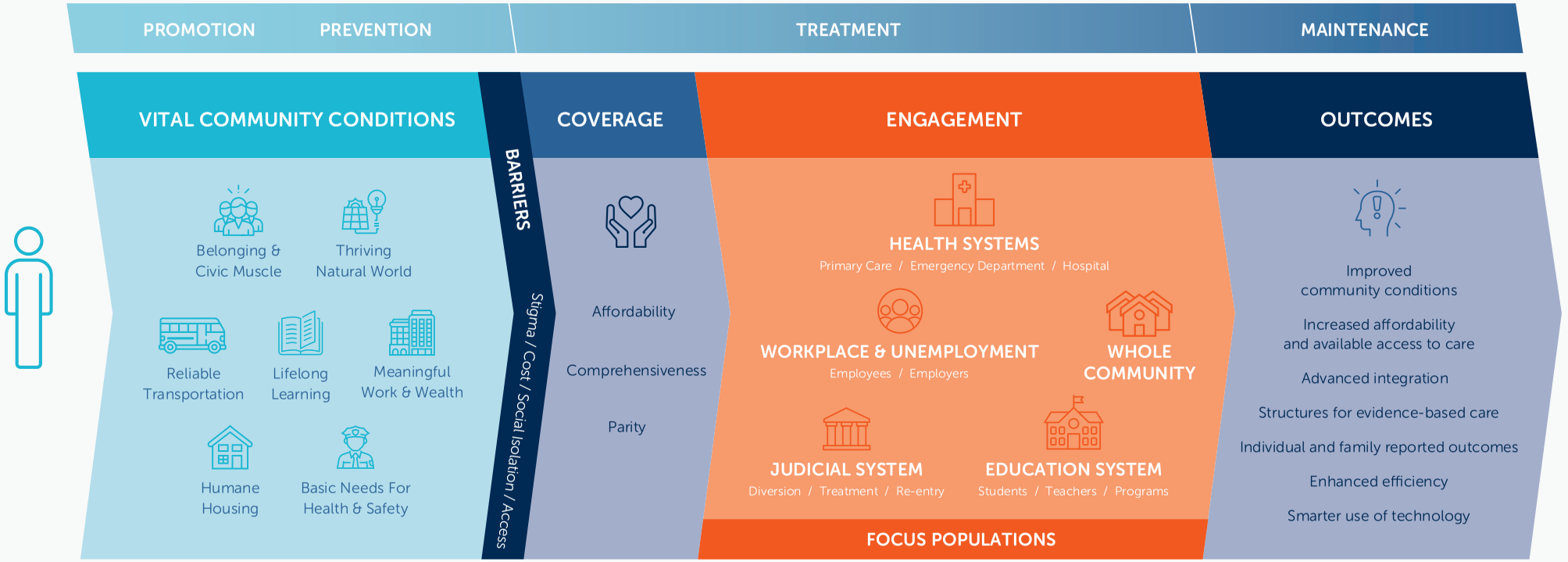
The majority of the recommendations put forth call upon the federal government to act. Many of which could be done through tools that Congress has at its disposal: notably oversight, funding, and delegation of tasks to agencies. Some of these proposals could be achieved outside of the legislative process through oversight and action at the Executive Branch level to implement or emphasize certain programs or policies. In the cases where other regulatory bodies are necessary in helping address the problem, they are called out or referred to.

How We Define the Terms We Use

This framework is meant to help advance mental health and addiction care in a thoughtful, consistent, comprehensive way. Central to the success of any framework and corresponding policy solution is the need to clearly define the terms we use. For example, our framework promotes the use of terms "mental health" and "addiction" to be as inclusive as possible for those who experience these health issues in their life.[5] We believe that mental health is inclusive of addiction, and policies should pursue both simultaneously as much as possible. Language changes culture, and we do not want to reinforce stigmatizing or inaccurate terms when describing mental health and addiction needs and solutions. For a full list of definitions, please see Appendix II.

Framework for excellence in mental health and well-being

The framework for excellence in mental health is a guide for changemakers at every level of society who seek to improve mental health outcomes and promote well-being for millions of Americans.



ENTRY POINTS TO ADVANCE MENTAL HEALTH

Health Systems

Health systems, defined in this framework as organizations providing health care – hospitals, outpatient and long-term care facilities, community health centers, and other health care clinicians – are a common point of contact for many people and have the most resources dedicated to addressing mental health conditions. The opportunity for effectively addressing mental health through health systems is immense – if mental health were treated like any other medical conditions and individuals were able to have timely access to care.

For many years mental health was separate from the rest of health care and relatively few resources were dedicated to it. Substance use was often seen as the purview of the criminal justice system; the moral frame precluding it from being an integral part of the health care system. In the past two decades, landmark federal legislation (e.g. MHPAEA) combined with a growing awareness of mental health needs led to a greater integration of mental health in mainstream health systems and a dramatic increase in available resources for addressing it. Unfortunately, the legacy of discrimination has left divisions in health systems that persist today. Health systems had to rapidly gain the knowledge, skills, and infrastructure to provide evidence informed mental health and substance use services. Almost all non-mental health providers have received little to no training on mental health, and mental health continues to not be well integrated into overall care in most systems. In addition, health systems were already battling systemic disparities within the physical health realm, adding mental health and addiction services requires accountability and outcomes measures to ensure systemic policies do not create inequities in this realm. Mental health care also does not receive the same policy attention for initiatives to advance quality, equity, comprehensiveness, and preventive aspects as other conditions.

As federal policy drives toward better access and value in health care for Americans, particular attention is needed to bring mental health along with these reforms and correct for the unique history that left it separated.

Integrate Physical and Mental Health Care

Integrating mental and physical health care is perhaps the most effective solution to increase access to mental health treatment for most people, improve diagnostic rates and treatment success, and lower the cost of patients with comorbid physical and mental health disorders.

Integration of mental health and physical health care must occur across three settings to be effective: primary care, inpatient and emergency care (hospitals), and community mental health care. This ensures that all individuals have access to the full continuum of whole-person care, no matter how they come into contact with a health system.

PRIMARY CARE

A gateway to mental health care. Primary care is the most common contact point for people with a health system. Over half of all people see their primary care provider in any given year.[6] For many health conditions, primary care is where a need is first identified – either through screening or when someone comes seeking care for a problem. Many needs can even be resolved directly by the primary care provider, or else the individual can be connected with a specialist for additional diagnosis and treatment.

The same should be true for mental health. Primary care providers should be able to screen and identify common mental health concerns, resolve mild-to-moderate needs with evidence-based interventions, when necessary, refer and coordinate with specialty care for those with more complex needs. Today, primary care providers do end up providing the majority of mental health care – more patients seek mental health care in primary care than in any other health system setting, and primary care providers prescribe more mental health medications than any other provider type. Unfortunately, primary care providers receive very little training in mental health and are often not otherwise well-equipped or supported to offer the most effective care.

Primary care is also becoming a focal point of health care reform efforts as the "quarterback" of care, with growing responsibilities for managing the health of individuals and their families over time. As primary care providers receive increased investment to coordinate care, integration of mental health will be all the more important.

While there are several evidence-based models for integrating mental health in primary care, it is likely that integration will need to take on a variety of forms to accommodate the diverse needs of primary care practices and their diverse patients. Ideally all practices would adopt an evidence-based model, but the role of policy must be to provide incentives and supports to all practices, no matter their starting point or current resources, to make steady progress toward greater integration and offer increasingly accessible and effective services through primary care.

PRIMARY CARE SOLUTIONS

1 Financing

Integrated delivery requires innovative financing as well as a recognition that many policies and financial models artificially separate out mental health and addiction services.[7] The way that mental health, addiction services, and primary care are financed often reinforce their siloed nature. Financial models that better support the provision of onsite mental health and addiction treatment in primary care require a move away from volume-based payment methods to value-based payment to provide more flexible and outcomes-based financial support for integrated teams. For example, global payments to primary care have shown promise in financially supporting integrated care as well as helping lower the total cost of care.[8] In any model, financing must consider the initial resources of the practice and ensure that they have the infrastructure needed to take advantage of the new financing opportunities and to assess whether outcome measures demonstrate improved outcomes across the diverse range of populations.

ACTION ITEMS:

- The federal government should require that all primary care payment models initiated by CMS or by the states through waivers include consideration of whether the model would equip the affected practices with the resources they need to effectively offer integrated mental health care. This should include auditing and revising existing models as well as initiating new ones as appropriate and may include carving certain mental health services out of the cost benchmark to ensure that there are adequate incentives for building out integrated care.
- The federal government should mandate payers and provider to assess outcomes across population subgroups in an effort to ensure integration is promoting positive outcomes across all populations. If not, the federal government should support changes that will provide the culturally appropriate integrated care needed to help eliminate disparities.
- The federal government should mandate prioritization of mental health screening and outcome measures in federal value-based payment models – including ensuring that the measures are weighted to reflect their importance for population health. The federal government should also create a fund that can help low-performing systems improve by implementing evidence-based integration approaches.
- The federal government should create a seed fund that supports primary care providers, and especially Federally-Qualified Health Centers and Rural Health Centers, in developing the necessary capacity to begin seeking sustainable reimbursement for integrated mental health care services (which could be effectively paired with parity initiatives, as described later in this report).
- The federal government should make available planning grants and state learning collaboratives to design and implement effective Medicaid waivers and state plan amendments that meaningfully expand access to high-quality mental health care.

2 Training

Every year, thousands of new primary care providers enter the field – the vast majority of whom receive little to no training on integrated care. For those already in practice, few receive any support in learning new skills and practice models for integrated care. Mental health care is not so different than the countless other health conditions that primary care providers deal with, but without training, effectively addressing it becomes an unreasonable expectation. Structured training opportunities for those both pre-service and in-service is critical for making mental health a standard part of primary care.

ACTION ITEMS:

- The federal government should provide incentives, through Graduate Medical Education (GME), Graduate Nursing Education (GNE), and other programs, for health care practitioner education institutions to offer training in integrated mental health care.
- Providers should be incentivized to take additional Continuing Medical Education (CME) classes on current best practices.[9]
- The federal government should focus existing federally funded quality improvement organizations on mental health integration across diverse primary care practices and for serving diverse populations, and financing additional learning collaboratives as necessary.

HOSPITALS

Where full integration begins. As deaths of despair have become a public health crisis, hospital emergency rooms and first responders are becoming overwhelmed with drug overdoses and mental health admissions. One-third of hospital stays are now related to mental health diagnoses and these admissions cost approximately twice as much.[10] Individuals reporting to the emergency department (ED) often end up waiting much longer, and in one survey 10% of EDs reported that individuals even stayed several weeks in the ED.[11]

Hospitals – as centralized units of care that may encompass emergency departments, short-term psychiatric (mental health and substance use disorder) treatment facilities, and other units – are critical for integration. If all units and specialties across a hospital system have a systematized way to identify and treat mental health, patients will have their mental needs more consistently addressed. Hospitals can also be a good point to identify people that have fallen through the cracks and who might not intersect with health care outside of showing up in the ED.[12] One study found more than half of young people in psychiatric crisis in the ED had not previously sought outpatient care, and rates of ED use due to lack of outside of mental health access in the US continues to rise.[13,14]

If policy better supports integration of mental health care throughout hospitals, they can become another entry point for whole-person care.

1/3 of hospital stays are now related to mental health diagnoses

and these admissions cost approximately twice as much

HOSPITAL SOLUTIONS

1 Identification and Intervention Across Specialties

While mental health is a common comorbidity with other physical health or medical conditions, it frequently goes undiagnosed – increasing costs and worsening outcomes. Further, hospitalization provides another point of contact with individuals for identifying needs, which should be leveraged. This is especially true in suicide prevention where hospital contacts have been found to be an effective entry point for intervening to prevent suicide.

ACTION ITEMS:

- The federal government should ensure that hospital payment models and quality programs incentivize assessing mental health at every interaction as a vital sign, and not only during well visits. This should include integrating screening and treatment into episode-based payment models for health conditions for which there are frequent mental health comorbidities, such as cardiovascular diseases, cancers, and pulmonary diseases.
- The federal government should increase incentives for reducing readmissions for mental health problems over ninety days and provide seed funds for safety net hospitals to have the necessary resources to perform well on these new incentives.
- Suicide and mental health crises should be included as part of hospital safety initiatives and evidence-based strategies should be integrated into federally funded hospital quality improvement programs. Examples include the Zero Suicide program.

2 Integrating Care in Emergency Departments

Many mental health crises lead to interactions with the ED, but many EDs are not well equipped to handle mental health crises. Integration remains key to improving the quality of emergency care on three levels: integrating mental and physical care within the ED, integrating care between Emergency Medical Services (EMS) and EDs, and integrating ED care with community-based treatment. Studies indicate that developing more integrated models may reduce service duplication and provide the least restrictive, most continuous care.[15]

ACTION ITEMS:

- The federal government should invest in piloting and scaling innovative information technology solutions to improving the successful triage and coordination of care for individuals with mental health conditions that present to EMS or the ED,[16,17] including connections with social services.[18]
- The federal government should provide funding or centralized administration to expand the availability of online "bed boards" that allow clinicians to find available psychiatric beds in other hospitals and transfer patients to those facilities with the caveat that these beds are not geographically prohibitive from a person having access to their family or caregiver.[19]
- The federal government should fund the development and dissemination of evidence-based training and continuing education materials on mental health for ED staff.
- The federal government should establish a three-digit suicide prevention lifeline number. The FCC has recommended that 9-8-8 be designated as the new lifeline number, and dollars should be appropriated to allow for local call centers to support ongoing services from the call line.

COMMUNITY MENTAL HEALTH CENTERS

Closing gaps in care. Community mental health centers provide mental health care for those individuals with the most complex needs and often limited resources. For these individuals, co-occurring physical issues can be common and deadly – partially explaining the massive gap in life expectancy compared to the general population. Having to navigate multiple types of specialty care in different settings with different treatment regimens can be a challenge, especially when individuals are already facing pressing mental health difficulties and other stressful circumstances.

Policy can drive better integration of primary care services into mental health settings (sometimes referred to as "reverse integration" or "bidirectional integration") and ensure that individuals that need specialty mental health services still get whole-person, comprehensive, and coordinated care.

COMMUNITY MENTAL HEALTH CENTER SOLUTIONS

1 Financing

As with primary care, segregated financing often made it difficult for specialty mental health settings to offer integrated, onsite primary care. Even as changes are made to reimbursement, few centers do not have the capacity to begin billing for these more comprehensive services. Community mental health centers have also not been meaningfully included in most payment reform efforts. Congress has initiated some innovative financing opportunities, but they are currently limited in scope and reach only a small proportion of those that could benefit.

ACTION ITEMS:

- The federal government should expand the Certified Community Behavioral Health Centers (CCBHC) initiative to provide a more flexible and comprehensive financing to mental health centers so that they have the resources they need to provide integrated care for all who could benefit while assuring quality and accountability for integrated care.
- The federal government should encourage better inclusion of community mental health centers in alternative payment models, such as Accountable Care Organizations (ACO). Community mental health centers could take on accountability for the population of people that would benefit from having their care coordinated from a specialty mental health setting.

2 Data Integration

Specialty mental health has also not been included in most health information technology (HIT) initiatives, making it difficult for them to provide integrated care and participate in different kinds of payment reform. Further, current regulations on data sharing (42 CFR part 2) create barriers for sharing some kinds of information, which make integration all the more challenging.

ACTION ITEMS:

- The federal government should amend the HITECH Act to extend financial incentives to mental health clinicians for using electronic health records. Mental health and addiction clinicians are not included as clinicians eligible for the Act's assistance.[20]
- The federal government should align 42 CFR part 2 with HIPAA, as a regulatory barrier, for purposes of treatment, payment, and health care operations so that Substance Use Disorder (SUD) information can be incorporated into health records while protecting privacy and individuals with mental health conditions can receive more integrated care.
- The federal government should extend Medicaid and Medicare electronic health record (EHR) Incentive program eligibility to include all mental health professionals providing care at psychiatric hospitals, mental health treatment facilities, and SUD treatment facilities. Only psychiatrists are currently eligible for this program, hindering the use of electronic health records among other mental health clinicians.

Health Systems Solutions for the Opioid Epidemic

A Public Health Problem, Not a Criminal Justice Issue.

On average, 130 Americans die every day from opioid overdose. The opioid epidemic costs the U.S. over $500 billion annually, nearly 3% of total GDP. Annually, only 10% of people with an alcohol or substance use disorder receive treatment.[21] These rates are even lower among low-income groups, rural communities, and communities of color.[22]

Federal policy should see opioid use disorder as a public health problem instead of a criminal justice issue, applying the best available evidence to save lives. In doing so, policy should aim to build sustainable systems that can prevent future addiction crises from occurring. And while progress has been made, there remains work to be done.[23]

OPIOID EPIDEMIC SOLUTIONS

1 Access to Effective Treatment

Most Americans do not have access to evidence-based treatments for addiction (regardless of their insurance) and very few have access to the full continuum of effective services. For example, while the proportion of SUD facilities that offer medication increased from 20% in 2007 to 36% in 2016, only 6.1% of facilities offer all three FDA-approved medications.[24] Fewer than half of treatment centers offer wraparound services, which often include social services and critical health care services like mental health or oral health.[25] Facilities in rural areas are even less likely to have the full range of options.[26] Without access to effective treatments, addictions become all the more disabling and even deadly.

Some states have addressed these issues by supporting the growth and development of multi-stakeholder coalitions. These coalitions—which include health plans, first responders, pharmacies, law enforcement, schools, public health departments, health care clinicians, consumers, and local and state government — work together to scale successful practices, build public awareness, and connect people to resources within the community. Multi-stakeholder coalitions offer the opportunity to engage whole communities in producing change while also promoting the uptake of evidence-based practices in different settings, but only a few areas around the country have seen meaningful implementation of such approaches.

ACTION ITEMS:

- The federal government should encourage the use of evidence-based treatments, including Medication-Assisted Treatment (MAT).
- All physicians should receive training on addiction in medical school and should then be able to prescribe MAT without separate training and waiver. This would require a reform to the DATA 2000 waiver.
- On the private insurance side, the federal government should enact new protections for MAT by requiring health plans to cover FDA-approved medication for SUD if medically necessary.

- The federal government should amend the Medicaid and Medicare statutes to substantially strengthen access to effective substance use treatments. Medicare and Medicaid should cover the full range of effective substance use treatments. These treatments should be mandatory benefits in Medicaid, which would build on the addition of MAT as a mandatory Medicaid benefit in the SUPPORT Act. The federal government should clarify how these treatments are covered under the Essential Health Benefits, which apply to exchange and Medicaid expansion, and parity for commercial plans. The federal government should also work with states that have not expanded Medicaid to identify solutions for ensuring coverage of low-income individuals.[27,28,29]
- The federal government should eliminate the limit on the number of patient's clinicians can treat with MAT, like buprenorphine.[30]
- CMS should create an expedited application process for coding MAT drugs with the Healthcare Common Procedure Coding System to streamline activities/oversight.[31]
- The federal government should also make MAT more accessible by directing the Health Services and Resources Administration to ensure that MAT is offered at all Federally Qualified Health Centers (FQHCs) and require all FQHCs clinicians to get DATA 2000 waivers to prescribe buprenorphine.
- The federal government should allocate additional funding and authorize uses of existing federal funding to support different stakeholders in forming, joining, and sustaining community coalitions focused on improving addiction and overdose outcomes. This should include Medicare and Medicaid, as is currently being piloted with the Accountable Health Communities Model.
- The federal government should direct the Centers for Medicare and Medicaid Services to issue an order that all state Medicaid programs must cover FDA-approved MAT drugs without prior authorization.
- The federal government should direct the Department of Health and Human Services, in consultation with the American Society of Addiction Medicine (ASAM), to develop model standards for the regulation of SUD treatment programs based on the Levels of Care standards set forth in the most recent version of The ASAM Criteria and condition receipt of certain federal grants on state adoption.
- The federal government should remove the legislative and regulatory barriers that prevent the use of federal funds for syringes used in syringe service programs (SSPs).
- The federal government should direct the National Institute of Health to provide more grants to researchers looking into treatment for SUD.
- The federal government build multi-stakeholder opioid safety coalitions. The federal government should support these coalitions by providing grants to states.

On average, 130 Americans
die every day from opioid overdose

2 Limit and Regulate Opioid Prescribing

One strategy for reversing the tide of the opioid overdose epidemic is limiting the flow of prescription drugs. Providers still need to be able to effectively manage pain, but prescription opioid analgesics should be prescribed according to CDC guidelines as to avoid putting patients at risk.[32] In addition, individuals should have access to a range of alternative pain management treatments. Beyond reducing addiction risk for patients, limiting opioid administration and offering alternative treatments lowers emergency department readmissions and overall costs for hospitals.[33]

ACTION ITEMS:

- The federal government should limit and regulate opioid prescribing by making educational grants and funding for medical programs contingent on their inclusion of safe-prescribing practices in curricula.
- The federal government should address the importance of clinically-indicated and evidence-based utilization management processes for ensuring that opioids are not inappropriately prescribed in Medicare and Medicaid.[34] The federal government should also initiate a multi-payer effort to encourage commercial insurers to adopt similar practices.
- The federal government should ensure that Medicare covers evidence-based alternatives for pain management, and fund systematic reviews that indicate how such therapies would fit within medical necessity guidelines of commercial plans.[35]
- The federal government should provide incentives in its funding for health care educational programs to include training on safe prescribing and related practices for minimizing risk of addiction.
- The federal government should publicize Take Back Days or implement permanent Take Back Programs, including funding the installation of permanent drug take-back drop-off boxes in federal facilities located in cities around the country.[36]
- The federal government should encourage states and local governments to raise awareness of the National Prescription Drug Take Back Day (October 26) or institute state-wide versions of the same drug-reduction effort.

1/3 of primary care clinicians find PDMPs difficult to access

and over half feel they take too long to pull up patient information

3 Overdose Reversal Drugs

Naloxone is an opioid-antagonist that reverses life-threatening central nervous system depression resulting from opioid overdose. It is simple enough to be administered by a minimally trained layperson without harming the person receiving the drug.[37] But while almost every state has approved laws empowering pharmacists to dispense Naloxone under a standing order and without an individual prescription, people appear to still be under-utilizing the drug.[38]

ACTION ITEMS:

- The federal government should mandate that naloxone be available in all federal facilities (e.g. post offices).
- Federal laws should be adjusted to require coverage of naloxone without co-pay by public and private insurers, and require co-dispensing naloxone with long-term (i.e., longer than a week) opioid prescriptions, which evidence suggests could cut opioid-related emergency visits by half within a year.[39]
- The federal government should make certain funding contingent on states implementing naloxone training programs for first responders and community members in relevant funding programs.
- The federal government should investigate making naloxone have an over the counter (OTC) status, but at a minimum, have a standard order or protocol in place.

4 Prescription Drug Monitoring Programs (PDMPs)

Prescription Drug Monitoring Programs offer databases that can track prescribing and dispensing of opioids to identify individuals who may be diverting or misusing drugs, and establish responsible prescribing practices and prevent patients from "doctor shopping" to find a physician who will prescribe them opioids. PDMPs can also limit the number of pharmacies patients with high addiction risk can receive prescriptions, potentially to a single clinician and/or pharmacy.[40] Evidence associates PDMPs with reductions in opioid prescribing and opioid-related deaths and that most primary care providers are aware of PDMPs and use them. However, one-third of primary care clinicians find PDMPs difficult to access and over half feel they take too long to pull up patient information.

ACTION ITEMS:

- The federal government should increase the efficacy of PDMPs by funding technical assistance and learning collaboratives for states, including facilitating data sharing between states, or by creating a nationwide PDMP.
- The federal government should build provider incentives for using PDMPs into existing programs that incentivize the use of health information technology.
- The federal government should increase the efficacy of PDMPs by directing the Department of Health and Human Services to issue a report on how to build a nationwide PDMP or facilitate data sharing between states.

Insurance and Reimbursement

Break Down Largest Barrier to Integration of Mental Health and Physical Health:

Health insurance reimbursement practices are a key factor in determining access to quality care. Historically, insurance discriminated against mental health and offered limited to no coverage. Many people had to either pay out-of-pocket for services or access publicly funded programs (which were also chronically underfunded). Even today, most public and private insurance systems separate out mental health in their processes, sometimes even delegating mental health to carve out programs.[41] Recent policy successes have gone a long way toward expanding access to mental health services for millions of Americans, but there is still much more work that needs to be done to ensure that access meets need.

While reimbursement does not determine everything about mental health care, how services are paid for does influence everything from workforce supply to how care is delivered. Public insurance, including Medicaid and Medicare, are controlled in part by federal law, and commercial insurance markets are regulated in part by federal laws. Thus, federal policy can play an important role in ensuring that reimbursement practices are fair, transparent, and ultimately promote access to needed mental health care.

INSURANCE AND REIMBURSEMENT SOLUTIONS:

1 Coverage Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance companies to not place any restrictions on coverage of mental health that they do not place on medical and surgical health.[42] This includes not placing restrictions on financial (i.e., copayments, coinsurance, etc.) and non-financial treatment standards (i.e., number of allowed visits, necessary prior authorizations, etc.) for mental health services more than any services. Under the Patient Protection and Affordable Care Act, parity was expanded to include new small group and individual market plans as mental health was covered under the Essential Health Benefit category.[43] While MHPAEA does not require insurers to provide mental health benefits (it only mandates parity between mental and physical health if mental health is covered), the Affordable Care Act requires most types of health plans to cover mental health. Some states have additional laws strengthening parity requirements or requiring insurers to cover mental health services.

While MHPAEA is a landmark law that prohibits discrimination in mental health and addiction coverage, it is not well implemented or enforced by either states or the federal government. As a result, coverage of mental health services continues to be inadequate, driving up out-of-pocket costs for consumers and denying many the treatment they need. Insurers pay primary care clinicians 20% more than mental health and addiction clinicians for the same services, resulting in grossly inadequate networks of mental health and addiction providers. Unable to find the in-network clinicians they need, people are forced to turn to out-of-network providers nearly six times more often for mental health and addiction care than for other types of medical care.[44] In fact, these inequities have grown – not decreased – over the past few years. And, in 2017, insurers spent only 1% of their health care reimbursement on substance use disorders care, and only 4% on mental health disorder care.[45] To end coverage disparities, state and federal regulators must aggressively enforce MHPAEA in a proactive way, rather than placing the burden on individuals and families experiencing a crisis.

ACTION ITEMS:[46]

- Congress should amend the Employee Retirement Income Security Act (ERISA) to authorize the Department of Labor to impose fines on plans and insurers offering health insurance coverage in connection with a group health plan that violate the parity law.
- The federal government should provide adequate funding for federal agencies to conduct random audits of health plans on an annual basis and establish a system for reviewing all consumer complaints for potential violations of MHPAEA. The federal government should assist states with funding to enforce MHPAEA.
- The federal government should require health plans to conduct detailed parity compliance analyses on their non-quantitative treatment limitations (NQTLs) and require that these analyses to be made public.
- The federal government should require each plan to conduct a MHPAEA "risk assessment" – similar to the existing HIPAA privacy and security risk assessment – that details the plan's capabilities to document, assess, and comply with all aspects of MHPAEA, thus encouraging the plan to develop a robust parity compliance program.
- The federal government should direct the Center for Consumer Information and Insurance Oversight to exercise its authority under the parity law to regulate plans in states that fail to "substantially enforce" the law by relying solely on consumer complaints to check for parity compliance.[47]
- The federal government should require that insurers cover the full range of intermediate mental health and addiction services, including residential care, intensive outpatient, and partial hospitalization services.
- The federal government should create a definition of medical necessity and require that all medically necessary mental health and addiction care be covered by insurers.
- The federal government should apply parity provisions to Medicare, Medicaid fee-for-service, and TRICARE, which currently are not subject to MHPAEA.
- The federal government should direct CMS and state Medicaid agencies to prioritize ongoing enforcement of MHPAEA for Medicaid managed care plans.
- The federal government should create health plan performance standards for mental health and addiction coverage that, if not met would trigger parity investigations.

Insurers pay primary care clinicians 20% more than mental health and addiction clinicians
for the same services, resulting in grossly inadequate networks of mental health and addiction providers

- The federal government should give the Department of Labor – like many state insurance departments – the power to charge health plans for the cost of parity investigations to help the Department increase the number of investigators (currently 1 per every roughly 10,000 plans).
- The federal government should require insurers to public report metrics comparing mental health and addiction coverage to medical/surgical coverage such as denial rates, utilization review practices, appeals, out-of-network usage, and reimbursement.
- The federal government should make it easier for patients wrongly denied care to protect their rights by ensuring all patients have the ability to access federal courts and to receive damages for harm caused by wrongful denials, and prohibiting insurance "discretionary clauses" where insurers are given the right to interpret the meanings of their own policies.
- The federal government should require the U.S. Department of Labor and other applicable federal agencies to enforce existing health insurance appeals protections to consumers, including disclosing the clinical review criteria used in a medical necessity denial and ensuring that health plans comply with statutory/regulatory timeframes for processing each appeal.
- The federal government should require the U.S. Department of Labor and other applicable federal agencies to publish an annual report card, which rates health plan parity compliance similar to CMS's Five-Star Quality Rating System.
- The federal government should promote parity compliance tools that help automate the compliance process such as 1) the CMS Compliance Toolkit Applying MH/SUD Parity Requirements to Medicaid and CHIP (Jan 2017); 2) The "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements published by The Kennedy Forum, American Psychiatric Association, and The Parity Implementation Coalition (September 2017); 3) the U.S. DOL Self-Compliance Tool for MHPAEA (May 2018); and ClearHealth Quality Institute ParityManager™ Compliance Tool (July 2019).

2 Statutory Limits on Care

Longstanding restrictions on coverage for Institutions for Mental Diseases (IMD) designed to limit federal financing and protect against overreliance on institutional services have protected those who were often subjected to dehumanizing conditions in state-run mental hospitals. It also supported access to services in new community health centers funded by the 1963 Community Mental Health Centers Act. Over time, limited availability of access to inpatient care have prompted revisiting of these longtime restrictions. Medicaid policy has evolved through the changes in managed care policy, recent 1115 demonstrations, and a SUPPORT Act provision. These new policies, while promising, vary with respect to service provision, quality, accreditation, and integration with community services.

In addition, Medicare has an arbitrary 190-day limit on inpatient psychiatric care. Considering that many older individuals with psychiatric conditions are gravely disabled, this limit almost always forces individuals with Medicare out of medically necessary treatment.

ACTION ITEMS:

- Congress should require MACPAC to assess the recent expansions of IMD access through Medicaid and recommend to Congress additional changes that expand access to both residential and community-based services and promote integration, and quality of mental health and substance use disorder services.
- The federal government should eliminate Medicare's 190-day lifetime limit on inpatient psychiatric hospital care.[48]

3 Recovery Services

Over the past several decades, communities responded to the lack of effective mental health care by building a range of innovative supports and services to better promote recovery – many of which were created by individuals in recovery. Many of these interventions have an effective evidence base being integrated into the continuum of care in many communities e.g. Peer Support Services.[49] While some Medicaid plans reimburse for these services, Medicare and few commercial insurers do not. As a result, only a small proportion of people get access to recovery services as part of their care.

ACTION ITEMS:

- The federal government should revise current Medicare fee-for-service payment policies to incorporate recovery services where appropriate.
- The federal government should task CMS to initiate multi-payer collaboratives, which engage both public and private insurers, to develop efficient reimbursement policies to spur the uptake of recovery services in communities.

4 Preventive Care

Federal law increasingly supports effective preventive care in mental health, with policies such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) in Medicaid or the requirement that most insurers cover certain services recommended by the U.S. Preventive Services Task Force. Unfortunately, these policies mostly support screening for early detection of mental health conditions and has not translated well for young children. Although the American Academy of Pediatrics recommends screening for depression in young children and developing psychosocial needs, coverage for interventions to address these identified needs is inconsistent and often unclear – often failing to ensure that children get access to clinically-indicated care.

ACTION ITEMS:

- Federal preventive care regulations should support coverage of services that promote healthy mental development and prevent the later onset of mental health conditions, rather than solely focusing on screening for early indications of a developing condition. In doing so, the regulations should include services provided to parents and primary caregivers of children, with or without the child present – appreciating the evidence for supporting parents in promoting mental health.

Investing in the Future of Health Systems

Ensuring Better Systems for Future Generations

Thus far, the recommendations in this agenda focused on coordinating and building on the existing health system resources, but existing resources for addressing mental health are woefully inadequate. Siloed systems, stigma and discrimination, and dramatic underinvestment left Americans with a health system workforce far too small and equipped with far too few tools to meet the current needs.

INVESTING IN THE FUTURE OF HEALTH SYSTEMS SOLUTIONS:

1 Building the Workforce of the Future

Currently, there are not enough mental health providers to meet the needs of the public. Fifty-five percent of U.S. counties have no practicing mental health workers and 77% of people with mental health conditions report unmet mental health needs due to lack of clinicians. Thirteen percent of U.S. counties still have a primary care physician shortage.[50] Not to mention a serious lack of diversity within the small workforce. "According to a 2004 study, non-Hispanic Whites accounted for 76% of all psychiatrists, 95% of psychologists, 85% of social workers, 80% of counselors, 92% of marriage and family therapists, and 90% of psychiatric nurses in marked contrast to the composition of the U.S. population, which is nearly one-third Latino, African American, Asian American, or Native American/Pacific Islander and also undergoing growth."[51] With the growing prevalence of mental health conditions, these gaps will only widen over time.

ACTION ITEMS:

- The federal government should fund a campaign to educate high school, college, and graduate students on the need for people to enter the mental health workforce, the diverse and changing opportunities it presents, and the increasing pay associated with parity and other regulatory changes.
- The federal government should expand funding programs that build institutional capacity to offer mental health specialties, such as the Behavioral Health Workforce Education and Training Program, and include incentives in other funding sources, such as Graduate Medical Education and Graduate Nursing Education.
- The federal government should expand programs that provide direct incentives for individuals to enter the mental health workforce, such as the National Health Service Corps or the Minority Fellowship Program.

55% of U.S. counties

do not have practicing mental health workers

77% of people

with mental health conditions report unmet mental health needs due to lack of clinicians

2 Investing in Research for the Future

Innovations in mental health treatment have been slow, and most people receive the same treatments that have been used for decades (with a few notable exceptions). While some progress is being made in laying the groundwork toward potentially game-changing breakthroughs, chronic public underinvestment and weariness from private investors has caused progress to be slower than in health conditions with comparable burdens of disease.

ACTION ITEMS:

- The federal government should expand mental health research funding so that it is commensurate with the burden of disease.
- The federal government should initiate a public-private partnership to communicate the opportunities for investment in mental health research and development to private investors and collaborate on ways to de-risk investments in the area.

3 Innovative Technologies

Although not widespread, waves of new technologies are being developed and tested for addressing different aspects of mental health. These technologies range from wearable sensors, to applications on phones, to new kinds of medical devices, and they attempt to improve the prevention, diagnosis, care coordination, and treatment of mental health conditions. Some of these technologies have even begun to demonstrate some evidence of effectiveness, but almost all lack clear pathways to reaching consumers at any level of evidence. This issue is especially true for Medicare and Medicaid. Policy can ensure that effective technologies have a way of reaching communities – including those with the least resources, like those on public insurance.

Further, the lines between standard consumer technologies and health are blurring. A study done by Well Being Trust and Hope Labs found that adolescents use digital resources for health information, tools, peer support, and online providers. Many young people who report symptoms of depression are using digital tools to learn about and help address their problems before seeking therapy. Social media is an integral part of adolescent lives, with many teens and young adults reporting a mix of both positive and negative aspects of its use. Policy incentives could more systematically ensure that consumer technologies become a constructive part of prevention, screening, and recovery.

ACTION ITEMS:

- CMS should delineate clear coverage pathways for the diverse new technologies being developed for mental health and should update Medicare and Medicaid statutes as necessary to create additional pathways.
- CMS should provide guidance on how new mental health technologies intersect with existing insurance regulations, especially as the technologies develop a stronger evidence.
- The federal government should fund public-private research collaboratives to better understand the impacts of consumer technologies on mental health and how to ensure that technologies best support mental health. The federal government should create a pot of funding to allocate awards to technology companies that ultimately adhere to what evidence-based guidelines emerge for developing technologies that most effectively promote mental health.

Judicial System

Each year, millions of people with mental health conditions end up in contact with justice systems for various minor offenses, in large part because they did not receive the mental health care they needed. Approximately half of individuals incarcerated in municipal, state, and federal facilities suffer from some form of mental health condition.[52] One-quarter of men and one-third of women in jails have a serious mental illness, a prevalence many times higher than observed in the general population.[53] Few of these individuals will get access to evidence-based treatment while incarcerated, and the environment of incarceration often exacerbates mental health conditions, increasing the suffering.[54]

Individuals incarcerated for their illness should be receiving mental health services in the community, not spending time in jails and prisons. This is a public health, human rights, and even an economic issue—inappropriate incarceration wastes millions of dollars annually in additional justice expenses. Individuals incarcerated with unaddressed mental health conditions require more medical attention, are twice as expensive to house and supervise, and have higher rates of misconduct and recidivism.[55] If individuals were served in the community instead, they would have a better opportunity to obtain competitive employment and contribute to the economy. This is especially the case with youth and juvenile justice, where involvement can disrupt their long-term educational and career outlook.

Incarceration of individuals with mental health conditions who have not committed a crime is a solution that serves no one, and a critical policy issue facing the nation.

Diversion From Incarceration

PREVENT UNFAIR AND COSTLY SENTENCES

People with mental health and substance use disorders too often become involved in the criminal justice system because our society fails to provide appropriate and timely treatment and support services. Our country should take a public health approach to mental health and substance use disorders, which recognizes the need to mainstream prevention, diagnostic, and treatment services within our healthcare system, rather than funnel people to the criminal justice system. Federal policies can provide incentives for systems to reorient toward a public health approach, and ultimately improve mental health outcomes while reducing societal costs for Americans.

1/4 of men and 1/3 of women in jails have a serious mental illness,
a prevalence many times higher than observed in the general population

DIVERSION FROM INCARCERATION SOLUTIONS:

1 Providing Enhanced Services for People At Risk

The first priority for reform should always be to prevent any event that may cause justice system interactions from occurring. While many of the health system and other policies described throughout this paper are effective diversion – they stop people from getting sick enough that they become at-risk of justice system involvement – certain programs specifically targeted at criminal justice diversion are also a critical part of the continuum. However, the legacy of systemic bias means that some diversion programs discriminate against people of color, evaluations and action should rectify these outcomes. "Disparities in prison and diversion to drug treatment among drug-involved offenders affect hundreds of thousands of citizens and might reinforce imbalances in criminal justice and health outcome."[56] Wraparound services that provide tailored services to at-risk teens and children have proven successful in reducing juvenile justice involvement.

ACTION ITEMS:

- The federal government should explicitly authorize healthcare payment models that target decreased justice system involvement as an outcome and provide planning grants and technical assistance to support innovative pilots that share justice system savings with healthcare when they reduce incarceration.

2 Changing Approaches to Crisis Intervention

Even with effective services, some people will still fall between the cracks and crises will still occur. In these moments, communities need access to effective resources for response. In most communities today, law enforcement officers respond, and often individuals are taken to jail – either because the officers were not provided with the necessary training to identify the situation as being related to mental health, or because there was simply nowhere else to take them. Innovative communities have begun to implement a range of different alternative approaches, such as Crisis Intervention Teams (CITs), in which teams within a police force specifically trained to respond to mental health crises and refer people to mental health services.[57] Other approaches have tested different types of responders aside from specially-trained law enforcement, and different kinds of service linkages, such as crisis respite services (e.g. safe places people can go that are not jails) that offer a less structured and non-clinical approach to de-escalation post-crisis.

ACTION ITEMS:

- The federal government should authorize use of Medicaid matching funds for information technology investments that enable more seamless service referrals after a crisis response.
- CMS should provide planning grants and funding for learning collaboratives for states to develop effective approaches to crisis response that include Medicaid covered services the Department of Justice should include target metrics of reducing preventable arrests and increasing successful mental health service linkages as performance measures across federal law enforcement funding streams to change incentives.

3 Supporting Formal Diversion Programs

While effective crisis response will reduce the total number of arrests, some people with mental health conditions will still get unfairly tangled in the justice system. Formal diversion programs should identify these individuals early, cease the justice proceedings, and ensure they get access to the services and supports they need to prevent further interactions. On the simplest end, this could simply mean releasing the individual, expunging the interaction from their record, and linking them with the services that the crisis team would have otherwise connected them with. On the more structured end, it could also involve referral to a specialized problem-solving court. First developed in the 1990's, specialized problem-solving courts (including mental health courts, veterans' treatment courts, and drug courts) offer a therapeutic non-adversarial treatment approach for non-violent, low-level offenses.[58] Studies across several states suggest that problem-solving courts are more effective than traditional judicial pathways in reducing re-arrests and increasing time-to-re-arrest, and they estimate that for every dollar invested, these courts save states $2.30-5.70.[59] While there are over 3,000 problem-solving courts in the U.S. most are near or at capacity.[60]

ACTION ITEMS:

- CMS should clarify to what extent Medicaid funds can be used for screening, diagnosis, and diversion from justice settings.
- The federal government should include incentives in federal justice system funding for establishing formal procedures for routine mental health screenings early in the process and diversion to services as appropriate.
- The federal government could provide capacity development grants to states, as they did in the SUPPORT Act for states to develop provider capacity for MAT.

Care While Incarcerated

ENSURE JUST AND EFFECTIVE SERVICES

In instances where people with mental health conditions do become incarcerated, access to evidence-based mental health care in correctional settings is critical. Unfortunately, most correctional facilities do not have the capacity to provide effective mental health services that meet the needs of those incarcerated,[61] and do not offer evidence-based substance use treatments.[62] Many mental health conditions are exacerbated while in custody as individuals face aversive conditions and inadequate treatment, leading to high levels of distress. While many jails and prisons are county and state run, federal policy can help create incentives that ensure people get access to the care they need.

CARE WHILE INCARCERATED SOLUTIONS:

1 Providing Incentives for Quality Care

Correctional health is separate from other health care settings and has not been included in many of the health care reform efforts focused on improving the quality of mental health services. In general, correctional health policies put forth certain minimum requirements for providing care, but do not have the same emphasis on improving access and outcomes as general health care. Without these incentives, quality and access is

more variable and the emphasis is on ensuring compliance with minimum standards. Relatedly, the correctional health system does not often coordinate with community providers, causing potentially dangerous gaps in care or changes in treatment.

ACTION ITEMS:

- The federal government should include requirements in federal justice system funding for aligning correctional health funding with quality and access standards for general health care, including penalties for failing to screen for mental health conditions and providing evidence-based services.
- The federal government should also promote quality classifications of facilities so that high-need inmates can be placed in facilities that have the capacity to meet their needs.[63]
- The federal government should expand interoperability and electronic health record incentives and requirements to correctional health settings, including allowing the use of Medicaid funds for information technology investments to promote integration between correctional and community providers.[64] In 2016, guidance authorized 90% match for connecting eligible providers to correctional health providers.[65]

2 Supporting Staff and Inmates

Both correctional staff and incarcerated individuals should be provided with skills to create an environment of positive mental health and recovery. In the same way that law enforcement officers are increasingly being supplied with greater mental health training, correctional officers should receive similar supports. Skill-building is a key part of treatment and recovery for mental health, and people should have access to these kinds of opportunities while incarcerated, increasing their likelihood of success upon release.

ACTION ITEMS:

- The federal government should offer initial funding to train correctional officers in evidence-based mental health supports, and increasingly make having staff with competencies in this area a requirement for receiving federal justice funding.
- The federal government should fund learning networks for implementing recovery supports in jails and prisons and allow incarcerated individuals to have access to federal education loans and grants to support access to formal educational opportunities as well.

Re-Entry Into Community

SUPPORT EACH PERSON TO THRIVE

For people with mental health conditions that fail to receive appropriate services and supports, the justice system can become a revolving door. Each period of incarceration disrupts continuity of any treatment being received and any progress toward recovery in community life. Thus, the period post-incarceration becomes a critical time for supporting people to thrive and escape the factors that led to the initial justice system interaction. Federal policy can ensure that every community has access to the resources and evidence-based information it needs to provide effective supports post-incarceration.

RE-ENTRY INTO COMMUNITY SOLUTIONS:

1 Continuity of Care

Medicaid does not cover services during periods of incarceration. In many states, incarceration causes people to become disenrolled entirely (note that it is not necessary to disenroll people from Medicaid while incarcerated – while Medicaid cannot pay for services during that time, beneficiaries can remain enrolled). This can lead to dangerous gaps in care for people with mental health conditions.[66] Research has found that ensuring enrollment post-release leads to higher rates of accessing mental health treatment,[67,68] which in turn has been linked to lower rates of recidivism.[69] Before release, people should be enrolled in coverage and connected to services in the community.

ACTION ITEMS:

- The federal government should introduce incentives into its justice system funding for enrolling people in Medicaid before release and require protocols for connecting to community services similar to those required for hospital discharge planning.
- The federal government should introduce a performance measure into its justice system funding of receiving mental health treatment 7- and 30-days post-release, similar to how hospital performance is measured.
- The federal government should support jails and prisons to build processes that automate enrollment of incarcerated individuals in Medicaid using the documentation for which states may already have access.[70,71]

2 Re-Entry Programming

Over the past several decades, access to re-entry services has increased dramatically and parole/probation practices are becoming more evidence-based. During this same time, evidence has also developed on how to most effectively support people with mental health conditions in successfully participating in social and economic life. The growth of re-entry programming can be built on by integrating evidence-based supports for mental health – especially now that the prevalence of mental health conditions in this population is so well documented.

ACTION ITEMS:

- CMS should clarify how Medicaid-funds can be used with treatment while incarcerated and re-entry programming to ensure that they meet the needs of individuals with mental health conditions and provide guidance on reimbursement and liability issues associated with hiring peer support specialists with the experience of being justice involved.[72]
- The federal government should fund additional demonstrations of specialty mental health parole and probation programs for justice systems.[73]
- The federal government should require re-entry programs it funds to create linkages with other community resources, including mental health services and supports, supportive housing programs, as well as other workforce programs that could continue to support individuals even after the re-entry period.[74] CMS should issue the 1115 guidance facilitating care transitions at re-entry that was required in the SUPPORT Act.

Education System (Schools & Early Care)

Schools (including universities) and early care education (ECE – child care, preschools, and Head Start) are in a particularly unique position to address youth mental health needs – children spend most of their waking hours there, they are a hub of neighborhood life, and they offer the opportunity to introduce healthy behaviors at a young age. With the proper resources, schools and ECE can effectively provide mental health services to students in need and encourage the early development of emotional wellbeing and resilience.

Mental health used to be viewed as ancillary to the educational mission of schools and ECE, but increasingly it is viewed as integral. Positive mental health and resilience are foundational conditions for learning – students learn best when they are calm, focused, and engaged, not when they are depressed, anxious, or angry. Unaddressed mental health problems also impact classroom management, as students end up being less on-task or more disruptive. Further, positive mental health is also being increasingly acknowledged as being as important (if not more so) than technical mastery for future career success.[75]

Despite the growing emphasis on mental health in educational settings, policy does not meaningfully support schools to implement the practices and policies that would be effective. And student mental health is getting increasingly worse in recent years – America has experienced a 84% increase in suicides for children under 17 from 2007 to 2016, and it is the number two cause of death in 15-24 year-olds.[76] Schools are busy places with many competing demands, and additional resources are needed to allow schools to meaningfully take on mental health and reverse these trends.

MENTAL HEALTH SUPPORT IN THE EDUCATION SYSTEM SOLUTIONS:

1 Mainstream Universal Mental Health Promotion

A growing body of evidence finds that interventions integrated directly into the day-to-day functioning of schools (including universities) and ECE can improve the mental health outcomes of all students and even prevent some mental health conditions from developing. These interventions can be built into the curriculum – teaching children key cognitive, emotional, and social skills as part of lessons to ensure that all kids are equipped with the tools they need to manage their mental health.[77,78] They can be built into the classroom management, as certain approaches to student engagement, teamwork, and discipline have been demonstrated to improve mental health outcomes. Finally, the interventions can be part of the policies and activities of the school, creating certain shared expectations, social opportunities, or supportive policies that benefit the mental health of all students.[79]

84% increase in suicides
for children under 17 from 2007 to 2016

Despite the availability of this research, many of these interventions are not effectively implemented. Substantial efforts have been made to increase the reach of some interventions, but schools and teachers need ongoing support to ensure that the effectiveness of the interventions are realized in practice. Federal policy can help direct resources toward the necessary infrastructure that can support the effective implementation of these programs.

ACTION ITEMS:

- The federal government should require that schools and universities select indicators related to student mental wellbeing, such as school culture and climate, as a core metric of school performance under federal education funding, and ensure that other federal education funding authorizes uses of funds to help schools perform well on the new indicators.
- The federal government should create incentives for the development of continuing education programs that build core competencies in addressing children's mental health and wellness. Specifically, the U.S. Department of Education should issue guidance to states on how professional development funding can be utilized to support the development of both training programs and continuing education programs that address children's mental health and wellness.
- The federal government should create incentives for teaching and childcare education programs to build core competencies in promoting classroom mental health and leading school-wide change, so that more teachers enter the workforce with these skills.
- The federal government should work to build the capacity of schools to understand the mental health needs of their students, and provide support for meaningful intervention. This could be through funding from Congress or guidance from the U.S. Department of Education. For example, providing guidance to schools on where they can access data to better understand student mental health needs and connect those needs with evidence-based interventions. The federal government should make funding available for schools to contract with quality improvement organizations that support schools and ECE programs to mainstream mental health promotion into their activities, evaluate outcomes, and learn over time.
- Congress should amend the Elementary and Secondary Education Act to highlight that training in mental well-being programs are allowable uses of Title II funding.
- Congress should amend the Head Start Act to direct the Department of Health and Human Services to prioritize implementation of trauma-informed programs and age-appropriate positive mental health interventions and supports.
- The federal government should encourage schools to respond to students with mental health issues with SEL lessons or with executive function training programs like the ACTIVATE program. State education agencies can do this by allocating Federal Title I education funds to these programs in schools. HHS can also research and implement methods to prevent suspension and expulsion in schools; or, HHS can issue guidance on the issue.
- The federal government should require private and public health plans to reimburse mental health screening during well-child exams. This screening should be based on SAMHSA's Screening, Brief Intervention, and Referral to Treatment approach and it should include an adverse childhood experience component.
- The federal government should fund grants to assist schools without the resources for in-house therapists.

- The federal government should equip schools with school-based health centers and school health providers (e.g. school nurses, school psychologists, school social workers) to improve adolescent mental health outcomes, drive a decline in depression, and ensure a reduced likelihood of suicide ideation among students.
- The federal government should fund teacher trainings that promote general knowledge of child and adolescent mental health, verbal de-escalation skills, incorporating mindfulness into teaching practices, and Youth Mental Health First Aid.
- The federal government should require cross-agency collaboration to develop a guide for creating high-quality frameworks. Schools and districts should adopt a prevention, intervention, response, and treatment framework to ensure that children with different levels of need get appropriate care, which requires coordination across teachers, health providers, and families.
- The federal government should establish equity in access by providing education about mental health services, directly engaging students instead of waiting for them to come to a mental health counselor and maintaining confidentiality of treatment. Cultural competency in mental health support should also be included in teacher training on mental health issues.
- The federal government should advance research and practices locally, and organize strategies into widely recognized frameworks, integrate mental health practices into schools' academic missions, introduce integrated models into schools, keep the needs of each specific community in mind, and facilitate communication across teams and providers.
- The federal government should scale existing state legislation:
  - Mental Health in School Curricula (NY and VA): The federal government should establish a pilot program that funds technical assistance for integrating mental health programming into school curricula. The Department of Education should issue a report evaluating the impact of curricula changes in NY and VA. Finally, while school curricula is not typically set at the federal level, Congress should pass a resolution encouraging states to follow the NY or VA model.
  - Additional Funding for School Mental Health clinicians (CA, DC, NC, SC): The Department of Education should to provide guidance on best practices for funding additional mental health counselors in schools.
  - Adapting Medicaid for Better School-Based Coverage (KY, MI, LV): Centers for Medicaid and Medicare Services should offer technical assistance to states that wish to improve Medicaid coverage of school-based mental health.
  - Suicide Prevention (CO, IL, KY, ME): The Department of Education should issue a report evaluating the effectiveness of these laws in reducing suicide and/or self-harm rates.
- Congress should support introduced legislation, including:
  - Elementary and Secondary School Counseling Act
  - Mental Health Services for Students Act of 2019
  - RISE from Trauma Act
  - Academic, Social, and Emotional Learning Act of 2015
  - Caring Start Act of 2015
  - Student Support Act

2 Increase Access to Mental Health Resources

Schools can be an important place for learning about mental health, screening for problems, and even accessing services directly. Some schools currently teach about mental health in health classes, but a more consistent, comprehensive, and evidence-based approach could better prepare students to access effective help. Although some school districts employ providers with mental health training, the need is so great and often provider's time is split between other duties. School-based health centers show promise. Specifically, schools equipped with school-based health centers have found improvements in adolescent mental health outcomes, a decline in depression, and a reduced likelihood of suicide ideation among students.[80] However, the majority of schools do not have access to well-equipped school-based health centers though, and the shortage of providers with training in mental health poses a barrier. Federal policy can help schools integrate adequate mental health resources to identify and address the needs of their students.

ACTION ITEMS:

- The federal government should fund the evaluation of school mental health curricula and create a center for dissemination and technical assistance for implementing effective programs.
- The federal government should provide planning grants and fund a learning collaborative for states to implement Medicaid waivers or state plan amendments that increase reimbursement for mental health screening and services in schools and ECE, either through providers employed by the school or through partnered school-based health centers, and including streamlining regulations for providing tele-mental health services in schools.
- The federal government should make available funds for training school-based health providers in evidence-based mental health early intervention, giving enough capacity for addressing mild-to-moderate needs when mental health providers are otherwise not accessible.
- The federal government should require cross-agency collaboration to build out a list of evidence-based mental health interventions. For example, ESSA requires schools to implement evidence-based interventions in response to findings from needs assessments, and the U.S. Department of Education's What Works Clearinghouse is a go-to resource for school districts on evidence-based interventions, but mental health interventions are largely absent.
- The federal government should further increase incentives for providers to practice in school and ECE settings through loan repayment programs.
- The federal government should fund learning networks and formal evaluations of student-led initiatives to improve mental health in schools and on campuses.

3 Establish Linkages with Community

While schools and ECE are an important site of intervention for children, everything that is needed for children to live well cannot occur within the four walls. Especially because so much of children's health is intertwined with their family's health and wellbeing, they need a coordinated system of services and supports after they go home. Children with serious emotional disturbance who are receiving Individualized Education Programs (IEPs) under the Individuals with Disabilities Education Act (IDEA) in particular need such coordination, but presently community mental health resources and in-school IEP resources are siloed, and stressed families are left to play the role of coordinator.

ACTION ITEMS:

- The Department of Education and/or Health and Human Services should make available model forms that navigate HIPAA-FERPA privacy issues and the federal government should increase the federal match in Medicaid for health information technology investments when used to integrate data systems between community providers and educational systems.
- The federal government should provide planning grants and fund a learning collaborative for states to implement Medicaid waivers or state plan amendments that align Medicaid, early intervention, and IEP services to create coordinated continuums of care for children.
- CMS should offer guidance or issue a state Medicaid Director letter on the topic of credentialing of mental health clinicians in schools as there is often confusion and inconsistencies on the topic.
- The federal government should set aside funds to support local community providers and educational partnerships in developing innovative payment and delivery models that coordinate health care and other services for whole families (including the parents) and teachers and staff through schools and ECE. These models could then be considered by the Centers for Medicare and Medicaid Innovation for potential further scaling.

Workplace & Unemployment

Just as schools are a perfect conduit for mental health interventions in young people, the workplace is an ideal intervention point for working-age adults, who constitute 63% of the U.S. population.[81]

On the other hand, workplaces can also cause or exacerbate mental health conditions when not well configured to promote mental health. The economic stress of the modern economy influences workplace mental health. Lack of access or ability to work is also associated with a range of negative outcomes. Providing supports and implementing interventions for employees in the workplace, or those experiencing unemployment, could significantly improve America's mental health outcomes.

Employers can play a major role in addressing workplace mental health from the benefits they purchase, to the onsite services and programs they offer, to employee turnover, and to high health care costs. Globally, mental health conditions cost an estimated $1 trillion dollars in lost productivity.[82] Unfortunately, many people who are at the greatest risk of poor mental health outcomes are in employment situations where their employers have made no attempt to integrate evidence from mental health to improve productivity and wellbeing. For those employers who want to tackle mental health, access to good evidence about effective strategies can be a challenge, and many use strategies that both lack evidence and are not being evaluated for effectiveness. For those experiencing unemployment, whether because of temporary job loss or disability, effective supports for positive mental health can be even more sparse.

Federal policy can support employers across America to create more mentally healthy workplaces that can increase productivity, further grow the economy, and enhance the wellbeing of millions of working adults, as well as ensure the wellbeing of those not currently, or not able to participate, in the workforce.

Globally, mental health conditions cost an estimated $1 trillion dollars in lost productivity

MENTAL HEALTH IN THE WORKPLACE & UNEMPLOYMENT SOLUTIONS:

1 Whole Workplace Interventions

Workplace factors impact mental health. In particular, aspects of workplace culture and climate have been associated with better or worse employee mental health. In addition, certain workplace-wide interventions have been tested and demonstrated effective in improving employee mental health. Despite this growing evidence, very few American employees actually receive any effective interventions.

ACTION ITEMS:

- The federal government should fund a research consortium on interventions for workplace culture and climate that improve employee mental health, and practical evaluation tools that employers can use to determine if interventions they implement are effective, along with incentives for employers to participate in the consortium.
- The federal government should create an incentive for employers who may not have the capacity to implement effective interventions (e.g. small employers) or who may not see the economic returns of effective interventions (e.g. high rates of employee turnover), but who employ individuals at an elevated risk of negative mental health outcomes (e.g. low-income individuals in low-paid jobs), to implement and evaluate effective interventions by contracting with certified vendors of evidence-based interventions.

2 Accommodations and Accessibility

Workplace policies impact the mental health of all employees, and in particular affect whether individuals with mental health conditions have the support they need to succeed. Although the positive effect of many of these policy changes on productivity are becoming increasingly well documented (and are actually required by law as accommodations for individuals with mental health conditions) many employers have not systematically implemented them – especially many employers of individuals at the highest risk.

ACTION ITEMS:

- The Department of Justice should issue guidance on the Americans with Disabilities Act compliance for mental health, including a set of evidence-based employer policies that are demonstrated to effectively promote accessibility for individuals with mental health conditions. Guidance for all employers with a certain number of employees should state the near certainty that at least one employee has a mental health condition and they should implement these policies to reduce the likelihood of violations.
- The federal government should provide funding for the Occupational Safety and Health Administration to implement requirements for preventing suicide and related mental health safety issues that result from workplace conditions, as well as placing limits on unfair liability.

3 Job Loss and Disability

Job loss is a critical moment for people's mental health. A lack of support during a loss can lead to exacerbation of mental health problems and worse employment outcomes in the future or even disability. While unemployment benefits and supports are available in some instances, they are highly stigmatized and accessing them can further compound mental health problems. If someone does become disabled, they enter a rigid set of policies that treat disability as a permanent status. Often disability policies discriminate against individuals with mental health and substance use disorder, which should not be allowed. Policy should better recognize that recovery is the new standard and be more flexible to support gradual returns to some amount of work. Federal policy can help initiate and scale pilots to test more effective approaches to supporting people during employment transitions and disability that improve mental health and economic productivity.

ACTION ITEMS:

- The federal government should create a center within the Social Security Administration that allows for the piloting of innovative models for providing benefits that can further improve outcomes by waiving certain current requirements, but which must still protect legally entitled access – similar to how the Center for Medicare and Medicaid Innovation functions, and that is encouraged to work with CMS on pilots that coordinate health care.
- The federal government should create incentives in federal workforce development programming to make arrangements with an employer's human resource department to be notified as soon as an employee loses their job, so that the workforce development program can actively outreach to offer services and supports to help the person reengage in the workforce as quickly as possible without stigma or shame.
- The federal government should extend eligibility for supplemental security and disability income to include people with substance use disorders.

Whole Community

The sectors explored this far in this agenda are especially effective entry points for improving mental health outcomes. Healing the nation requires cross-cutting reforms that help these sectors be greater than the sum of their parts. Mental health and recovery are impacted by all aspects of community life and engaging whole communities to improve mental health will be more powerful than any single program or intervention.

Build Toward Collective Impact

CREATING AN INFRASTRUCTURE FOR COLLABORATION

Coordination is a theme throughout the recommendations, but rather than having each organization figure out its own web of collaborations, some communities have pioneered approaches to bringing everyone to the table at once to have collective impact. Decades of local leadership have offered lessons in how these cross-sector initiatives can be effective, and increasingly organized networks across the country are trying to iteratively build on these efforts. While many different federal programs support collective impact approaches related to mental health, they tend to each focus a little bit of resources toward many different issues, such as child abuse, opioid overdose prevention, or suicide prevention, rather than building the fundamental capacity in the community to collaborate effectively regardless of the goal and make faster progress on all of these outcomes. Note that collective impact approaches are especially effective for addressing the vital conditions as they relate to mental health.

BUILD AN ACCOUNTABLE COMMUNITY FOR HEALTH SOLUTIONS:

1 Set Common Goals

Right now, federal funding streams each come with their own goals and metrics. To the extent these goals and metrics do not align, they can make it hard for different stakeholders to collaborate on common objectives. For example, if housing providers are evaluated on how many people they find housing for, mental health providers are evaluated by how many people they serve, and community development is evaluated on the number of units it builds that are available to low-income individuals, it might make it hard for the two to work together to ensure people get access to housing that meets their specific needs and receive the support they need to thrive once in their housing placements (activities that might reduce the number of people served by each program but improve overall outcomes across the population). Federal policy can allow communities to align goals and metrics across programs to facilitate collective impact.

ACTION ITEMS:

- The federal government should initiate a review of current measures used across programming and the extent to which grantees in communities across the programs are likely to collaborate, and implement a streamlined measure set – which should recognize the centrality of mental health (and the role of families in the case of children's mental health).
- The federal government should allow for waivers of certain federal program requirements when grantees are engaged in collective impact around common goals that advance the purpose of the program, allowing grantees to focus on metrics and activities relevant to the common goals, and which may be implemented in tandem with Medicaid innovations.

2 Share Infrastructure for Continuous Improvement

To make progress toward common goals, stakeholders will need to be able to share data and develop some capacity to learn together about how to most effectively serve their population. Currently, some communities have found ways to share data across sectors, but it often took years and received very little support from federal policy. Once shared, some communities are able to use the data to inform decision-making, but few if any have been able to implement a system to drive systematic improvement that spans sectors. For example, some communities have used data to "hot spot" areas that are experiencing especially poor outcomes and deploy additional healthcare and social services in those areas, but few are able to then rapidly evaluate the impact of the intervention and share learnings to improve for next time.

ACTION ITEMS:

- The federal government should ensure that all federal funding streams to communities specify privacy and data sharing requirements in the context of collective impact that effectively advances the program's goals.
- The federal government should increase the Medicaid matching funds for IT investments that support collective impact for population health, and systematically specify the extent to which other federal funding streams may be used to contribute toward a shared data infrastructure.
- The federal government should fund a network of quality improvement organizations that support collective impact in communities for population health, with a focus on mental health (and the role of families in the case of children's mental health).

3 Ensure Financial Sustainability

Many collective impact arrangements are sustained by a grant and may not survive once the grant is over. Further, some grants provide enough resources for stakeholders to come together and identify common problems, but not enough to implement a shared solution. For example, a grant may bring stakeholders together on child maltreatment, where they identify an issue of lack of social support for new parents, but then there are no resources available to implement even a small program to provide that support. Federal policy can ensure that investments in communities are better leveraged by supporting the sustainability and effectiveness of collective impact.

ACTION ITEMS:

- The federal government should fund a learning collaborative and technical assistance for states in implementing Medicaid waivers or state plan amendments that allow some amount of Medicaid funds to support collective impact to advance population health.
- The federal government should systematically specify the extent to which federal funds across various programs can be used to sustain collective impact activities that advance the goals of the program – although does not need to be (and should not be) a separate collective impact initiative specific to that program's goals.
- The federal government should fund technical assistance and learning collaboratives for implementing community-level financing approaches that can make available the necessary resources for meeting common goals and include the participation of various federal agencies to ensure that their program requirements align with the financing approaches.

Strengthen Positive Norms

SPREADING HOPE AND INCLUSION

Community norms and attitudes have a tremendous impact on mental health. Community attitudes toward mental health impact how likely individuals are to discuss needs and seek help once a need is identified. Community attitudes toward the inclusion or exclusion of individuals with mental health conditions affect recovery by creating or limiting social and economic opportunities. Finally, community norms can even influence whether mental health conditions are developed at all – communities that prioritize emotional wellbeing, mutual support, and optimism toward the future experience lower rates of mental health problems.[83] While community norms and attitudes are shaped indirectly through a range of social and economic policies, federal policy can also target norms and attitudes directly.

STRENGTHEN POSITIVE NORMS SOLUTIONS:

1 Tackle Stigma and Discrimination

Negative attitudes toward individuals with mental health conditions prevent individuals from seeking help they need and prevent individuals in treatment from having access to critical social and economic opportunities. Policy can assert the acceptability of seeking services and the inclusion of people with mental health conditions to improve outcomes.

ACTION ITEMS:

- The federal government should incorporate funding to support prominently displays of messaging around mental health screening across a variety of federal funding programs that are likely to reach underserved populations.
- The Department of Justice should issue guidance on requirements under the Americans with Disabilities Act to initiate certain universal accommodations (modifications that are available without having request individualized accommodations, such as wheelchair ramps on buildings) for mental health. Although individuals currently have a right to individualized accommodations for mental health, no guidance has been issued on the need for universal accommodations despite the high prevalence of mental health as a disability.
- The federal government should place a requirement in federal funding of mental health programs to include screenings for potential legal needs around discrimination and indicate that such screenings may be covered under state Medicaid plans, and increase federal funding for the Protection and Advocacy of Individuals with Mental Illness program to accommodate the additional need.

2 Promoting Positive and Supportive Norms

Mental health can and should be everyone's job. Each person's mental health and wellbeing is determined in large part by the daily interactions they have with others in the community. On the extreme ends, experiences of interpersonal trauma are linked to worse mental health outcomes, while access to someone that can act as a meaningful source of social support is linked to better mental health outcomes. While not everyone can be a source of meaningful source of social support for everyone else, each person can at least make a positive contribution to the people they interact with. Further, attitudes across the community also impact outcomes. If most people feel like their community is able to work together to overcome challenges and attain a bright future, everyone experiences better mental health outcomes. Federal policy can help generate and disseminate the best available evidence for how to improve mental health across communities and invest in norm change interventions to make it second nature for communities across the country.

ACTION ITEMS:

- The federal government should fund a learning network of community social norm and attitudinal change interventions that test different approaches and evaluate impacts on population mental health outcomes.
- The federal government should fund projects to test methods of social norm and attitudinal changes through national or regional media, potentially including television, movies, and books, and evaluating impacts on population mental health outcomes.
- The federal government should create incentives for the development of new consumer technologies that advance social norm, and attitudinal change, and evaluate impacts on population mental health outcomes.

Vitalize Social and Economic Life

CREATING OPPORTUNITY OF ALL KINDS

So much of mental health promotion and recovery revolves around ensuring stable engagement in positive social and work-related activities. Many mental health prevention and recovery programs focus on connecting people with these opportunities in communities and supporting them to succeed. But what happens when positive social and work-related opportunities are not available? This is a reality that some community programs have begun to grapple with, and it is a hard problem for a community program to solve. It also likely explains many of the poor mental health outcomes that people face – they were not able to access an opportunity at a critical point in their life, and they experienced worse outcomes as a result. Federal support for coordinated efforts to vitalize the social and economic life of communities could improve mental health across America.

VITALIZE SOCIAL AND ECONOMIC LIFE SOLUTIONS:

1 Leverage Community Development

Congress currently supports billions of dollars of investment in the economic development of underserved communities. Despite a growing evidence base on how different approaches to economic development can improve or hurt the mental health of a community, mental health impacts are rarely considered in the way these funds are used.[84,85] This represents a tremendous missed opportunity that federal policy can more effectively leverage.

ACTION ITEMS:

- The federal government should fund a research consortium to advance the evidence for community development and mental health and create recommended approaches and evaluation tools for community development projects that seek to improve mental health.
- The federal government should pilot altering some of the existing community development funds so that they must both increase investment in underserved area and improve the mental health of the current community members, including support for evaluation.
- The federal government should put requirements for meaningful engagement with community members (and especially those with mental health conditions or other disabilities) in community, economic, and workforce development federal funding programs.

2 Prioritize Social Inclusion

Although more and more research connects social isolation with mental health problems and a range of other chronic conditions, relatively few resources have been invested in creating social opportunities at the community level.[86] When local stakeholders do go above and beyond and create new social opportunities in their community, they do not have tools to evaluate the effectiveness and improve over time – especially for ensuring that everyone ultimately feels included and has opportunities to interact with diverse groups. Without dedicated resources and tools for evaluation and improvement, communities will not be able to meaningfully advance inclusive social opportunities for their members.

ACTION ITEMS:

- The federal government should fund the development of a common set of evaluation tools and methods for community social outcomes, including the extent to which each individual's experience needed forms of social support and community and whether individuals have access to diverse social opportunities.
- The federal government should review federal funding in communities and systematically include, as appropriate, measures of community social outcomes to help various programs add to the vibrancy of the community – including a particular focus on community development funding.

FOCUS POPULATIONS

Special considerations should be given to how specific populations are impacted differently by mental health problems and the continuum of care provided to address them, because current approaches do not meet the needs of many.

Mental health care is not accessible to a population if the care provided is not effective for them. Further, certain backgrounds or experiences are also associated with particular mental health needs, and policy needs to ensure that everyone gets the supports that are relevant and necessary for them. This section discusses policy-making that takes into account intersecting identities in general, and then gives specific recommendations for several populations:

- Individuals with Co-Occurring Mental Health Disorders and Intellectual and Developmental Disabilities
- Pregnant and Postpartum Women
- Unhoused Individuals
- Native Americans
- Veterans
- LGBTQ People
- Immigrants

Addressing Unique Needs

Individuals with mental health needs are not a homogenous group – each individual has a range of other identities based on their race, ethnicity, primary language, gender or gender identity, sexual orientation, disability, veteran's status, or life circumstances.

Unfortunately, most mental health services were developed and tested by non-Hispanic white middle-class men on Caucasian middle-class men. This legacy informs the training that mental health providers receive and impacts the care that they are able to provide. Research demonstrates this empirically – evidence-based treatments are not as effective for some groups when applied without adaptation,[87] and for issues like linguistic differences, may not be effective at all. In some cases, miscommunications about needs or insensitivity to differences may even lead to worse outcomes than no treatment at all.[88] Access to mental health services and supports is meaningless unless they are effective for that individual.

ADDRESSING INTERSECTING NEEDS SOLUTIONS:

1 Access to Effective Services

As federal policy works to expand access to care for individuals with mental health conditions, it must consider their unique needs by understanding their experiences and communities and what this means for the effectiveness of the care delivered. Access to services, non-discrimination, and other requirements meant to ensure fair treatment of all need to take the perspectives of individuals with intersecting identities in order to make the policies meaningful.

ACTION ITEMS:

- The federal government should ensure that incentives in federally-funded mental health care access programs for underserved populations, including provider training programs, consider the unique needs of each community and what qualifies as underserved.
- The federal government should direct specific guidance on, and fund audits of, access and non-discrimination requirements for Medicaid managed care and fee-for-service state plan design as they relate to access to effective mental health care for different intersections. This includes ensuring coverage of the mental health services that best meet the needs of individuals and requiring corrective action to train providers in effectively addressing the mental health needs of people with different intersections.
- The federal government should increase the incentives for individuals to join the mental health workforce and for training programs to actively recruit and effectively train individuals with different intersections to meet underserved needs.

2 Supporting Equity-Focused Research

Many mental health interventions have not been meaningfully evaluated for effectiveness on different subpopulations, and it is unclear whether they are effective and whether they need to be adapted. In addition, many interventions pioneered by subpopulations for dealing with mental health in their communities have not received funding for evaluation, so they have not had the opportunity to demonstrate effectiveness and attain scale. Mental health research policy must help dive deeper in current directions, but also increase breadth to ensure that it is inclusive and ultimately effective for everyone.

ACTION ITEMS:

- The federal government should institute a scoring preference in grants for research that promotes the efficacy of interventions for subpopulations.
- The federal government should set-aside research funding to support evaluations of innovations pioneered by subpopulations that have not had the chance to be evaluated.

Individuals with Co-Occurring Mental Health Disorders and Intellectual and Developmental Disabilities

People with intellectual and developmental disabilities (IDD) die 16 years earlier, on average, than the rest of the population. Health care clinicians too often fail to understand their health care needs resulting in the denial of critically needed services – especially related to mental health. Not only do many clinicians generally lack the knowledge and skills to serve people with IDD, but they also frequently misunderstand whether behaviors are associated with the person's IDD or mental health condition. Individuals with IDD face a higher prevalence of mental health conditions, and policy must better promote health equity for this population.

MENTAL HEALTH SUPPORT FOR INDIVIDUALS WITH CO-OCCURRING MENTAL HEALTH DISORDERS AND DEVELOPMENTAL DISABILITIES SOLUTIONS:

1 Ensuring Access to Effective Care

By more intentionally considering the intersecting needs of individuals with IDD and mental health conditions, federal policy can ensure that they receive access to meaningful care.

ACTION ITEMS:

- The federal government should provide long-term funding to states to continue programs like Money Follows the Person (MFP) and the Balancing Incentive Program (BIP) to ensure that people with IDD and mental health conditions have consistent access to comprehensive and high-quality services and supports outside of institutional settings.
- The federal government should put in place incentives in federal funding streams in both mental health and IDD to strengthen the coordination between the two systems on the ground and ensure that individuals with IDD and mental health conditions get access to effective care.

People with intellectual and developmental disabilities (IDD)
die 16 years earlier, on average, than the rest of the population

Pregnant and Postpartum Women

Maternal depression occurs in 10–20% of new mothers and the likelihood increases if the mother has had previous depression or financial hardship. One-in-four mothers of infants below poverty threshold experience moderate-to-severe maternal mental health disorders and only 15% receive care.[89] Maternal mental health affects the health of the child as well, with unaddressed problems increasing the child's risk of developing their own mental health problems later in life.[90] Despite the prevalence of maternal mental health (MMH) conditions and their impact on early childhood development, pregnant and postpartum women consistently lack access to educational, economic, and health-related assistance.

PREGNANT AND POSTPARTUM WOMEN SUPPORT SOLUTIONS:

1 Integrating Services

Integration of effective mental health services and supports into maternity care has received even less attention than other primary care settings, despite the increased stress and developmental implications of pregnancy. A number of innovative maternity care models have been pioneered as well that provide different kinds of support to women that have been linked to better mental health outcomes, but these have not attained scale. Federal policy can accelerate the integration of services and expand access to effective models of care.

ACTION ITEMS:

- The federal government should make Medicaid coverage for women up to one year postpartum a mandatory eligibility category for coverage.
- The federal government should include measures of screening and effective coordination of care for maternal behavioral health in hospital incentive programs for care transitions and quality/safety – including coordination with social services throughout the perinatal period, such as the early intervention Program for Infants and Toddlers with Disabilities (Part C of the Individuals with Disabilities Education Act).
- The federal government should dedicate community development resources for building new centers that offer evidence-based models of comprehensive perinatal care that includes behavioral health supports in underserved areas, in instances where such care would be covered by state Medicaid programs but raising initial capital presents a barrier.
- The federal government should create a seed fund that supports maternity care providers in developing the necessary capacity to begin seeking sustainable reimbursement for evidence-based models of comprehensive perinatal care that includes behavioral health supports.
- The federal government should make available planning grants and state learning collaboratives to design and implement effective Medicaid waivers and state plan amendments that meaningfully expand access to evidence-based models of comprehensive perinatal care that includes behavioral health supports.

Unhoused Individuals

Nearly half of America's unhoused population suffers from a severe mental health condition and/or SUD.[91] Having a mental health condition puts individuals at increased risk of becoming unhoused, and becoming unhoused increasing exposures to trauma and adversity that also increase the risk of developing a mental health condition or exacerbating a current need. It is critical to prevent losses of housing or minimize the duration of being unhoused as much as possible to decrease the negative mental health impacts.

UNHOUSED INDIVIDUALS MENTAL HEALTH SUPPORT SOLUTIONS:

1 Preventing Housing Insecurity

While healthcare has begun to identify housing insecurity as a top priority associated with higher costs and worse outcomes, much less attention has been given to systematic approaches to preventing housing insecurity. Screening and intervention strategies should help connect people to services when they are at risk of becoming housing insecure – not only once they have reached that point. Federal policy can pilot and scale effective approaches to prevention, and it can help ensure that there are affordable housing opportunities available.

ACTION ITEMS:

- The federal government should allow Medicaid funds to be used to reimburse educating housing authorities about risks for housing insecurity and what resources are available to meet those needs, and to coordinate those connections if any of those risks are immediately present.
- The federal government should create incentives in funding programs that go to municipalities for having in place effective policies or strategies for ensuring access to affordable housing.

2 Access to Permanent Housing

If someone does become unhoused, the most effective intervention is to place them in new housing and support them in this placement. Cost-benefit analyses show that this approach, often called Housing First, cost $23,000 less per person each year than individuals who are housed in shelters.[92] Federal policy can help communities better capture these longer-term financial benefits and invest in affordable housing.

ACTION ITEMS:

- The federal government should expand the Department of Housing and Urban Development's (HUD's) Housing First approach, and also dedicate some funds to supporting communities to initiate different financial mechanisms and instruments that could promote additional investment based on the long-term benefits of the program.
- The federal government should include incentives in both HUD and Medicaid funding for coordination to comprehensively support people in their housing placements.

Native Americans

Native Americans have been disproportionally affected by the opioid and suicide epidemic, partially due to intergenerational trauma. While Native Americans require intentional consideration as outlined earlier in the agenda, Native Americans also face particularly complex policy issues – the Indian Health Service is funded as a separate system from Medicaid and Native Americans on tribal lands are governed by tribes instead of states, both of which can lead to disparities in how well Native Americans are included in policy reforms.

MENTAL HEALTH SUPPORT FOR NATIVE AMERICANS SOLUTIONS:

1 Focus Mental Health Policy Reforms for Native Americans

Native Americans could benefit from all of the reforms discussed throughout the agenda and need policy to support them as they face vast health disparities. In doing so though, federal policy must consider the need for additional capacity building, given a legacy of federal disinvestment. Policy must also appreciate the sovereignty of the tribes and ensure that the sovereign tribes have what they need to implement evidence-based strategies for mental health.

ACTION ITEMS:

- The federal government should require that all federal funding sources for mental health be distributed to tribes as well, and given priority based on the greater mental health disparities.
- The federal government should ensure that the Indian Health Service is engaged in the same reform efforts as CMS in mental health and increase funding to build capacity for these efforts as appropriate.
- The federal government should make funds available for tribes to build the necessary capacity to join states in the learning collaboratives around different mental health reforms advocated for in this agenda.

Veterans

Data shows that veterans often experience greater mental health needs at a higher incidence than the general population. One-in-five veterans of Iraq or Afghanistan conflict have major depression or Post-Traumatic Stress Disorder (PTSD), and one in four show signs of substance use disorders.[93] From 2008 to 2016 there were over 6,000 suicides by veterans per year.[94] Not only do veterans have higher rates of need, they also have a separate system serving them – the Veteran's Health Administration – which comes with additional policy considerations.

MENTAL HEALTH SUPPORT FOR VETERANS SOLUTIONS:

1 Ensure Services for Elevated Needs

Being a veteran is another intersection that requires intentional policy consideration. Policy also needs to ensure that the Veteran's Health Administration is included in reform efforts and has sufficient capacity to meet needs. Federal policy can further build the capacity of the Veteran's Health Administration for mental health and ensure that it remains cutting-edge.

ACTION ITEMS:

- The federal government should ensure that the Veteran's Health Administration is engaged in the same reform efforts as CMS for mental health, and that Veteran's Health Administration sites are included in incentive programs for expanding access to underserved populations.
- The federal government should provide funding to ensure that all veterans transitioning to civilian life are connected with comprehensive services and supports and receive education on possible warning signs in the future, for which they may want to seek services (e.g. depression).

LGBTQ People

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) people experience profound mental health disparities, and recently the rates are getting worse – especially for children. For example, children who identified as a sexual or gender minority were almost twice as likely as their heterosexual, cisgender, or binary peers to report feeling so sad or hopeless that it interfered with their daily activities, and more than three times as likely to have attempted suicide.[95] Much of these disparities likely arise from discrimination and isolation, and are compounded by lack of access to care that considers the specific needs and experiences of the population.

MENTAL HEALTH SUPPORT FOR LGBTQ PEOPLE SOLUTIONS:

1 Set Strong Norms for Safety and Inclusion

Many of the reforms for LGBTQ individuals in general will promote access to more effective care. Additional policy attention is needed to prevent the discrimination and exclusion that is likely driving the disparities. The policy opportunities build off of many of the education, workplace, and community policies to offer solutions that are more specific to the needs of this population.

ACTION ITEMS:

- The federal government should codify comprehensive non-discrimination protections for individuals that identify as LGBTQ.
- The federal government should create incentives in policy reforms that advance school climate and culture or student mental health, providing additional financing for schools that implement effective strategies to reduce disparities in belonging and safety for students that identify as LGBTQ. This should include specialized services for suicide prevention for LGBTQ youth.
- The federal government should include requirements in federal funding for child welfare and transition-aged-youth programs for evidence-based training in effective strategies for children and youth who identify as LGBTQ.

Immigrants

Immigrants often face worse mental health outcomes than the general population. Policy should ensure that people immigrating to America have the support they need to thrive; unfortunately, many people immigrate to America to escape circumstances that were traumatizing, and these individuals are at a high risk of negative mental health outcomes. Once in America, individuals may face exclusion and isolation as they try to navigate a new social and economic context, and this too may lead to worse mental health outcomes. Lack of documentation or other barriers can also prevent some individuals from getting access to mental health services once a need develops. This can lead to fear of legal consequences that increases stress.

MENTAL HEALTH SUPPORT FOR IMMIGRANTS SOLUTIONS:

1 Proactively Engage Immigrants

Being an immigrant is another identity for which more considerate mental health access policy can improve outcomes. Being an immigrant also comes with unique policy associated with being in a new setting and potentially facing legal barriers to accessing care, which policy should take into account. Federal policy can invest in more proactive systems for engaging immigrants to improve mental health and ensure that they have what they need to thrive in their new lives in America.

ACTION ITEMS:

- The federal government should make it impermissible to use any information related to seeking mental health treatment for any aspect of immigration enforcement and provide funding to disseminate this information to immigrants.
- The federal government should fund education about the availability of mental health services as part of immigration services, along with screening and referral to culturally competent mental health care for those interested.
- The federal government should fund municipalities to pilot, evaluate, and scale different approaches to socially and economically engage immigrants and reduce the rates of isolation and exclusion.

APPENDIX

I. Acronyms

ACA - Affordable Care Act

ACH - Accountable Communities for Health

ADA - Americans with Disabilities Act

ASQ - Ask Suicide Screening Questions

CBT - Cognitive Behavioral Therapy

CCBHC - Certified Community Behavioral Health Clinics

CDC - Centers for Disease Control

CIT - Crisis Intervention Team

CHIP - Children's Health Insurance Program

CMS - Centers for Medicare and Medicaid Services

CSMHS - Comprehensive School Mental Health Systems

ED - Emergency Department

EHR Incentive - Electronic Health Record Incentive

EMS - Emergency Medical Services

ERISA - Employee Retirement Income Security Act

ESL - English as a Second Language

FACT - Forensic Assertive Community Treatment

FDA - Food and Drug Administration

FQHC - Federally Qualified Health Center

DOL - US Department of Labor

GDP - Gross Domestic Product

HCPCS - Healthcare Common Procedure Coding System

HEDIS - Health Effectiveness Data Information Set

HEADS-ED - Home, Education, Activities and Peers, Drugs and Alcohol, Suicidality, Emotions, and Behavior

HHS - US Department of Health and Human Services

HMO - Health Management Organization

HUD - US Department of Housing and Urban Development

HUD-DVASH - US Department of Housing and Urban Development and Department of Veterans' Affairs Supportive Housing

IMD Exclusion - Institutions for Mental Diseases Exclusion

MAT - Medication-Assisted Treatment

MassTAPP - Massachusetts Technical Assistance Partnership for Prevention

MHIP - Mental Health Integration Program

MHPAEA - Mental Health Parity and Addiction Equity Act of 2008

MMH - Maternal Mental Health

MTSS - Multi-Tiered System of Supports

NADD - National Association for Developmental Disabilities

NQTL - Non-Quantitative Treatment Limitations

PBIS - Positive Behavioral Interventions and Supports

PCP - Primary Care Physician

PDMP - Prescription Drug Monitoring Program

PPS - Prospective Payment System

PTSD - Post-Traumatic Stress Disorder

RDoC - National Institute for Mental Health's Research Domain Criteria

SAMHSA - Substance Abuse and Mental Health Services Administration

SBIRT - Screening, Brief Intervention, and Referral to Treatment

SEL - Social and Emotional Learning

SMI - Serious Mental Illness

SUD - Substance Use Disorder

USPSTF - US Preventive Services Task Force

WHO - World Health Organization

II. Definitions

Language matters as language changes culture.

Well Being Trust aims to be progressive with our language making it reflective of our understanding of health and wellness. For us, mental health is essential to whole health; whole health is essential to well- being. To accelerate the adoption of strategies that help support health and wellness, we want our language to guide our discussions, our policy work, and our grant making.

Below we offer a glossary of terms and definitions to ensure consistency across WBT grantees, partners, and other stakeholders. Just as we unite our language, we must also unite our understanding of the direction we are trying to go for health.

Health: Health is a state of complete physical, mental and social well-being and is not merely the absence of disease or infirmity. Health is the foundation of achievement.[96]

Mental health and well-being: Mental health is a state of well-being in which individual potential is realized, one can ably cope with normal life stressors, works productively, and contributes to the community.

Addiction: Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Well-being: Well-being is a positive outcome that is meaningful for people and for many sectors of society, because it tells us that people perceive that their lives are going well. Good living conditions (e.g., housing, employment) are fundamental to well-being.

Resilience: Is the process of adapting well in the face of adversity whether this is a traumatic event or a daily stressor. It is how well we maintain a stable trajectory of healthy functioning after a highly adverse event.

Trust (noun): Confidence in the reliability, truth, ability, or strength of someone or something. Trust can also be defined as a relationship in which one person holds title to property, subject to an obligation to keep or use the property for the benefit of another.

Trust (verb): To believe in the reliability, truth, ability, or strength of someone or something.

Trauma: An intolerable event or experience that causes the person to be overwhelmed physiologically and causes psychological harm.

Adverse Childhood Experiences (ACEs): Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.

Adverse Community Experiences (ACEs): Communities are plagued by trauma from experiencing adverse community conditions, including interpersonal violence and structural violence. Addressing community trauma requires attention at a population level and consideration of what can be done to prevent trauma in the first place.

Upstream: A term used to describe solving for a problem before it occurs.

Integrated mental health: The care that results from a practice team of medical and mental health clinicians, working together with patients and families, using systematic and cost-effective approaches to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors that contribute to the care pf chronic medical illnesses, life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.

Mental health care: A wide array of services and treatments meant to address suffering from mental illnesses of all types to decrease suffering and disability and to enable healthier, longer, more productive lives. Often defined separately, chemical/dependency substance use services are widely regarded as an integral aspect of mental health care. The continuum of mental health need may range from mild and moderate to people who have more serious and persistent mental health need.

Chemical dependency/Substance use care: Services, treatments, and support to help people with all forms of addiction and substance abuse, to decrease suffering and disability and to enable healthier, longer, more productive lives.

Behavioral health care: A broad category often used as an umbrella term for care that addresses the effect of behavior on health, including patient activation and health behaviors, substance use, mental health conditions, and other behaviors that relate to health. In this sense, behavioral health care is a part of all care settings, and is carried out by clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals. It is simultaneously a systematic and individual competency.

Policy: Movement in a direction for a reason. Policies are often a set of principles that reflect the goal of an organization, state, system, or community. Policies should help promote movement towards a desired goal.

Prevention:

- **Primary prevention:** Aim is to decrease number of new cases; precedes onset of disease; applies to well population
- **Secondary prevention:** Identify and treat disease early; focuses on early intervention in at-risk population; screening for depression and substance use is a prime example of secondary prevention; and,
- **Tertiary prevention:** Aim is to decrease level of disability associated with existing disorder, restore function, and prevent complications; encompasses rehabilitation and continuing care

Wellness: Wellness is an optimal state of health of individuals and groups. There are two aspects: the realization of the fullest potential of an individual physically, psychologically, socially, spiritually, and economically, and the fulfilment of one's role expectations in the family, community, workplace, and other settings.

Stigma: Stigma is dependent on social, economic, and political power and exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a situation that allows them.

Impact investing: Impact investing is investing that intentionally seeks measurable social and environmental benefits.

Social movement: Social movements are forms of collective action that emerge in response to situations of inequality, oppression and/or unmet social, political, economic or cultural demands. They comprise 'an organized set of constituents pursuing a common political agenda of change over time.'

Health Equity: Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Social Justice: The virtue that inclines one to cooperate with others in order to help make the institutions of society better serve the common good. While the obligation of social justice falls upon the individual, that person cannot fulfill the obligation alone, but must work in concert with others, through organized bodies, as a member of a group whose purpose is to identify the needs of society, and, by the use of appropriate means, to meet these needs locally, regionally, nationally, and even globally.

Healthy Community: A healthy community is one in which a diverse group of stakeholders collaborate to use their expertise and local knowledge to create a community that is socially and physically conducive to health. Community members are empowered and civically engaged, assuring that all local policies consider health. The community has the capacity to identify, address, and evaluate their own health concerns on an ongoing basis, using data to guide and benchmark efforts.

Agency: Possessing a sense of control and having the ability and opportunity to make purposeful choices. This exists at a personal, and community level.

III. Access, Coverage, Standards

Access:

Access is a complex concept associated with several features: adequacy of supply, affordability of services, geographic accessibility to facilities and clinicians, and social acceptability of services. Mental health care in the US falls short of providing full access in a number of ways: 1) individuals often have to wait too long for care; 2) "service deserts" across the country make it difficult for people to get to treatment locations; 3) coverage is often inadequate where services are denied or people are asked to pay out of pocket for care; 4) there is a dearth in the availability of culturally and linguistically competent mental health and addiction services and clinicians accessible to racial and ethnic minorities; and, 5) we are missing key opportunities to reach more individuals through the workplace, judicial system, education system, and health systems.

Three-quarters of Americans believe that mental health services are not accessible to everyone, and over half think that clinicians and facilities are too limited. It's easy to see why when 96 million Americans, over a third of the US population, had to wait longer than a week to get access to a mental health clinician, and almost half have to drive over an hour round trip to get to a mental health or substance use treatment location.

If we are serious about our national commitment to support mental health and addiction, we must consider novel approaches to increase access to supportive community-based resources and clinical services rather than simply depending on a referrals mental health specialist. Redistributing mental health clinicians throughout the health care system and emphasizing community peer support networks can provide more timely access. Investments that strengthen underlying community environments can further promote optimal mental health and well-being. Considering mental health services remain unaffordable for many people, and that community-level investments remain nominal, these issues will require a new and bold strategy to improve upon long-standing, entrenched conditions. Achieving optimal well-being is enhanced through supportive social, physical, and economic community environments and the availability of affordable, culturally and linguistically appropriate clinicians and services to navigate challenges.

Coverage:

Being underinsured or uninsured is another foundational barrier to receiving mental health and addiction treatment in the United States. Forty-two percent of the population reported that lack of insurance coverage prevented them from seeking mental health care in 2018, with one-in-five survey respondents saying they had to choose between physical and mental health care for financial reasons. Despite federal laws that require most health insurers to cover physical and mental health conditions at the same level, lack of enforcement has allowed these companies to skimp on benefits. A 2017 Milliman analysis using 2015 data found that mental health was provided out-of-network four to six times as often as medical care and that insurers paid primary care clinicians 20% more than they paid mental health and addiction specialists.[97] In a 2016 survey, three times as many respondents reported having difficulty finding mental health clinicians who took their insurance when compared to primary care physicians (PCP).[98]

Full coverage goes beyond ensuring that public and private insurance companies reimburse all necessary mental and physical health care at fair rates, it means addressing ways to allow for all Americans to have access to affordable and comprehensive health insurance. Many groups are at disproportionate risk of being uninsured, lacking access to care, and experiencing worse health outcomes. For example, people of color and low-income individuals are more likely to be uninsured, face barriers to accessing care, and have higher rates of certain conditions compared to Caucasians and those at higher incomes. Despite major gains stemming from the Affordable Care Act (ACA), one-in-ten nonelderly Americans is uninsured. Half of these people are uninsured due to financial reasons, and another 20% are uninsured because they recently lost their job.[99]

Standards:

Lastly, improving mental health care in the United States relies on implementing high standards of care. This includes standardizing quality across locations and populations. Low-income people and rural residents should receive as high of quality care as wealthier people or those living in cities. This also means developing and distributing care guidelines that provide the most up-to-date evidence-based treatment information to mental health clinicians. One tenth of psychiatric patients discharged from hospitals are readmitted within 30 days, suggesting unmet needs and poor transitions between hospitals and community care clinicians.[100]

One central component of ramping up mental health care quality is integrating mental and physical health care into a single, whole-person oriented system. A plethora of studies and research on integrated care shows that coordinated, co-located, and fully integrated care reduces morbidity and mortality from both psychiatric and physical conditions, cuts down on overall health care costs, and improves patient satisfaction and happiness.

IV. Examples of Currently Introduced Congressional Legislation for Mental Health and Addiction

Protecting Pre-Existing Conditions and Making Health Care Affordable Act of 2019	H.R. 1884	Combats attacks on ACA and pre-existing conditions.
Mental Health Services for Students Act	S.1122/ H.R.1109	Expands the scope of the Project Advancing Wellness and Resilience Education (AWARE) program by providing on-site licensed mental health professionals in schools across the country
Comprehensive Addiction Resources Emergency (CARE) Act	S. 1365 / H.R. 2569	$100 billion over 10 years for addiction
Parity Enforcement Act	H.R. 2848	DOL civil monetary penalty authority
Behavioral Health Coverage Transparency Act	S. 1576 / H.R. 2874	Reporting requirements on parity
LIVE Well Act (HR 2625)	H.R. 2625	Amends existing USDA school and community-based nutrition education and obesity prevention programs to include eating disorders prevention.
Supporting Eating Disorders Recovery through Vital Expansion (SERVE) Act	H.R.2767	Requires TRICARE to cover eating disorder treatment.
Mental Health Professionals Workforce Shortage Loan Repayment Act of 2019	H.R. 2431	Establish a loan repayment program for mental health care providers who commit to working in designated communities with a lack of accessible care.
Medicaid Mental Health Bump Act	H.R. 1920	Provides higher matching rate for MHSUD services.
Stabilize Medicaid and CHIP Coverage Act	S. 873 / H.R. 1879	Provides for continuous 12-month enrollment.
RISE (Resilience Investment, Support, and Expansion) from Trauma Act	S. 1770 / H.R. 3180	Expands and supports the trauma-informed workforce in schools, health care settings, social services, first responders, and the justice system, and increase resources for communities like Chicago to address the impact of trauma.
Excellence in Mental Health and Addiction Expansion Act	S. 824/H.R. 1767	Provides for 2-year funding of CCBHCs and expands to all states that applied.
Mainstreaming Addiction Treatment Act	S. 2074/H,R, 2482	Eliminates separate waiver to prescribe MAT.
Mental Health Access Improvement Act	S. 286/ H.R. 945	Provides for the coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program.
Medicaid Reentry Act	H.R. 1329	Grant states flexibility to restart Medicaid benefits 30 days prior to release.

V. Summary of Solutions

Summary of Health Systems Solutions for Integrating Physical and Mental Health Care

Primary Care

FINANCING

- The federal government should require that all primary care payment models initiated by CMS or by the states through waivers include consideration of whether the model would equip the affected practices with the resources they need to effectively offer integrated mental health care. This should include auditing and revising existing models as well as initiating new ones as appropriate and may include carving certain mental health services out of the cost benchmark to ensure that there are adequate incentives for building out integrated care.
- The federal government should mandate payers and provider to assess outcomes across population subgroups in an effort to ensure integration is promoting positive outcomes across all populations. If not, the federal government should support changes that will provide the culturally appropriate integrated care needed to help eliminate disparities.
- The federal government should mandate prioritization of mental health screening and outcome measures in federal value-based payment models – including ensuring that the measures are weighted to reflect their importance for population health. The federal government should also create a fund that can help low-performing systems improve by implementing evidence-based integration approaches.
- The federal government should create a seed fund that supports primary care providers, and especially Federally-Qualified Health Centers and Rural Health Centers, in developing the necessary capacity to begin seeking sustainable reimbursement for integrated mental health care services (which could be effectively paired with parity initiatives, as described later in this report).
- The federal government should make available planning grants and state learning collaboratives to design and implement effective Medicaid waivers and state plan amendments that meaningfully expand access to high-quality mental health care.

TRAINING

- The federal government should provide incentives, through Graduate Medical Education (GME), Graduate Nursing Education (GNE), and other programs, for health care practitioner education institutions to offer training in integrated mental health care.
- Providers should be incentivized to take additional Continuing Medical Education (CME) classes on current best practices.[101]
- The federal government should focus existing federally funded quality improvement organizations on mental health integration across diverse primary care practices and for serving diverse populations, and finance additional learning collaboratives as necessary.

Hospitals

IDENTIFICATION AND INTERVENTION ACROSS SPECIALTIES

- The federal government should ensure that hospital payment models and quality programs incentivize assessing mental health at every interaction as a vital sign, and not only during well visits. This should include integrating screening and treatment into episode-based payment models for health conditions for which there are frequent mental health comorbidities, such as cardiovascular diseases, cancers, and pulmonary diseases.
- The federal government should increase incentives for reducing readmissions for mental health problems over ninety days and provide seed funds for safety net hospitals to have the necessary resources to perform well on these new incentives.
- Suicide and mental health crises should be included as part of hospital safety initiatives and evidence-based strategies should be integrated into federally funded hospital quality improvement programs. Examples include the Zero Suicide program.

INTEGRATING CARE IN EMERGENCY DEPARTMENTS

- The federal government should invest in piloting and scaling innovative information technology solutions to improving the successful triage and coordination of care for individuals with mental health conditions that present to EMS or the ED,[102,103] including connections with social services.[104]
- The federal government should provide funding or centralized administration to expand the availability of online "bed boards" that allow clinicians to find available psychiatric beds in other hospitals and transfer patients to those facilities with the caveat that these beds are not geographically prohibitive from a person having access to their family or caregiver.[105]
- The federal government should fund the development and dissemination of evidence-based training and continuing education materials on mental health for ED staff.
- The federal government should establish a three-digit suicide prevention lifeline number. The FCC has recommended that 9-8-8 be designated as the new lifeline number, and dollars should be appropriated to allow for local call centers to support ongoing services from the call line.

Community Mental Health Centers

FINANCING

- The federal government should expand the Certified Community Behavioral Health Centers (CCBHC) initiative to provide a more flexible and comprehensive financing to mental health centers so that they have the resources they need to provide integrated care for all who could benefit while assuring quality and accountability for integrated care.
- The federal government should encourage better inclusion of community mental health centers in alternative payment models, such as Accountable Care Organizations (ACO). Community mental health centers could take on accountability for the population of people that would benefit from having their care coordinated from a specialty mental health setting.

DATA INTEGRATION

- The federal government should amend the HITECH Act to extend financial incentives to mental health clinicians for using electronic health records. Mental health and addiction clinicians are not included as clinicians eligible for the Act's assistance.[106]
- The federal government should align 42 CFR part 2 with HIPAA, as a regulatory barrier, for purposes of treatment, payment, and health care operations so that Substance Use Disorder (SUD) information can be incorporated into health records while protecting privacy and individuals with mental health conditions can receive more integrated care.
- The federal government should extend Medicaid and Medicare electronic health record (EHR) Incentive program eligibility to include all mental health professionals providing care at psychiatric hospitals, mental health treatment facilities, and SUD treatment facilities. Only psychiatrists are currently eligible for this program, hindering the use of electronic health records among other mental health clinicians.

Summary of Health Systems Solutions for The Opioid Epidemic

Access to Effective Treatment

- The federal government should encourage the use of evidence-based treatments, including Medication-Assisted Treatment (MAT).
- All physicians should receive training on addiction in medical school and should then be able to prescribe MAT without separate training and waiver. This would require a reform to the DATA 2000 waiver.
- The federal government should amend the Medicaid and Medicare statutes to substantially strengthen access to effective substance use treatments. Medicare and Medicaid should cover the full range of effective substance use treatments. These treatments should be mandatory benefits in Medicaid, which would build on the addition of MAT as a mandatory Medicaid benefit in the SUPPORT Act. The federal government should clarify how these treatments are covered under the Essential Health Benefits, which apply to exchange and Medicaid expansion, and parity for commercial plans. The federal government should also work with states that have not expanded Medicaid to identify solutions for ensuring coverage of low-income individuals.[107,108,109]
- On the private insurance side, the federal government should enact new protections for MAT by requiring health plans to cover FDA-approved medication for SUD if medically necessary.
- The federal government should eliminate the limit on the number of patient's clinicians can treat with MAT, like buprenorphine.[110]
- CMS should create an expedited application process for coding MAT drugs with the Healthcare Common Procedure Coding System to streamline activities/oversight.[111]
- The federal government should also make MAT more accessible by directing the Health Services and Resources Administration to ensure that MAT is offered at all Federally Qualified Health Centers (FQHCs) and require all FQHCs clinicians to get DATA 2000 waivers to prescribe buprenorphine.

- The federal government should allocate additional funding and authorize uses of existing federal funding to support different stakeholders in forming, joining, and sustaining community coalitions focused on improving addiction and overdose outcomes. This should include Medicare and Medicaid, as is currently being piloted with the Accountable Health Communities Model.
- The federal government should direct the Centers for Medicare and Medicaid Services to issue an order that all state Medicaid programs must cover FDA-approved MAT drugs without prior authorization.
- The federal government should direct the Department of Health and Human Services, in consultation with the American Society of Addiction Medicine (ASAM), to develop model standards for the regulation of SUD treatment programs based on the Levels of Care standards set forth in the most recent version of The ASAM Criteria and condition receipt of certain federal grants on state adoption.
- The federal government should remove the legislative and regulatory barriers that prevent the use of federal funds for syringes used in syringe service programs (SSPs).
- The federal government should direct the National Institute of Health to provide more grants to researchers looking into treatment for SUD.
- The federal government build multi-stakeholder opioid safety coalitions. The federal government should support these coalitions by providing grants to states.

Limit and Regulate Opioid Prescribing

- The federal government should limit and regulate opioid prescribing by making educational grants and funding for medical programs contingent on their inclusion of safe-prescribing practices in curricula.
- The federal government should address the importance of clinically-indicated and evidence-based utilization management processes for ensuring that opioids are not inappropriately prescribed in Medicare and Medicaid.[112] The federal government should also initiate a multi-payer effort to encourage commercial insurers to adopt similar practices.
- The federal government should ensure that Medicare covers evidence-based alternatives for pain management, and fund systematic reviews that indicate how such therapies would fit within medical necessity guidelines of commercial plans.[113]
- The federal government should provide incentives in its funding for health care educational programs to include training on safe prescribing and related practices for minimizing risk of addiction.
- The federal government should publicize Take Back Days or implement permanent Take Back Programs, including funding the installation of permanent drug take-back drop-off boxes in federal facilities located in cities around the country.[114]
- The federal government should encourage states and local governments to raise awareness of the National Prescription Drug Take Back Day (October 26) or institute state-wide versions of the same drug-reduction effort.

Overdose Reversal Drugs

- The federal government should mandate that naloxone be available in all federal facilities (e.g. post offices).
- Federal laws should be adjusted to require coverage of naloxone without co-pay by public and private insurers, and require co-dispensing naloxone with long-term (i.e., longer than a week) opioid prescriptions, which evidence suggests could cut opioid-related emergency visits by half within a year.[115]
- The federal government should make certain funding contingent on states implementing naloxone training programs for first responders and community members in relevant funding programs.
- The federal government should investigate making naloxone have an over the counter (OTC) status, but at a minimum, have a standard order or protocol in place.

Prescription Drug Monitoring Programs (PDMPs)

- The federal government should increase the efficacy of PDMPs by funding technical assistance and learning collaboratives for states, including facilitating data sharing between states, or by creating a nationwide PDMP.
- The federal government should build provider incentives for using PDMPs into existing programs that incentivize the use of health information technology.
- The federal government should increase the efficacy of PDMPs by directing the Department of Health and Human Services to issue a report on how to build a nationwide PDMP or facilitate data sharing between states.

Summary of Health Systems Solutions for Insurance and Reimbursement

Coverage Parity

- Congress should amend the Employee Retirement Income Security Act (ERISA) to authorize the Department of Labor to impose fines on plans and insurers offering health insurance coverage in connection with a group health plan that violate the parity law.
- The federal government should provide adequate funding for federal agencies to conduct random audits of health plans on an annual basis and establish a system for reviewing all consumer complaints for potential violations of MHPAEA. The federal government should assist states with funding to enforce MHPAEA.
- The federal government should require health plans to conduct detailed parity compliance analyses on their non-quantitative treatment limitations (NQTLs) and require that these analyses to be made public.
- The federal government should require each plan to conduct a MHPAEA "risk assessment" – similar to the existing HIPAA privacy and security risk assessment – that details the plan's capabilities to document, assess, and comply with all aspects of MHPAEA, thus encouraging the plan to develop a robust parity compliance program.

- The federal government should direct the Center for Consumer Information and Insurance Oversight to exercise its authority under the parity law to regulate plans in states that fail to "substantially enforce" the law by relying solely on consumer complaints to check for parity compliance.[116]
- The federal government should require that insurers cover the full range of intermediate mental health and addiction services, including residential care, intensive outpatient, and partial hospitalization services.
- The federal government should create a definition of medical necessity and require that all medically necessary mental health and addiction care be covered by insurers.
- The federal government should apply parity provisions to Medicare, Medicaid fee-for-service, and TRICARE, which currently are not subject to MHPAEA.
- The federal government should direct CMS and state Medicaid agencies to prioritize ongoing enforcement of MHPAEA for Medicaid managed care plans.
- The federal government should create health plan performance standards for mental health and addiction coverage that, if not met would trigger parity investigations.
- The federal government should give the Department of Labor – like many state insurance departments – the power to charge health plans for the cost of parity investigations to help the Department increase the number of investigators (currently 1 per every roughly 10,000 plans).
- The federal government should require insurers to public report metrics comparing mental health and addiction coverage to medical/surgical coverage such as denial rates, utilization review practices, appeals,
out-of-network usage, and reimbursement.
- The federal government should make it easier for patients wrongly denied care to protect their rights by ensuring all patients have the ability to access federal courts and to receive damages for harm caused by wrongful denials, and prohibiting insurance "discretionary clauses" where insurers are given the right to interpret the meanings of their own policies.
- The federal government should require the U.S. Department of Labor and other applicable federal agencies to enforce existing health insurance appeals protections to consumers, including disclosing the clinical review criteria used in a medical necessity denial and ensuring that health plans comply with statutory/regulatory timeframes for processing each appeal.
- The federal government should require the U.S. Department of Labor and other applicable federal agencies to publish an annual report card, which rates health plan parity compliance similar to CMS's Five-Star Quality Rating System.
- The federal government should promote parity compliance tools that help automate the compliance process such as 1) the CMS Compliance Toolkit Applying MH/SUD Parity Requirements to Medicaid and CHIP (Jan 2017); 2) The "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements published by The Kennedy Forum, American Psychiatric Association, and The Parity Implementation Coalition (September 2017); 3) the U.S. DOL Self-Compliance Tool for MHPAEA (May 2018); and ClearHealth Quality Institute ParityManager™ Compliance Tool (July 2019).

Statutory Limits on Care

- Congress should require MACPAC to assess the recent expansions of IMD access through Medicaid and recommend to Congress additional changes that expand access to both residential and community-based services and promote integration, and quality of mental health and substance use disorder services.
- The federal government should eliminate Medicare's 190-day lifetime limit on inpatient psychiatric hospital care.[117]

Recovery Services

- The federal government should revise current Medicare fee-for-service payment policies to incorporate recovery services where appropriate.
- The federal government should task CMS to initiate multi-payer collaboratives, which engage both public and private insurers, to develop efficient reimbursement policies to spur the uptake of recovery services in communities.

Preventive Care

- Federal preventive care regulations should support coverage of services that promote healthy mental development and prevent the later onset of mental health conditions, rather than solely focusing on screening for early indications of a developing condition. In doing so, the regulations should include services provided to parents and primary caregivers of children, with or without the child present – appreciating the evidence for supporting parents in promoting mental health.

Summary of Health Systems Solutions Investing in the Future of Health Systems

Building the Workforce of the Future

- The federal government should fund a campaign to educate high school, college, and graduate students on the need for people to enter the mental health workforce, the diverse and changing opportunities it presents, and the increasing pay associated with parity and other regulatory changes.
- The federal government should expand funding programs that build institutional capacity to offer mental health specialties, such as the Behavioral Health Workforce Education and Training Program, and include incentives in other funding sources, such as Graduate Medical Education and Graduate Nursing Education.
- The federal government should expand programs that provide direct incentives for individuals to enter the mental health workforce, such as the National Health Service Corps or the Minority Fellowship Program.

Investing in Research for the Future

- The federal government should expand mental health research funding so that it is commensurate with the burden of disease.
- The federal government should initiate a public-private partnership to communicate the opportunities for investment in mental health research and development to private investors and collaborate on ways to de-risk investments in the area.

Innovative Technologies

- CMS should delineate clear coverage pathways for the diverse new technologies being developed for mental health and should update Medicare and Medicaid statutes as necessary to create additional pathways.
- CMS should provide guidance on how new mental health technologies intersect with existing insurance regulations, especially as the technologies develop a stronger evidence.
- The federal government should fund public-private research collaboratives to better understand the impacts of consumer technologies on mental health and how to ensure that technologies best support mental health. The federal government should create a pot of funding to allocate awards to technology companies that ultimately adhere to what evidence-based guidelines emerge for developing technologies that most effectively promote mental health.

Summary of Judicial Systems Solutions

Diversion From Incarceration

PROVIDING ENHANCED SERVICES FOR PEOPLE AT RISK

- The federal government should explicitly authorize healthcare payment models that target decreased justice system involvement as an outcome and provide planning grants and technical assistance to support innovative pilots that share justice system savings with healthcare when they reduce incarceration.

CHANGING APPROACHES TO CRISIS INTERVENTION

- The federal government should authorize use of Medicaid matching funds for information technology investments that enable more seamless service referrals after a crisis response.
- CMS should provide planning grants and funding for learning collaboratives for states to develop effective approaches to crisis response that include Medicaid covered services the Department of Justice should include target metrics of reducing preventable arrests and increasing successful mental health service linkages as performance measures across federal law enforcement funding streams to change incentives.

SUPPORTING FORMAL DIVERSION PROGRAMS

- CMS should clarify to what extent Medicaid funds can be used for screening, diagnosis, and diversion from justice settings.
- The federal government should include incentives in federal justice system funding for establishing formal procedures for routine mental health screenings early in the process and diversion to services as appropriate.
- The federal government could provide capacity development grants to states, as they did in the SUPPORT Act for states to develop provider capacity for MAT.

Care While Incarcerated

PROVIDING INCENTIVES FOR QUALITY CARE

- The federal government should include requirements in federal justice system funding for aligning correctional health funding with quality and access standards for general health care, including penalties for failing to screen for mental health conditions and providing evidence-based services.
- The federal government should also promote quality classifications of facilities so that high-need inmates can be placed in facilities that have the capacity to meet their needs.[118]
- The federal government should expand interoperability and electronic health record incentives and requirements to correctional health settings, including allowing the use of Medicaid funds for information technology investments to promote integration between correctional and community providers.[119] In 2016, guidance authorized 90% match for connecting eligible providers to correctional health providers.[120]

SUPPORTING STAFF AND INMATES

- The federal government should offer initial funding to train correctional officers in evidence-based mental health supports, and increasingly make having staff with competencies in this area a requirement for receiving federal justice funding.
- The federal government should fund learning networks for implementing recovery supports in jails and prisons and allow incarcerated individuals to have access to federal education loans and grants to support access to formal educational opportunities as well.

Re-Entry Into Community

CONTINUITY OF CARE

- The federal government should introduce incentives into its justice system funding for enrolling people in Medicaid before release and require protocols for connecting to community services similar to those required for hospital discharge planning.
- The federal government should introduce a performance measure into its justice system funding of receiving mental health treatment 7- and 30-days post-release, similar to how hospital performance is measured.
- The federal government should support jails and prisons to build processes that automate enrollment of incarcerated individuals in Medicaid using the documentation for which states may already have access.[121,122]

RE-ENTRY PROGRAMMING

- CMS should clarify how Medicaid-funds can be used with treatment while incarcerated and re-entry programming to ensure that they meet the needs of individuals with mental health conditions and provide guidance on reimbursement and liability issues associated with hiring peer support specialists with the experience of being justice involved.[123]
- The federal government should fund additional demonstrations of specialty mental health parole and probation programs for justice systems.[124]
- The federal government should require re-entry programs it funds to create linkages with other community resources, including mental health services and supports, supportive housing programs, as well as other workforce programs that could continue to support individuals even after the re-entry period.[125] CMS should issue the 1115 guidance facilitating care transitions at re-entry that was required in the SUPPORT Act.

Summary of Solutions in the Education System

Mainstream Universal Mental Health Promotion

- The federal government should require that schools and universities select indicators related to student mental wellbeing, such as school culture and climate, as a core metric of school performance under federal education funding, and ensure that other federal education funding authorizes uses of funds to help schools perform well on the new indicators.
- The federal government should create incentives for the development of continuing education programs that build core competencies in addressing children's mental health and wellness. Specifically, the U.S. Department of Education should issue guidance to states on how professional development funding can be utilized to support the development of both training programs and continuing education programs that address children's mental health and wellness.

- The federal government should create incentives for teaching and childcare education programs to build core competencies in promoting classroom mental health and leading school-wide change, so that more teachers enter the workforce with these skills.
- The federal government should work to build the capacity of schools to understand the mental health needs of their students, and provide support for meaningful intervention. This could be through funding from Congress or guidance from the U.S. Department of Education. For example, providing guidance to schools on where they can access data to better understand student mental health needs and connect those needs with evidence-based interventions. The federal government should make funding available for schools to contract with quality improvement organizations that support schools and ECE programs to mainstream mental health promotion into their activities, evaluate outcomes, and learn over time.
- Congress should amend the Elementary and Secondary Education Act to highlight that training in mental well-being programs are allowable uses of Title II funding.
- Congress should amend the Head Start Act to direct the Department of Health and Human Services to prioritize implementation of trauma-informed programs and age-appropriate positive mental health interventions and supports.
- The federal government should encourage schools to respond to students with mental health issues with SEL lessons or with executive function training programs like the ACTIVATE program. State education agencies can do this by allocating Federal Title I education funds to these programs in schools. HHS can also research and implement methods to prevent suspension and expulsion in schools; or, HHS can issue guidance on the issue.
- The federal government should require private and public health plans to reimburse mental health screening during well-child exams. This screening should be based on SAMHSA's Screening, Brief Intervention, and Referral to Treatment approach and it should include an adverse childhood experience component.
- The federal government should fund grants to assist schools without the resources for in-house therapists.
- The federal government should equip schools with school-based health centers and school health providers (e.g. school nurses, school psychologists, school social workers) to improve adolescent mental health outcomes, drive a decline in depression, and ensure a reduced likelihood of suicide ideation among students.
- The federal government should fund teacher trainings that promote general knowledge of child and adolescent mental health, verbal de-escalation skills, incorporating mindfulness into teaching practices, and Youth Mental Health First Aid.
- The federal government should require cross-agency collaboration to develop a guide for creating high-quality frameworks. Schools and districts should adopt a prevention, intervention, response, and treatment framework to ensure that children with different levels of need get appropriate care, which requires coordination across teachers, health providers, and families.
- The federal government should establish equity in access by providing education about mental health services, directly engaging students instead of waiting for them to come to a mental health counselor and maintaining confidentiality of treatment. Cultural competency in mental health support should also be included in teacher training on mental health issues.

- The federal government should advance research and practices locally, and organize strategies into widely recognized frameworks, integrate mental health practices into schools' academic missions, introduce integrated models into schools, keep the needs of each specific community in mind, and facilitate communication across teams and providers.
- The federal government should scale existing state legislation:
  - Mental Health in School Curricula (NY and VA): The federal government should establish a pilot program that funds technical assistance for integrating mental health programming into school curricula. The Department of Education should issue a report evaluating the impact of curricula changes in NY and VA. Finally, while school curricula is not typically set at the federal level, Congress should pass a resolution encouraging states to follow the NY or VA model.
  - Additional Funding for School Mental Health clinicians (CA, DC, NC, SC): The Department of Education should to provide guidance on best practices for funding additional mental health counselors in schools.
  - Adapting Medicaid for Better School-Based Coverage (KY, MI, LV): Centers for Medicaid and Medicare Services should offer technical assistance to states that wish to improve Medicaid coverage of school-based mental health.
  - Suicide Prevention (CO, IL, KY, ME): The Department of Education should issue a report evaluating the effectiveness of these laws in reducing suicide and/or self-harm rates.
- Congress should support introduced legislation, including:
  - Elementary and Secondary School Counseling Act
  - Mental Health Services for Students Act of 2019
  - RISE from Trauma Act
  - Academic, Social, and Emotional Learning Act of 2015
  - Caring Start Act of 2015
  - Student Support Act

Increase Access to Mental Health Resources

- The federal government should fund the evaluation of school mental health curricula and create a center for dissemination and technical assistance for implementing effective programs.
- The federal government should provide planning grants and fund a learning collaborative for states to implement Medicaid waivers or state plan amendments that increase reimbursement for mental health screening and services in schools and ECE, either through providers employed by the school or through partnered school-based health centers, and including streamlining regulations for providing tele-mental health services in schools.
- The federal government should make available funds for training school-based health providers in evidence-based mental health early intervention, giving enough capacity for addressing mild-to-moderate needs when mental health providers are otherwise not accessible.

- The federal government should require cross-agency collaboration to build out a list of evidence-based mental health interventions. For example, ESSA requires schools to implement evidence-based interventions in response to findings from needs assessments, and the U.S. Department of Education's What Works Clearinghouse is a go-to resource for school districts on evidence-based interventions, but mental health interventions are largely absent.
- The federal government should further increase incentives for providers to practice in school and ECE settings through loan repayment programs.
- The federal government should fund learning networks and formal evaluations of student-led initiatives to improve mental health in schools and on campuses.

Establish Linkages with Community

- The Department of Education and/or Health and Human Services should make available model forms that navigate HIPAA-FERPA privacy issues and the federal government should increase the federal match in Medicaid for health information technology investments when used to integrate data systems between community providers and educational systems.
- The federal government should provide planning grants and fund a learning collaborative for states to implement Medicaid waivers or state plan amendments that align Medicaid, early intervention, and IEP services to create coordinated continuums of care for children.
- CMS should offer guidance or issue a state Medicaid Director letter on the topic of credentialing of mental health clinicians in schools as there is often confusion and inconsistencies on the topic.
- The federal government should set aside funds to support local community providers and educational partnerships in developing innovative payment and delivery models that coordinate health care and other services for whole families (including the parents) and teachers and staff through schools and ECE. These models could then be considered by the Centers for Medicare and Medicaid Innovation for potential further scaling.

Summary of Solutions for Workplace and Unemployment

Whole Workplace Interventions

- The federal government should fund a research consortium on interventions for workplace culture and climate that improve employee mental health, and practical evaluation tools that employers can use to determine if interventions they implement are effective, along with incentives for employers to participate in the consortium.
- The federal government should create an incentive for employers who may not have the capacity to implement effective interventions (e.g. small employers) or who may not see the economic returns of effective interventions (e.g. high rates of employee turnover), but who employ individuals at an elevated risk of negative mental health outcomes (e.g. low-income individuals in low-paid jobs), to implement and evaluate effective interventions by contracting with certified vendors of evidence-based interventions.

Accommodations and Accessibility

- The Department of Justice should issue guidance on the Americans with Disabilities Act compliance for mental health, including a set of evidence-based employer policies that are demonstrated to effectively promote accessibility for individuals with mental health conditions. Guidance for all employers with a certain number of employees should state the near certainty that at least one employee has a mental health condition and they should implement these policies to reduce the likelihood of violations.
- The federal government should provide funding for the Occupational Safety and Health Administration to implement requirements for preventing suicide and related mental health safety issues that result from workplace conditions, as well as placing limits on unfair liability.

Job Loss and Disability

- The federal government should create a center within the Social Security Administration that allows for the piloting of innovative models for providing benefits that can further improve outcomes by waiving certain current requirements, but which must still protect legally entitled access – similar to how the Center for Medicare and Medicaid Innovation functions, and that is encouraged to work with CMS on pilots that coordinate health care.
- The federal government should create incentives in federal workforce development programming to make arrangements with an employer's human resource department to be notified as soon as an employee loses their job, so that the workforce development program can actively outreach to offer services and supports to help the person reengage in the workforce as quickly as possible without stigma or shame.
- The federal government should extend eligibility for supplemental security and disability income to include people with substance use disorders.

Summary of Solutions for the Whole Community

Build Toward Collective Impact

SET COMMON GOALS

- Congress should ensure that all federal funding streams to communities specify privacy and data sharing requirements in the context of collective impact that effectively advances the program's goals.
- The federal government should initiate a review of current measures used across programming and the extent to which grantees in communities across the programs are likely to collaborate, and implement a streamlined measure set – which should recognize the centrality of mental health (and the role of families in the case of children's mental health).
- The federal government should allow for waivers of certain federal program requirements when grantees are engaged in collective impact around common goals that advance the purpose of the program, allowing grantees to focus on metrics and activities relevant to the common goals, and which may be implemented in tandem with Medicaid innovations.

SHARE INFRASTRUCTURE FOR CONTINUOUS IMPROVEMENT

- The federal government should ensure that all federal funding streams to communities specify privacy and data sharing requirements in the context of collective impact that effectively advances the program's goals.
- The federal government should increase the Medicaid matching funds for IT investments that support collective impact for population health, and systematically specify the extent to which other federal funding streams may be used to contribute toward a shared data infrastructure.
- The federal government should fund a network of quality improvement organizations that support collective impact in communities for population health, with a focus on mental health (and the role of families in the case of children's mental health).

ENSURE FINANCIAL SUSTAINABILITY

- The federal government should fund a learning collaborative and technical assistance for states in implementing Medicaid waivers or state plan amendments that allow some amount of Medicaid funds to support collective impact to advance population health.
- The federal government should systematically specify the extent to which federal funds across various programs can be used to sustain collective impact activities that advance the goals of the program – although does not need to be (and should not be) a separate collective impact initiative specific to that program's goals.
- The federal government should fund technical assistance and learning collaboratives for implementing community-level financing approaches that can make available the necessary resources for meeting common goals and include the participation of various federal agencies to ensure that their program requirements align with the financing approaches.

Strengthen Positive Norms

TACKLE STIGMA AND DISCRIMINATION

- The federal government should incorporate funding to support prominently displays of messaging around mental health screening across a variety of federal funding programs that are likely to reach underserved populations.
- The Department of Justice should issue guidance on requirements under the Americans with Disabilities Act to initiate certain universal accommodations (modifications that are available without having request individualized accommodations, such as wheelchair ramps on buildings) for mental health. Although individuals currently have a right to individualized accommodations for mental health, no guidance has been issued on the need for universal accommodations despite the high prevalence of mental health as a disability.
- The federal government should place a requirement in federal funding of mental health programs to include screenings for potential legal needs around discrimination and indicate that such screenings may be covered under state Medicaid plans, and increase federal funding for the Protection and Advocacy of Individuals with Mental Illness program to accommodate the additional need.

PROMOTING POSITIVE AND SUPPORTIVE NORMS

- The federal government should fund a learning network of community social norm and attitudinal change interventions that test different approaches and evaluate impacts on population mental health outcomes.
- The federal government should fund projects to test methods of social norm and attitudinal changes through national or regional media, potentially including television, movies, and books, and evaluating impacts on population mental health outcomes.
- The federal government should create incentives for the development of new consumer technologies that advance social norm, and attitudinal change, and evaluate impacts on population mental health outcomes.

Vitalize Social and Economic Life

LEVERAGE COMMUNITY DEVELOPMENT

- The federal government should fund a research consortium to advance the evidence for community development and mental health and create recommended approaches and evaluation tools for community development projects that seek to improve mental health.
- The federal government should pilot altering some of the existing community development funds so that they must both increase investment in underserved area and improve the mental health of the current community members, including support for evaluation.
- The federal government should put requirements for meaningful engagement with community members (and especially those with mental health conditions or other disabilities) in community, economic, and workforce development federal funding programs.

PRIORITIZE SOCIAL INCLUSION

- The federal government should fund the development of a common set of evaluation tools and methods for community social outcomes, including the extent to which each individual's experience needed forms of social support and community and whether individuals have access to diverse social opportunities.
- The federal government should review federal funding in communities and systematically include, as appropriate, measures of community social outcomes to help various programs add to the vibrancy of the community – including a particular focus on community development funding.

Summary of Solutions for Focus Populations

Addressing Unique Needs

ACCESS TO EFFECTIVE SERVICES

- The federal government should ensure that incentives in federally-funded mental health care access programs for underserved populations, including provider training programs, consider the unique needs of each community and what qualifies as underserved.
- The federal government should direct specific guidance on, and fund audits of, access and non-discrimination requirements for Medicaid managed care and fee-for-service state plan design as they relate to access to effective mental health care for different intersections. This includes ensuring coverage of the mental health services that best meet the needs of individuals and requiring corrective action to train providers in effectively addressing the mental health needs of people with different intersections.
- The federal government should increase the incentives for individuals to join the mental health workforce and for training programs to actively recruit and effectively train individuals with different intersections to meet underserved needs.

SUPPORTING EQUITY-FOCUSED RESEARCH

- The federal government should institute a scoring preference in grants for research that promotes the efficacy of interventions for subpopulations.
- The federal government should set-aside research funding to support evaluations of innovations pioneered by subpopulations that have not had the chance to be evaluated.

Individuals with Co-Occurring Mental Health Disorders and Intellectual and Developmental Disabilities

ENSURING ACCESS TO EFFECTIVE CARE

- The federal government should provide long-term funding to states to continue programs like Money Follows the Person (MFP) and the Balancing Incentive Program (BIP) to ensure that people with IDD and mental health conditions have consistent access to comprehensive and high-quality services and supports outside of institutional settings.
- The federal government should put in place incentives in federal funding streams in both mental health and IDD to strengthen the coordination between the two systems on the ground and ensure that individuals with IDD and mental health conditions get access to effective care.

Pregnant and Postpartum Women

INTEGRATING SERVICES

- The federal government should make Medicaid coverage for women up to one year postpartum a mandatory eligibility category for coverage.
- The federal government should include measures of screening and effective coordination of care for maternal behavioral health in hospital incentive programs for care transitions and quality/safety – including coordination with social services throughout the perinatal period, such as the early intervention Program for Infants and Toddlers with Disabilities (Part C of the Individuals with Disabilities Education Act).
- The federal government should dedicate community development resources for building new centers that offer evidence-based models of comprehensive perinatal care that includes behavioral health supports in underserved areas, in instances where such care would be covered by state Medicaid programs but raising initial capital presents a barrier.
- The federal government should create a seed fund that supports maternity care providers in developing the necessary capacity to begin seeking sustainable reimbursement for evidence-based models of comprehensive perinatal care that includes behavioral health supports.
- The federal government should make available planning grants and state learning collaboratives to design and implement effective Medicaid waivers and state plan amendments that meaningfully expand access to evidence-based models of comprehensive perinatal care that includes behavioral health supports.

Unhoused individuals

PREVENTING HOUSING INSECURITY

- The federal government should allow Medicaid funds to be used to reimburse educating housing authorities about risks for housing insecurity and what resources are available to meet those needs, and to coordinate those connections if any of those risks are immediately present.
- The federal government should create incentives in funding programs that go to municipalities for having in place effective policies or strategies for ensuring access to affordable housing.

ACCESS TO PERMANENT HOUSING

- The federal government should expand the Department of Housing and Urban Development's (HUD's) Housing First approach, and also dedicate some funds to supporting communities to initiate different financial mechanisms and instruments that could promote additional investment based on the long-term benefits of the program.
- The federal government should include incentives in both HUD and Medicaid funding for coordination to comprehensively support people in their housing placements.

Native Americans

FOCUS MENTAL HEALTH POLICY REFORMS FOR NATIVE AMERICANS

- The federal government should require that all federal funding sources for mental health be distributed to tribes as well, and given priority based on the greater mental health disparities.
- The federal government should ensure that the Indian Health Service is engaged in the same reform efforts as CMS in mental health and increase funding to build capacity for these efforts as appropriate.
- The federal government should make funds available for tribes to build the necessary capacity to join states in the learning collaboratives around different mental health reforms advocated for in this agenda.

Veterans

ENSURE SERVICES FOR ELEVATED NEEDS

- The federal government should ensure that the Veteran's Health Administration is engaged in the same reform efforts as CMS for mental health, and that Veteran's Health Administration sites are included in incentive programs for expanding access to underserved populations.
- The federal government should provide funding to ensure that all veterans transitioning to civilian life are connected with comprehensive services and supports and receive education on possible warning signs in the future, for which they may want to seek services (e.g. depression).

LGBTQ People

SET STRONG NORMS FOR SAFETY AND INCLUSION

- The federal government should codify comprehensive non-discrimination protections for individuals that identify as LGBTQ.
- The federal government should create incentives in policy reforms that advance school climate and culture or student mental health, providing additional financing for schools that implement effective strategies to reduce disparities in belonging and safety for students that identify as LGBTQ. This should include specialized services for suicide prevention for LGBTQ youth.
- The federal government should include requirements in federal funding for child welfare and transition-aged-youth programs for evidence-based training in effective strategies for children and youth who identify as LGBTQ.

Immigrants

PROACTIVELY ENGAGE IMMIGRANTS

- The federal government should make it impermissible to use any information related to seeking mental health treatment for any aspect of immigration enforcement and provide funding to disseminate this information to immigrants.
- The federal government should fund education about the availability of mental health services as part of immigration services, along with screening and referral to culturally competent mental health care for those interested.
- The federal government should fund municipalities to pilot, evaluate, and scale different approaches to socially and economically engage immigrants and reduce the rates of isolation and exclusion.

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