



Navigating The New Frontier of Mental Health and Addiction:

A Guide for the 115th Congress



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I'd like to extend a warm welcome to the 115th Congress, and share with you and your staff the following guide, which will help your efforts to bring about meaningful change for the millions of Americans living with a mental health condition or addiction.

It is time to end the needless suffering across America, as well as in your home districts. The stakes couldn't be clearer: The opioid epidemic continues to rage, and more than 55,000 Americans died of accidental drug overdose in 2015 alone. Over 27 million Americans reported using illicit or prescription drugs, and another 66 million reported binge drinking. One in four Americans are impacted by a mental health condition. Furthermore, there exists a strong co-morbidity between these illnesses themselves and a host of other physical health conditions.

This crisis is mostly the result of a systemic lack of care and coverage, despite the fact that everybody knows somebody affected by these illnesses. Too many of your constituents are surrounded by shame and stigma and forced to suffer in silence and fear because of the harsh societal criticisms surrounding their conditions and the discriminatory practices of insurance companies who routinely deny them care.

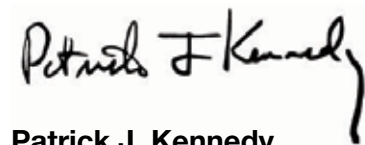
While we can't change stigma in a generation, we can and must put an end to the illegal discrimination of those living with these health conditions. This is our medical civil rights movement and, as policymakers, we must rise to the challenge.

I was the primary sponsor of the 2008 Mental Health Parity and Addiction Equity Act, which mandated that insurance companies treat mental illnesses just the same as they would treat any other physical malady. But we are literally living in denial when we refuse to acknowledge that this law is being blatantly disregarded on a daily basis, leaving millions of Americans unable to access needed mental health and addiction treatment and services.

Insurance companies retain the power to deny care, and often do not disclose the reasons for which the care was denied. The only accountability therefore depends on those with these illnesses to speak up about being denied care for conditions that society has falsely condemned as weaknesses and moral failures. What's worse is that we expect the patient to take this tremendously courageous leap into self-advocacy while he or she is often in the throes of their suffering.

But every problem has a solution, and we are in the solutions business. We have created the first-ever Congressional guide for mental health and addiction. No matter which committee you serve on, or which department you lead, you will find within these pages a clear path towards positively impacting the people you serve, especially when it comes to securing equality for all health conditions.

We have benchmarked progress towards parity, state by state, through our ParityTrack project. This paints a clear picture of what's working and what's not, and where we need to go moving forward. Furthermore, we have introduced ParityRegistry.org, a simple and streamlined resource for reporting parity violations. ParityRegistry empowers those who have been living in the shadows, afraid and unable to access the care they deserve under the law, to step into The New Frontier of Mental Health and Addiction under this Congress and proclaim "I won't be denied."

A handwritten signature in black ink that reads "Patrick J. Kennedy". The signature is fluid and cursive, with a long, sweeping tail on the final letter.

Patrick J. Kennedy

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Introduction

Every day, 246 people die from suicide or drug overdoses.^{i,ii} Approximately 1 in 5 adults aged 18 or older—43.6 million Americans—experience a mental illness in a year.ⁱⁱⁱ About half of this number—21.5 million Americans—have a substance use disorder. This public health crisis costs the nation at least \$467 billion annually in health care, lost earnings, and public disability payments.^{iv} Yet over half of individuals with a mental illness do not receive medically necessary treatment services. Even more astounding, 90% of Americans with a substance use disorder do not receive appropriate care.ⁱⁱⁱ Inadequate access to medically necessary treatment is partly responsible for the disease and economic burden attributable to these illnesses.

Despite this dire and growing epidemic, our country's response has been inadequate at best and willfully negligent at worst. The disparity between how we treat illnesses of the brain and illnesses that affect the rest of the body is stark. One of the easiest ways to see this disparity is to look at health insurance laws that specify coverage of mental illness and addiction treatment. Many state-based laws have restrictive inpatient and outpatient limits, along with annual and lifetime dollar limits, that would be considered unconscionable if they were in place for cancer or diabetes. That's why President George W. Bush signed the Mental Health Parity and Addiction Equity Act (the Federal Parity Law) in 2008. This law states that the separate and unequal insurance coverage for behavioral health conditions, which was the norm for decades, is illegal. However, compliance with the law remains largely unenforced. We will never solve the opioid epidemic or our country's suicide crisis if the Federal Parity Law is not fully implemented.

Insurance coverage is not the only area in which we see great disparity between mental health conditions and substance use disorders and other medical conditions. The current state of affairs for mental health is not on par with the rest of healthcare in many areas, namely timely access to care, care coordination, disease surveillance, research funding, electronic medical records, how law enforcement and the criminal justice system interface with people with behavioral health conditions, and investment in early intervention, just to name a few.

We have failed as a nation in how we have approached the fundamental views, treatment, funding, and research of mental health conditions and substance use disorders. Our health system has a long way to go to achieve true parity between these conditions and others. That's the bad news. The good news is that we have an opportunity before us to work together to fix it.

Anyone will tell you that we have a broken system: Republicans, Democrats, providers, insurers, wardens, police officers, family members, and those living with mental illness and addiction. It doesn't matter who you ask, we all agree that something must be done. We also agree that what we have tried in the past didn't work and we desperately need a new approach.

We will never solve this problem with piecemeal solutions and demonstration grants. We need bold, innovative ideas that challenge us all to think differently while incorporating the existing ideas that have merit and promise.

The industries behind alcohol, prescription opioids and, more recently, high potency marijuana have all demonstrated, time and again, that they are willing to trade public health for personal profit. It is clear, now more than ever, that we need a new approach to protect ourselves from these multinational, corporate interests benefiting from substance misuse.

We have the means to transform our behavioral health system so that we can save lives, improve health outcomes, break down barriers to care, and improve the way our society approaches mental health and addiction outside clinical settings like schools, communities, and the workforce. Below you will find the roadmap for applying comprehensive solutions to our mental health system that is badly in need of an overhaul. You will see the broad categories that must be addressed and find specific recommendations for relevant committees in Congress that will actualize the solutions we need.

General Solutions

Full Implementation of the Federal Parity Law

The Federal Parity Law has been in place for nearly a decade, yet insurance coverage for mental health and substance use disorder care is still more restrictive than coverage for other medical care. Health plans and issuers have simply shifted the way they suppress costs so that disparity is no longer in plain view. Gone are restrictive numerical impositions like outpatient visit limits, inpatient day limits, high coinsurance rates, and paltry annual and lifetime dollar limits. Those types of separate and unequal restrictions were easy to see, so plans and issuers quickly moved to eliminate them.

However, these numerical restrictions have been replaced by managed care techniques that are not so easy to see. These managed care practices are often designed and applied to mental health and addiction care in ways that are far more stringent than how those same practices are designed and applied to other medical care, which violates the Federal Parity Law. We know this takes place because the few times regulators have performed systematic audits, they've found gross violations across the board for all plans examined.^{vi,vii,viii,ix} This continued lack of parity has shattered families, devastated communities, and shifted the cost of care from private insurers to government programs.

Right now, far too much of the burden determining compliance falls upon consumers and their family members. Consumers must request that plans and issuers disclose certain information that would allow them to compare how the mental health and substance use disorder benefits were designed and applied with how the other medical benefits were designed and applied. This information includes extraordinarily complex terminology.^x

For example, is it reasonable to ask a person, especially someone who may be deep in the throes of mental illness or addiction, to decide if, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying a nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits? Of course not. Only a lawyer or policy expert could be expected to figure that out.

This is why we need enhanced consumer protection. People are purchasing health insurance plans, and they are paying a lot of money for them. These plans are supposed to be in compliance with

the Federal Parity Law. We need agencies like the federal Department of Labor (DOL) and state insurance departments to make sure that individuals and small business owners are getting what they pay for when they buy health insurance. Plans and issuers should be required to submit the disclosure information to the relevant regulatory bodies and allow those entities to determine if there is compliance. And, if it is determined that there is non-compliance, or it is not clear, the agencies must follow up and secure compliance. Thankfully, the recently-signed 21st Century Cures Act requires the DOL and the Departments of Treasury and Health and Human Services (HHS) to devise an action plan for enhanced parity implementation.^{xi} The Departments must also hold a meeting to solicit input from stakeholders about the substance of the action plan no later than June 13th. However, there is no reason to wait until June to hold this meeting. This meeting should take place as soon as possible so that the Departments can continue to build on their recent work that was described in the Mental Health and Substance Use Disorder Parity Task Force Final Report issued in October.^{xii}

Screening and Surveillance

Every medical examination must include a mental illness and substance use disorder evaluation—one that is automatically connected, when indicated, to an aggressive plan of early diagnosis and intervention. At every age, we need to get a simple “checkup from the neck up” every time we see a healthcare provider, starting with the depression screen that, though it is now fully covered, many doctors still aren’t using. To ensure our clinical workforce is prepared to deliver these screenings, all healthcare providers should be required to take additional Continuing Medical Education classes on current brain health issues to keep their licenses. Further, the Centers for Medicare & Medicaid Services (CMS) and all private insurers should not only encourage these screenings through reimbursement, but also require that providers consistently use standardized outcomes measures to track patient progress.

The Centers for Disease Control and Prevention (CDC) should establish a broad behavioral health surveillance system so that we have accurate, regularly updated information and statistics on all aspects of the epidemics of mental illness and substance use disorder, including prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses the CDC already covers. The work that the CDC already does on incidence of suicide and some other discreet areas of mental health and addiction, the National Survey on Drug Use and Health done by the Substance Abuse and Mental Health Services Administration (SAMHSA), and other smaller efforts are simply not sufficient for public officials, or the public, to understand and track the burdens of these diseases. Parity is about more than insurance; we also need parity in epidemiology.

Expand Integrated Care

Integrated care is an evidence-based concept with dozens of randomized controlled trials demonstrating its efficacy.^{xiii} A big part of achieving parity between mental health and substance use disorder care and general medicine is eliminating the artificial distinction between them, which is exactly what integrated care is designed to do. Its primary goal is to integrate both medical and mental health care in primary and clinical settings. It has also demonstrated tremendous return on investment. For example, the Washington State Institute for Public Policy found that collaborative primary care for anxiety treatment returned \$23.95 for every dollar spent. Other data indicates similarly positive value in collaborative care for other conditions.^{xiv}

Programs exist around the country that are already doing this at a large scale, demonstrating that this can be replicated in every primary care setting. One example is the Mental Health Integration Program (MHIP) in the state of Washington, sponsored by the Community Health Plan of Washington, and Seattle and King County Public Health.^{xv} It provides access to collaborative care for all mental illnesses and substance use disorders by bringing together primary care and community mental health centers. It also uses a unique payment system tied to quality improvement metrics, and a patient registry that tracks and measures patient goals and clinical outcomes, facilitating treatment adjustments if patients aren't improving.

Another program utilizing these techniques is the Community Mental Health Center (CMHC) Healthcare Homes initiative run by the State's Medicaid Authority (MO HealthNet), the Department of Mental Health, the Missouri Coalition for Community Behavioral Healthcare, and the Missouri Primary Care Association. The program is designed for Medicaid recipients with severe mental illness.^{xvi} It combines many of the latest ideas about diverting "high utilizers" from emergency room care into more long-term coordinated care, but is among the first in the country to include a focus on high utilizers whose primary medical problem is severe mental illness. Their cases are overseen by what are called "health homes" that combine aspects of primary care and community mental health, with cases actively overseen by nurse liaisons and case managers.

For integration of care in emergency rooms and across socioeconomic groups, an excellent model is the work done at Grady Health System in Atlanta with the Morehouse School of Medicine's Satcher Health Leadership Institute and the Georgia Department of Behavioral Health and Developmental Disabilities. This program created an integrated crisis response and emergency medical system and behavioral health-EMS co-response teams that has generated significant cost savings for the health system and decreased emergency department wait times.^{xvii}

Incentivize Value in Service Delivery

There are many different ways for both private and public payers to pay for services. Fee-for-service, cost-based reimbursement, bundled payments, and full capitation are just several of many ways to reimburse providers for delivering care. While there is no “right” system—and variation is crucial depending on populations served, geographic variables, and whether the care is delivered in inpatient, outpatient, or intermediate settings – payment systems that are flexible and reward value in care delivery are critical to improving patient outcomes and containing spiraling costs, especially in tax-payer funded programs.

It is particularly important that we pursue innovative and cost-effective payment models for community-based behavioral health services delivered through Medicaid to improve outcomes and eliminate inefficiency. Fortunately, we already have an existing blueprint for how to do this in the prospective payment systems (PPS) established by the Excellence in Mental Health Act, which was incorporated into the Protecting Access to Medicare Act of 2014.^{xvii} The Excellence Act created a demonstration program that requires the creation of Certified Community Behavioral Health Clinics (CCBHCs) specifically designed to provide services for Medicaid recipients with the most challenging mental health needs. There are eight states participating in the demonstration program and they must use one of two PPS models to pay CCBHCs.

Of particular interest is the second PPS model, which was delineated in guidance from SAMHSA in 2015.^{xix} This PPS establishes a base monthly rate to reimburse CCBHCs, a separate monthly payment rate to reimburse for additional costs associated with treating special populations with certain behavioral health conditions, separate outlier payments for costs that go beyond a state’s established thresholds, and, very importantly, mandates use of quality bonus payments for CCBHCs that meet certain benchmarks in delivering care. This PPS gives states significant flexibility in determining how they structure their separate monthly payments for treatment of special populations by allowing states to create separate rates for different subsets within that population. For example, a state could establish one monthly rate to reimburse for treatment of adults with serious mental illness and co-occurring substance use disorder and another rate for children with serious emotional disturbance who are high utilizers of care. This PPS empowers states to design reimbursement structures that best meet their unique needs, and it demands efficiency by requiring CCBHCs to pursue value-based care.

Increase Use of Medication Assisted Treatment for Opioid Use Disorders

We must respond to the opioid epidemic in cost-effective ways that are consistent with modern science. This response must include much broader use of medication assisted treatment (MAT)—buprenorphine, methadone, and naltrexone; the three Food and Drug Administration (FDA)-approved medications for MAT.^{xx} Public and private insurance plans must begin by covering all three FDA-approved medications and removing onerous fail-first requirements before MAT is approved.

We must also remove dangerous limits on the number of patients a treatment provider who prescribes MAT can have. The current limitations in the law are not based on solid reasoning or scientific evidence. When a nation is in the grips of a serious epidemic that claims over 40,000 lives every year, it can't enact arbitrary barriers that serve no purpose other than to decrease access to lifesaving and life-restoring medication. The opioid epidemic has swept across the country with disregard for socioeconomic status, political affiliation, or geographic location. This is not a political issue but rather a public health issue that requires the best that medicine and science have to offer.

Remove Barriers to Inpatient Treatment in Medicaid and Medicare

We must remove the Medicaid Institutions for Mental Diseases (IMD) exclusion—a law from the 1960s meant to prevent dilapidated facilities from refilling their beds when Medicare/Medicaid was passed—which has instead become the single largest impediment to quality inpatient mental health care, by preventing many facilities from getting Medicaid reimbursement for patients between the ages of 22 and 64.^{xxi} The original purpose of the IMD exclusion was noble—preventing the snakepits that “treated” people with mental illness with barbarous methods from perpetuating mistreatment with federal funding. However, much has changed in the last five decades and it's time for the law to align with current realities. The IMD exclusion is a gross parity violation, there is no valid justification for its continued existence, and it greatly hinders efforts to secure treatment for the most vulnerable in our society.

Congress must also eliminate Medicare's arbitrary 190-day lifetime limit on inpatient psychiatric hospital care—a restriction that does not exist for any other inpatient Medicare service.^{xxii} This limit is particularly harmful for adults between the ages of 22 and 64 who are eligible for both Medicaid and Medicare because of disability status. Many of these individuals with psychiatric conditions are gravely disabled and will likely need more than 190 days of inpatient care throughout their lifetimes. However, once they reach the 190-day limit, the future of their inpatient care is limited to acute hospital stays thanks to this limit and the IMD exclusion. The sickest in our country deserve better.

Removing these senseless treatment limitations will help, but there is another systematic barrier in place. Medicaid reimbursement rates to behavioral health providers and facilities are notoriously low. These low rates disincentivize many behavioral health professionals from accepting Medicaid patients, which hinders access to quality care for those who can least afford to pay out of pocket. Congress can address this problem by passing the Mental and Behavioral Health Care Bump Act, which will require Medicaid to reimburse states for 90 percent of the cost of providing new mental and behavioral health services in excess of states' certain 2017 spending.

Integrate Electronic Health Records

Records for mental health and substance use disorder treatment must be integrated into electronic health record systems so providers have the information needed to treat the whole person—while still protecting patient privacy. While it is true that patients with behavioral health conditions can face poorer care based on their diagnoses on their electronic health records—a phenomenon known as diagnostic overshadowing—we must utilize 21st Century technology and integrate with the rest of health care if we are ultimately going to see real progress.^{xxiii} To protect against diagnostic overshadowing, we should educate general health professionals, including administrative staff and nurses, to correct any negative and inaccurate stereotypes they may have about people with behavioral health conditions.

Additionally, HHS should finalize the update of federal regulation “42 CFR part 2” so substance use disorder information can be incorporated into health records.^{xxiv} Congress must amend the Health Information Technology for Economic and Clinical Health (HITECH) Act and CMS must update its final rule so that mental health professionals and facilities are eligible for financial incentives and reimbursement associated with electronic health records.

Individuals with Comorbid Developmental Disabilities

Our society tends to forget that many youth and adults with intellectual and developmental disorders (IDD) also have a mental illness and/or substance use disorder. The fact is, individuals with IDD are at greater risk for developing other mental health conditions or substance use disorders than the rest of the population.^{xxv} We have a duty and an obligation to provide appropriate care for individuals with both IDD and another psychiatric condition while protecting the dignity and autonomy of those affected.

We must prioritize mental health diagnosis and treatment for individuals with co-occurring developmental disability, mental illness, and substance use disorder and continue to fund successful federal programs, such as Medicaid waivers, Money Follows the Person, and the Balancing

Incentive Payment program. In addition, day rehabilitation treatment programs for adults with dual diagnoses of intellectual disabilities and mental illness that promote independence and focus on transitional planning should be reimbursed by public and private payers. Furthermore, any federal funding to individuals and facilities treating children and adults with co-occurring disabilities must be contingent upon meeting qualifications standards, such as the NADD Accreditation and Staffing Certification Guidelines.^{xxvi}

Mental Health in the Education System and Early Childhood

The mental health of our youth is broadly recognized as an issue of paramount importance to the overall well-being of the country. Children and adolescents spend much of their time in school, and therefore it is critical that our education system is properly equipped to address the social, emotional, and mental health needs of its students and their families. In order to do this we must adopt a multi-faceted approach that is proactive, adaptive, and sustainable. We must also balance our desire for foundational change with the knowledge that under-resourced schools have legitimate concerns about their ability to implement necessary steps unless there is a renewed commitment to funding education at the federal, state, and local levels.

Schools must have a collaborative relationship with the larger community in order to best identify students in need and ensure that they receive support in the appropriate setting. Schools must implement programs that emphasize prevention and early intervention while also promoting resiliency and self-advocacy. A central component of this approach would be universal screening at key transition points in elementary, middle, and high schools. These screenings must use validated tools and have clear procedural guidelines for intervention while also protecting the privacy rights of students and their families.

None of this is possible unless we concurrently create a nation of “mindful educators.” Teachers and other school personnel often feel incapable of identifying and addressing the mental health needs of children in their schools. We must provide educators with training that focuses on general knowledge of child and adolescent mental health, the impact of trauma on learning, verbal de-escalation skills to utilize when conflict arises, and ways to incorporate mindfulness into teaching practices. It is also vital that all school personnel are trained in Youth Mental Health First Aid, which is primarily designed for adults who regularly interact with youth and adolescents.^{xxvii}

All schools should implement interventions that improve learning and brain fitness, as well as build resilience in youth. Programs for social and emotional learning (SEL), executive function training, neurofeedback, mindfulness, and brain literacy help young people improve their traditional educations, but also allow development of better processing skills, promote emotional resilience, and help reduce stress.^{xxviii} They can also temper some of the underlying environmental triggers of mental illness—and the systems created by the interventions often help schools and

parents identify at-risk students.^{xxvii} These programs are easy to integrate into school curricula and don't take a lot of time every day. For SEL, we recommend the Responsive Classroom from the Center for Responsive Schools in northern Massachusetts, which is also supported by the Collaborative for Academic, Social, and Emotional Learning (CASEL), the country's leading organization in SEL research and policy. We recommend that the Department of Education fully embrace all of the policy recommendations put forth by CASEL as the Department implements the Every Student Succeeds Act of 2015.^{xxix}

Law Enforcement and Criminal Justice Solutions

Training grants for Crisis Intervention Team (CIT) programs that follow the Memphis Model should be prioritized.^{xxx} Far too often in our country, interactions between police and those in crisis end in violence that endangers both the person in need and the police officers on the scene.^{xxxi} CIT programs focus on de-escalation techniques and connecting people in crisis with appropriate medical care rather than putting them in county jails on minor charges, where they often languish for months. This is the humane and ethical way to intervene with those in crisis, and it is also much cheaper to send individuals to treatment instead of jail.

Federal Courts should implement, and states and units of local government should be incentivized to implement, a system that diverts individuals with serious mental illnesses or substance use disorders into community-based treatment and support services instead of putting them in jail. The groundbreaking Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) from Miami-Dade has been an incubator for programs, large and small, that can be emulated nationwide.^{xxxii} Any federal funding should be contingent upon using that model. And for those already incarcerated with mental illnesses, states should be incentivized to adopt a version of the Mentally Ill Offender Community Transition Program in Washington State, a collaboration between the Department of Corrections and the Department of Mental Health that made a large impact on recidivism rates.^{xxxiii}

Supported Housing

Homelessness is a significant problem facing our country and it's no secret that many individuals who are chronically homeless have serious mental illnesses and substance use disorders. Up to 46% of the homeless population suffers from a severe mental illness and/or substance use disorder.^{xxxiv} The most effective solution to homelessness, particularly for those who are chronically homeless, is the Housing First model. It also saves public and private dollars compared to other approaches. Housing First operates under the basic premise—which is supported by tangible evidence—that a basic need like stable housing must be provided before other needs like obtaining a job or addressing behavioral health issues are addressed.^{xxxv} Housing First also offers a wide array

of supportive services to its participants to help them address substance use and underlying mental health issues. Research has shown that people enrolled in a Housing First approach are more likely to remain housed a year later than in other models and that Housing First programs can cost \$23,000 less per person each year than those who are in a shelter program.^{xxvi}

The Department of Housing and Urban Development (HUD) should expand its Housing First approach within the Continuum of Care Program and HUD and the Department of Veterans' Affairs Supportive Housing (HUD-VASH) program should be promoted aggressively.

Suicide Prevention

We must make an impact on the nation's rising suicide rate. We support the important work of the JED Foundation in schools, the American Foundation for Suicide Prevention, the National Action Alliance for Suicide Prevention, and the Suicide Prevention Resource Center. The last two groups have also developed a unique effort called Zero Suicide that brings the most modern tools and ideas to a special at-risk group: patients in hospital settings, whose suicides are considered the most clearly preventable of all.^{xxvii}

Zero Suicide began as an aspirational concept in the Air Force in the 1990s and was later used as an experimental benchmark in the Perfect Depression Care Initiative of the Henry Ford Health System.^{xxviii} This new Zero Suicide healthcare initiative employs a unique systems approach involving everyone who interacts with patients, not just their clinicians, and a toolkit that allows much closer study of the processes leading to suicide attempts than previously possible.

But it is time to make “zero suicide” our national standard of care, by accepting that most suicides represent an end-stage of illness for a brain disease and the only real way to prevent them is to improve brain health screening, diagnosis, and treatment. We need to better integrate means reduction, traditional hotlines and innovative crisis text lines, online media tools, and work to reduce the stigma associated with being open about suicidal ideation, suicide attempts, and completed suicides.

Research and Clinical Outcomes

The field of mental health has lagged behind other disciplines in terms of research into the causes of and most effective treatments for mental health and substance use disorders, as well as outcome evaluations for the providers and facilities that administer behavioral health treatment. This is not to say that we lack a substantial research base or that we have failed to evaluate outcomes, but rather that these things are not at parity with other health science. We must increase funding for behavioral health research and also incentivize innovation within the private sector so that behavioral health research is viewed as a viable pathway to pursue.

We must continue to prioritize the Research Domain Criteria Initiative (RDoC), which seeks to move behavioral health diagnoses away from symptom-based identification and towards a more biological framework that incorporates genetics and neuroscience while still allowing for behavioral and experiential factors to have weight in determining clinical diagnoses.^{xxxix}

One of the most important areas of research is that which investigates early intervention for those experiencing first-episode psychosis (FEP) and prodromal symptoms that may portend future psychosis. The Recovery After an Initial Schizophrenia Episode (RAISE) project consisted of two large-scale studies examining the use of coordinated specialty care (CSC) for those experiencing FEP. The RAISE Early Treatment Program examined if CSC worked better than usual care and the RAISE Implementation and Evaluation Study investigated the best way for facilities and providers to implement CSC.^{xl, xli} The North American Prodrome Longitudinal Study (NAPLS) began in 2003 and has been extended twice, most recently in 2014.^{xlii} It studies individuals who have an elevated risk for developing psychotic symptoms to determine the biological mechanisms that may indicate a stronger likelihood of psychosis. We must work to actively disseminate the findings of these studies to clinics and providers throughout the country and seek ways to conduct further research that builds on the findings of the RAISE project and we must expand funding to NAPLS.

While research is critical in determining evidence-based treatments for behavioral health conditions, it is of little use if there is no outcome measurement and performance evaluation of those who use it in clinical settings. Providers and facilities must be accountable and not only incorporate evidence-based practices as intended, but also measure the effectiveness of those practices on client and patient outcomes. This field will never achieve parity with the rest of medicine until it can demonstrate that its clinical methods are just as effective as those employed to treat other diseases.

Discouraging Drug and Alcohol Misuse

This nation also needs an education and awareness campaign about the dangers of drugs and alcohol that is tantamount to the successful effort against smoking. In the absence of such a campaign, social media and other channels are inundated with dangerous and incorrect information about drugs of initiation, including alcohol and marijuana. A fact-based campaign reiterating the emerging science, and reinforcing other efforts in schools and communities, is imperative.

This is especially needed in the current environment which is legitimizing misuse of certain substances, particularly alcohol and marijuana. It is impossible to grapple with substance use and mental health disorders without tackling drugs of initiation, like alcohol, tobacco, and marijuana. Congress should resist efforts to legalize and further legitimize marijuana. Our nation cannot afford to make the same mistakes with marijuana that we made with legal opioids or tobacco in the past.

Congress should put a stop to efforts to legitimize marijuana businesses (for example, by strictly regulating the capacity at which banks can have financial dealings with marijuana businesses), lest we inadvertently support and encourage another entity whose profit motives conflict with the public health interest of preventing substance misuse and addiction.

We also need increased accountability from the transnational corporations that generate over \$200 billion in revenue each year from the sale of beer, wine, and liquor in the United States. Alcohol marketing is ubiquitous in our society, seen everywhere from Super Bowl television commercials to 10-second vertical video ads on Snapchat Live Stories. We acknowledge that these major corporations have reinvested a fractional percentage of their overall earnings into programs that promote responsible drinking, dissuade drunk driving, and prevent underage drinking. However, they should also fund initiatives that help people with alcohol use disorders identify their problematic drinking patterns and seek treatment. This would be a small price to pay towards improved public health, reduced long-term disability, and fewer alcohol-related deaths.

Specific Recommendations for Congress

Below are actionable recommendations for the relevant committees in both the House and the Senate and a table that identifies to which committee(s) each recommendation applies. The two committees most responsible for behavioral health are the Energy and Commerce Committee in the House and the Committee on Health, Education, Labor, and Pensions in the Senate. In the Senate, the Committees on Appropriations, Finance, Judiciary, and Veterans' Affairs also have specific recommendations. In the House, the Appropriations, Education and Workforce, Judiciary, Veterans' Affairs, and Ways and Means are also relevant committees.

The recommendations for each committee are grouped into six categories:

- I. Access to Services**
- II. Prevention and Early Intervention**
- III. Vulnerable Populations**
- IV. Behavioral Health Workforce**
- V. Social Determinants**
- VI. Research**

For the purposes of this document we have arranged the items in each category into two subcategories:

- Items that are likely under a committee's jurisdiction
- Items that could possibly fall under a committee's jurisdiction

Access to Services

Adequate access to services requires that individuals with mental health needs can obtain affordable treatment in a timely fashion, in the community in which they live, and that treatment is delivered in a way that best meets the needs of the individual. Without any of these components, individuals do not have sufficient access to care.

Prevention and Early Intervention

Prevention aims to protect individuals prior to the development of signs or symptoms of a disease. Early intervention identifies persons during the earliest stages of disease in the hopes of connecting them with treatment. Through these early treatment connections, early intervention aims to prevent and reduce negative consequences. Behavioral health screenings, such as Screening, Brief, Intervention, and Referral to Treatment (SBIRT), are examples of early intervention tools with a significant evidence base.^{xliii} If prevention and early intervention were properly integrated into our health care system, individuals would be treated prior to disease onset or in the early stages of illness, resulting in fewer adverse symptoms.

Vulnerable Populations

Several populations are more significantly impacted by mental health and substance use disorders. Some of these vulnerable groups include veterans, the economically disadvantaged, racial and ethnic minorities, the uninsured, the elderly, children in foster care, and individuals experiencing homelessness. When developing mental health interventions, programs and treatments must specifically focus on the elimination of these disparities.

Behavioral Health Workforce

The behavioral health workforce consists of a diverse array of providers, including psychiatrists and other physicians, psychologists, social workers, psychiatric nurses, marriage and family therapists, addiction and mental health counselors, peer support specialists, among others. These professionals deliver prevention, health care, and social service interventions in community-based and inpatient treatment settings.

Social Determinants

The conditions in which a person is born, lives, works, plays, worships, and grows are all social determinants of an individual's health. Socioeconomic conditions, public safety, access to educational opportunities, social support, and exposure to crime across each area also have an impact. These determinants are largely responsible for health disparities between different populations. The social determinants of health are largely acknowledged as critically important when creating solutions aimed at improving population health.

Research

Scientific research on how the brain works and the effects of different interventions is crucial to improving prevention, diagnosis, and treatment of mental illness and addiction. This research becomes the evidence base upon which treatment decisions should be made.

**Table 1: U.S. Senate
Committee Recommendations**

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
Access to Services							
HHS, DOL, and state regulatory agencies should strongly enforce the federal parity law by conducting random audits of health plans on an annual basis, and all regulatory agencies—both state and federal—should scrutinize all consumer complaints for possible violations of the federal parity law		X		X			
Congress must require all health plans to report on how they design and apply medical management criteria and protocols for both behavioral healthcare and medical/surgical care to federal regulators				X			
Payment obstacles that hinder the integration of behavioral health care into all other medical settings, including primary, should be removed		X	X	X			
Evidence-based programs aimed at care coordination following early diagnosis, such as the NIMH's RAISE project, should be further funded and disseminated nationwide		X		X			
CMS should extend eligibility for the Medicare and Medicaid EHR Incentive Program to include all behavioral health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities		X	X	X			
The HITECH Act must be amended to extend financial incentive eligibility for electronic health record use to mental health and addiction treatment providers				X			

Table 1: U.S. Senate Committee Recommendations

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
HHS must finalize the update of federal regulation “42 CFR part 2” so that substance use disorder information can be incorporated into health records while protecting patient privacy				X			
Congress should amend MHPAEA to specify that insurance plans cannot exclude benefits for residential treatment for substance use disorders or eating disorders if they cover benefits for sub-acute inpatient medical and surgical care				X			
Guidance on the implementation of multi-tiered systems of supports for mental health services must be developed and disseminated by the Department of Education				X			
Congress should increase the highest limit on the number of eligible patients providers can treat with medication assisted treatment from 250 to 500				X		X	
Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities		X	X	X			
Congress should pass the Mental and Behavioral Health Care Bump Act, which requires Medicaid to reimburse states for 90 percent of the cost of providing new mental and behavioral health services in excess of states’ certain spending			X				
Congress should incentive states to prioritize the behavioral health diagnosis and treatment of individuals with co-occurring developmental disability, mental illness, and substance use disorder, through the continuation of programs like Money Follows the Person and the Balancing Incentive Payment Program		X		X			

Table 1: U.S. Senate Committee Recommendations

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
Prevention and Early Intervention							
All programs operated or supported by SAMHSA should incorporate the best available science, use evidence-based practices, and measure their effectiveness and efficiency through the adherence to clearly identified goals				X			
Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models			X	X			
Congress should enact legislation requiring all providers to provide and all health plans to reimburse for evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT)		X	X	X			
Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development on mental health conditions in children		X		X			
Congress should amend the Head Start Act so that the HHS secretary is required to prioritize programs that support evidence-based trauma-informed programs, age-appropriate positive behavioral interventions and supports, early childhood mental health consultation, and prevention of suspension and expulsion				X			
Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports		X	X	X			

Table 1: U.S. Senate Committee Recommendations

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
Congress should expand upon the provisions of the Excellence in Mental Health Act that were included in the Protecting Access to Medicare Act of 2014 and implement alternative payment models that incentivize coordination between community-based services		X	X	X			
Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations		X		X		X	
All positive behavioral health screens should be followed by standardized tools used to measure patient outcomes				X			
Vulnerable Populations							
HHS should create the Inter-Departmental Serious Mental Illness Coordinating Committee, which will evaluate the effect on public health of federal programs related to serious mental illness that includes data about health outcomes and other social outcomes such as employment, homelessness, and incarceration rates				X			
Congress should continue to authorize the CLASS program, which provides adults with functional and/or cognitive limitations a cash benefit to purchase non-medical long term support services such as day care, home health care, and transportation services				X			
Congress should extend the National Health Service Corps to include Veterans' Administration Hospitals		X		X			X
Congress must fully fund the Individuals with Disabilities Education Act, which funds a grant program to help states provide special education and related services to children with disabilities		X		X			
Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide	X		X	X			

Specific Recommendations for Congress

Table 1: U.S. Senate Committee Recommendations

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth		X	X	X			
Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region		X		X			
Annual appropriations for the Foster Care Program under Title IV-E of the Security Act should be quadrupled in order to provide adequate support for the children who have been subjected to trauma and adverse childhood experiences (ACEs) <i>Children who have experienced multiple ACEs are more likely to develop mental health conditions and/or substance use disorders as they approach adulthood</i>		X					
The Indian Health Services, a division of HHS, must develop a strategy to address the high incidence of suicide and untreated substance use disorders in Native American communities				X	X		
Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands		X		X			X
The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs		X		X			X
The Behavioral Workforce							
Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals		X		X			

Table 1: U.S. Senate Committee Recommendations

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
Congress should appropriate additional funds to the Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental health and substance use disorders among racial and ethnic minority populations		X		X			
Medical training programs must include discussions of safe-prescribing practices based off of the CDC Guideline for Prescribing Opioids for Chronic Pain, including the use of opioid treatment alternatives when appropriate				X			
Social Determinants							
Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools		X		X			
Unemployment and homeless rates among individuals identified as living with a behavioral health disorder should be tracked				X			
The Occupational Safety and Health Administration should develop a national psychological health and safety in the workplace standard—similar to physical health and safety standards—to help organizations achieve measurable improvement in the psychological health of employees				X			
Titles I and II of the Americans with Disabilities Act (ADA) must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness				X		X	
Expand eligibility for supplemental security income and supplemental security disability income to include people with substance use disorders			X	X			

Specific Recommendations for Congress

Table 1: U.S. Senate Committee Recommendations

Recommendation	Aging	Appropriations	Finance	Health, Education, Labor, and Pensions	Indian Affairs	Judiciary	Veterans' Affairs
Medicaid coverage must be extended to cover evidence-based housing support programs			X	X			
Congress should increase funding for the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs				X			X
Research							
Congress should direct NIH to allocate more funding to the NIMH, NIDA, and NIAA for critically-needed behavioral health research				X			
Congress should continue to appropriate funding to the NIMH Research Domain Criteria (RDoC) initiative				X			
Congress should appropriate funding to the NIMH for research on the determinants of self-directed violence				X			
The CDC should establish a broad and coordinated behavioral health surveillance system that tracks prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses				X			
Brain health research funding should be contingent upon the use of open science principles to increase data sharing across disciplines and institutional boundaries				X			
Federal research grants for behavioral health treatments should include a translational research component on the financial, ethical, logistic, and regulatory aspects impacting dissemination of therapies into clinical and community settings				X			

**Table 2: House of Representatives
Committee Recommendations**

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
Access to Services						
HHS, DOL, and state regulatory agencies should strongly enforce the federal parity law by conducting random audits of health plans on an annual basis, and all regulatory agencies—both state and federal—should scrutinize all consumer complaints for possible violations of the federal parity law			X			X
Congress must require all health plans to report on how they design and apply medical management criteria and protocols for both behavioral healthcare and medical/surgical care to federal regulators			X			
Payment obstacles that hinder the integration of behavioral health care into all other medical settings, including primary, should be removed	X		X			
Evidence-based programs aimed at care coordination following early diagnosis, such as the NIMH's RAISE project, should be further funded and disseminated nationwide	X		X			
CMS should extend eligibility for the Medicare and Medicaid EHR Incentive Program to include all behavioral health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities			X			X
The HITECH Act must be amended to extend financial incentive eligibility for electronic health record use to behavioral health providers			X			
HHS must finalize the update of federal regulation "42 CFR part 2" so that substance use disorder information can be incorporated into health records while protecting patient privacy			X			
Congress should amend MHPAEA to specify that insurance plans cannot exclude benefits for residential treatment for substance use disorders or eating disorders if they cover benefits for sub-acute inpatient medical and surgical care			X			X

Specific Recommendations for Congress

Table 2: House of Representatives Committee Recommendations

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
Guidance on the implementation of multitiered systems of supports for behavioral health services must be developed and disseminated by the Department of Education		X	X			
Congress should increase the highest limit on the number of eligible patients providers can treat with medication assisted treatment from 250 to 500			X	X		
Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities	X		X			X
Congress should pass the Mental and Behavioral Health Care Bump Act, which re-quires Medicaid to reimburse states for 90 percent of the cost of providing new mental and behavioral health services in excess of states' certain spending			X			
Congress should incentivize states to prioritize the behavioral health diagnosis and treatment of individuals with co-occurring developmental disability, mental illness, and substance use disorder, through the continuation of programs like Money Follows the Person and the Balancing Incentive Payment Program	X		X			
Prevention and Early Detection						
All programs operated or supported by SAMHSA should incorporate the best available science, use evidence-based practices, and measure their effectiveness and efficiency through the adherence to clearly identified goals			X			
Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models	X		X			

Table 2: House of Representatives Committee Recommendations

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
Congress should enact legislation requiring all providers to provide and all health plans to reimburse for evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT)	X		X			
Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development on mental health conditions in children	X	X	X			
Congress should amend the Head Start Act so that the HHS secretary is required to prioritize programs that support evidence-based trauma-informed programs, age-appropriate positive behavioral interventions and supports, early childhood mental health consultation, and prevention of suspension and expulsion		X	X			
Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports	X		X	X		
Congress should expand upon the provisions of the Excellence in Mental Health Act that were included in the Protecting Access to Medicare Act of 2014 and implement alternative payment models that incentivize coordination between community-based services	X		X			
Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations			X	X		
All positive behavioral health screens should be followed by standardized tools used to measure patient outcomes			X			

Specific Recommendations for Congress

Table 2: House of Representatives Committee Recommendations

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
Vulnerable Populations						
Congress should extend the National Health Service Corps to include Veterans' Administration Hospitals	X		X		X	
Congress should continue to authorize the CLASS program, which provides adults with functional and/or cognitive limitations a cash benefit to purchase non-medical long term support services such as day care, home health care, and transportation services			X			
Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide	X	X	X			
Congress must fully fund the Individuals with Disabilities Education Act, which funds a grant program to help states provide special education and related services to children with disabilities	X	X	X			
Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth	X		X			
Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region	X		X			
Annual appropriations for the Foster Care Program under Title IV-E of the Security Act should be quadrupled in order to provide adequate support for the children who have been subjected to trauma and adverse childhood experiences (ACEs)" <i>Children who have experienced multiple ACEs are more likely to develop behavioral health conditions as they approach adulthood</i>	X					
The Indian Health Services, a division of HHS, must develop a strategy to address the high incidence of suicide and untreated substance use disorders in Native American communities			X			

Table 2: House of Representatives Committee Recommendations

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands	X		X		X	
The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs	X		X		X	
Behavioral Health Workforce						
Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals	X		X			
Congress should appropriate additional funds to the Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations	X		X			
Medical training programs must include discussions of safe-prescribing practices based off of the CDC Guideline for Prescribing Opioids for Chronic Pain, including the use of opioid treatment alternatives when appropriate		X	X			
Social Determinants						
Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools	X	X	X			
Unemployment and homeless rates among individuals identified as living with a behavioral health disorder should be tracked			X			

Specific Recommendations for Congress

Table 2: House of Representatives Committee Recommendations

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
The Occupational Safety and Health Administration should develop a national psychological health and safety in the workplace standard—similar to physical health and safety standards—to help organizations achieve measurable improvement in the psychological health of employees			X			
Titles I and II of the Americans with Disabilities Act (ADA) must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness			X	X		
Expand eligibility for supplemental security income and supplemental security disability income to include people with substance use disorders			X			X
Medicaid coverage must be extended to cover evidence-based housing support programs	X		X			X
Congress should increase funding for the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs	X		X			
Research						
Congress should direct NIH to allocate more funding to the NIMH, NIDA, and NIAA for critically-needed behavioral health research	X		X			
Congress should continue to appropriate funding to the NIMH Research Domain Criteria (RDoC) initiative	X		X			
The CDC should establish a broad and coordinated behavioral health surveillance system that tracks prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses	X		X			

Recommendation	Appropriations	Education and the Workforce	Energy and Commerce	Judiciary	Veterans' Affairs	Ways and Means
Brain health research funding should be contingent upon the use of open science principles to increase data sharing across disciplines and institutional boundaries	X		X			
Federal research grants for behavioral health treatments should include a translational research component on the financial, ethical, logistic, and regulatory aspects impacting dissemination of therapies into clinical and community settings	X		X			

U.S. Senate Committee on Aging

These are the specific recommendations for the Senate Committee on Aging within the following category:

III. Vulnerable Populations

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

Possibly Under the Jurisdiction of Aging:

- Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide.

Zero suicide is a program that prevents all suicide deaths within any health setting. Given that elderly and university studies are particularly vulnerable to suicide, these principles should be applied to these settings as well.

U.S. Senate Committee on Appropriations

These are the specific recommendations for the Senate Committee on Appropriations within each of these five categories:

- I. Access to Services**
- II. Prevention and Early Intervention**
- III. Vulnerable Populations**
- IV. Behavioral Health Workforce**
- V. Social Determinants**

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

Possibly Under the Jurisdiction of Appropriations:

- HHS, DOL, and state regulatory agencies should strongly enforce the federal parity law by conducting random audits of health plans on an annual basis, and all regulatory agencies—both state and federal—should scrutinize all consumer complaints for possible violations of the federal parity law.

Random audits ensure that health plans remain in compliance with MHPAEA. Given the lack of awareness of MHPAEA, consumers rarely use the word parity when making a complaint.

- Payment obstacles that hinder the integration of behavioral health care into all other medical settings, including primary, should be removed.

Evidence shows that the integration of behavioral health care into other medical settings improves health outcomes and reduces costs.

- Evidence-based programs aimed at care coordination following early diagnosis, such as the National Institute for Mental Health (NIMH)'s RAISE project, should be further funded and disseminated nationwide.

Care coordination starting from the moment diagnoses are shown to be cost-saving and medically effective.

- CMS should extend eligibility for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program to include all behavioral health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities *Of mental health and substance use disorder providers, only psychiatrists are eligible for this program, hindering the dissemination of electronic health records across the wider behavioral health provider community.*
- Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities.
The IMD exclusion prohibits mental health and substance use disorder facilities with more than 16 beds from receiving federal Medicaid financing in Medicaid fee for service. A recent revision of the Medicaid managed care final rule allows federal financial participation for 15 days or less in a given month in an IMD. This rule must be removed completely for both Medicaid fee for service and managed care because it currently prohibits individuals from accessing evidence based and medically necessary treatment.
- Congress should incentivize states to prioritize the behavioral health diagnosis and treatment of individuals with co-occurring developmental disability, mental illness, and substance use disorder, through the continuation of programs like Money Follows the Person and the Balancing Incentive Payment Program.
These programs increase access to community based services and long term care for individuals with disabilities and comorbid conditions.

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

Possibly Under the Jurisdiction of Appropriations:

- Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models.
Home visiting programs provide families with health, social, and child development services that are shown to improve health and behavioral outcomes.
- Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations.
Crisis intervention teams (CITs) are a model for community policing that brings together law enforcement, mental health providers, medical centers, and individuals with mental illness to improve responses to people in crisis. CIT programs are shown to enhance communication, connect individuals with resources, and ensure officers receive the necessary training.

- Congress should enact legislation requiring all health plans to reimburse for evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component, as higher ACE scores are associated with a greater likelihood of numerous medical and behavioral conditions in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Behavioral health screenings, such as SBIRT and adverse childhood experience assessment, are critical components of prevention and early intervention.

- Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development in mental wellness programs, such as social and emotional learning, early warning sign identification, and trauma-informed approaches.

An evidence base supports the education of teachers and other school personnel on mental health conditions in children.

- Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports.

An evidence base supports the adoption of prescription drug monitoring programs, naloxone training, and MAT therapy for substance use disorder and overdose prevention.

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

Possibly Under the Jurisdiction of Appropriations:

- Congress should extend the National Health Service Corps to include Veterans' Administration (VA) Hospitals.

Veterans' Administration Hospitals are ineligible to apply to become National Health Service Corps sites, a program that provides financial assistance to providers and sites in underserved communities.

- Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region

Fetal alcohol syndrome is a completely preventable disorder that can be addressed through individual and community level training and education. While the CDC currently funds six PICs, these services should be available to individuals in every region.

- Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands.

The VA cannot currently meet care demands because of provider shortages. Contracting with providers external to the agency is a potential solution.

- The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs.

The VA can not currently meet care demands because of provider shortages. Additional funding to the Department of Veterans Affairs to hire more providers is a potential solution.

- Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth.

A substantial evidence base supports benefits of medication assisted treatment for women both during and after pregnancy.

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

Possibly Under the Jurisdiction of Appropriations:

- Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals.

The extreme shortage of mental health and substance use disorder providers across the country requires increased funding to support financial incentive programs, such as the National Health Service Corps, to drive individuals into pursuing careers in behavioral health care.

- Congress should appropriate additional funds to the Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations.

Providers must be able to meet the specific needs of minority populations who are disproportionately impacted by behavioral health disorders.

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

Possibly Under the Jurisdiction of Appropriations:

- Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools.

Research indicates that it is more productive and cost-effective to proactively engage students that have demonstrated behavioral issues rather than to punish and discard them.

U.S. Senate Committee on Finance

These are the specific recommendations for the Senate Committee on Finance within each of these four categories:

- I. **Access to Services**
- II. **Prevention and Early Intervention**
- III. **Vulnerable Populations**
- V. **Social Determinants**

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

Likely Under the Jurisdiction of Finance:

- CMS should extend eligibility for the Medicare and Medicaid EHR Incentive Program to include all behavioral health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities.
Of mental health and substance use disorder providers, only psychiatrists are eligible for this program, hindering the dissemination of electronic health records across the wider behavioral health provider community.
- Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities.
The IMD exclusion prohibits mental health and substance use disorder facilities with more than 16 beds from receiving federal Medicaid financing in Medicaid fee-for-service. A recent revision of the Medicaid managed care final rule allows federal financial participation for 15 days or less in a given month in an IMD. This rule must be removed completely for both Medicaid fee for service and managed care because it currently prohibits individuals from access evidence based and medically necessary treatment.
- Evidence-based programs aimed at care coordination following early diagnosis, such as the NIMH's RAISE project, should be further funded and disseminated nationwide.
Care coordination starting from the moment of diagnosis is shown to be cost-saving and medically effective.

- Congress should pass the Mental and Behavioral Health Care Bump Act, which requires Medicaid to reimburse states for 90 percent of the cost of providing new mental and behavioral health services in excess of states' certain spending. .

Low reimbursement rates for behavioral health providers severely limit our ability to build and maintain an adequate workforce to treat those with mental illnesses and substance use disorders.

Possibly Under the Jurisdiction of Finance:

- Payment obstacles that hinder the integration of mental health care into all other medical settings, including primary, should be removed.

Evidence shows that the integration of behavioral health care into other medical settings improves health outcomes and reduces costs.

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

Likely Under the Jurisdiction of Finance:

- Congress should expand upon the provisions of the Excellence in Mental Health Act that were included in the Protecting Access to Medicare Act of 2014 and implement alternative payment models that incentivize coordination between community-based services.

This would increase the number of states that can participate in the Certified Community Behavioral Health Clinic demonstration program which increases access to community mental health services to include all 24 states that applied.

Possibly Under the Jurisdiction of Finance:

- Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models.

Home visiting programs provide families with health, social, and child development services that are shown to improve health and behavioral outcomes.

- Congress should enact legislation requiring all providers to provide and all health plans to reimburse for evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Behavioral health screenings, such as SBIRT and adverse childhood experience assessment, are critical components of prevention and early intervention.

- Congress should require states to strengthen prescription drug monitoring programs, encourage training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports.

An evidence base supports the adoption of prescription drug monitoring programs, naloxone training, and MAT therapy for substance use disorder and overdose prevention.

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

Possibly Under the Jurisdiction of Finance:

- Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth.

A substantial evidence base supports benefits of medication assisted treatment for women both during and after pregnancy.

- Universities and facilities serving the elderly should develop suicide prevention plans based on Zero Suicide.

Zero Suicide is a program that prevents all suicide deaths within any health setting. Given that individuals in elderly care and university settings are particularly vulnerable to suicide, these principles should be applied to these settings as well.

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

Likely Under the Jurisdiction of Finance:

- Medicaid coverage must be extended to cover evidence-based housing support programs.

Research overwhelmingly demonstrates that supportive housing improves individual outcomes, enhances communities, and saves public dollars.

Possibly Under the Jurisdiction of Finance:

- Eligibility for supplemental security income and supplemental security disability income must be expanded to include people with substance use disorders.

The regressive exclusion of benefits for people disabled by substance use disorders is not in line with modern science.

U.S. Senate Committee on Health, Education, Labor, and Pensions

These are the specific recommendations for the Senate Committee on Health, Education, Labor, and Pensions within each of these six categories:

- I. **Access to Services**
- II. **Prevention and Early Intervention**
- III. **Vulnerable Populations**
- IV. **Behavioral Health Workforce**
- V. **Social Determinants**
- VI. **Research**

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

Likely Under the Jurisdiction of Health, Education, Labor, and Pensions:

- HHS, DOL, and state regulatory agencies should strongly enforce the federal parity law by conducting random audits of health plans on an annual basis, and all regulatory agencies—both state and federal—should scrutinize all consumer complaints for possible violations of the federal parity law.

Random audits ensure that health plans remain in compliance with MHPAEA. Given the lack of awareness of MHPAEA, consumers rarely use the word parity when making a complaint.

- Congress must require all health plans to report on how they design and apply medical management criteria and protocols for both behavioral healthcare and medical/surgical care to federal regulators.

It is impossible to determine compliance with MHPAEA without reporting this critical information regarding the design and application of medical management practices used for both behavioral health and general health.

- Payment obstacles that hinder the integration of behavioral health care into all other medical settings, including primary care, should be removed.

Evidence shows that the integration of behavioral health care into other medical settings improves health outcomes and reduces costs.

- Evidence-based programs aimed at care coordination following early diagnosis, such as the NIMH's RAISE project, should be further funded and disseminated nationwide.

Care coordination starting from the moment of diagnosis are shown to be cost-saving and medically effective.

- CMS should extend eligibility for the Medicare and Medicaid EHR Incentive Program to include all behavioral health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities.

Of mental health and substance use disorder providers, only psychiatrists are eligible for this program, hindering the dissemination of electronic health records across the wider behavioral health provider community.

- The HITECH Act must be amended to extend financial incentive eligibility for electronic health record use to behavioral health providers.

Mental health and addiction treatment providers are not included as providers eligible for HITECH Act technical assistance.

- HHS must finalize the update of federal regulation "42 CFR part 2" so that substance use disorder information can be incorporated into health records while protecting patient privacy.

This rule was issued at a time of great concern for the privacy of individuals with substance use disorders but now inhibits the integration of behavioral health information into electronic health records that facilitate care coordination.

- Congress should amend MHPAEA to specify that insurance plans cannot exclude benefits for residential treatment for substance use disorders or eating disorders if they cover benefits for sub-acute inpatient medical and surgical care.

Insurance plans sometime include blanket exclusions of residential treatment, which is a critically important form of care for people with certain mental health conditions.

- Guidance on the implementation of multitiered systems of supports for behavioral health services must be developed and disseminated by the Department of Education.

Multitiered systems of support is an evidence based model that integrates academic and behavioral instruction and intervention within the school setting.

- Congress should incentivize states to prioritize the behavioral health diagnosis and treatment of individuals with co-occurring developmental disability, mental illness, and substance use disorder, through the continuation of programs like Money Follows the Person and the Balancing Incentive Payment Program.

These programs increase access to community based services and long term care for individuals with disabilities and comorbid conditions.

Possibly Under the Jurisdiction of Health, Education, Labor, and Pensions:

- Congress should increase the limit on the number of patients eligible providers can treat with medication assisted treatment from 250 to 500.

This arbitrary limit creates a barrier for individuals to access medication assisted treatment, which is the standard of care for substance use disorders.

- Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities.

The IMD exclusion prohibits mental health and substance use disorder facilities with more than 16 beds from receiving federal Medicaid financing in Medicaid fee for service. A recent revision of the Medicaid managed care final rule allows federal financial participation for 15 days or less in a given month in an IMD. This rule must be removed completely for both Medicaid fee for service and managed care because it currently prohibits individuals from access evidence based and medically necessary treatment.

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

Likely Under the Jurisdiction of Health, Education, Labor, and Pensions:

- All programs operated or supported by SAMHSA should incorporate the best available science, use evidence-based practices, and measure their effectiveness and efficiency through the adherence to clearly identified goals.

By requiring evidence-based standards and evaluation metrics, SAMHSA will ensure the effectiveness of programs receiving federal funding.

- Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models.

Home visiting programs provide families with health, social, and child development services that are shown to improve health and behavioral outcomes.

- Congress should enact legislation requiring all providers to provide, and all health plans to reimburse for, evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Behavioral health screenings, such as SBIRT and adverse childhood experience assessment, are critical components of prevention and early intervention.

- Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development on mental health conditions in children.
An evidence base supports the education of teachers and other school personnel on mental health conditions in children.
- Congress should amend the Head Start Act so that the HHS secretary is required to prioritize programs that support evidence-based trauma-informed programs, age-appropriate positive behavioral interventions and supports, early childhood mental health consultation, and prevention of suspension and expulsion.
These programs delivered in community settings are shown to improve health and behavioral outcomes.
- Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports.
An evidence base supports the adoption of prescription drug monitoring programs, naloxone training, and MAT therapy for substance use disorder and overdose prevention.

Possibly Under the Jurisdiction of Health, Education, Labor, and Pensions:

- Congress should expand upon the provisions of the Excellence in Mental Health Act that were included in the Protecting Access to Medicare Act of 2014 and implement alternative payment models that incentivize coordination between community-based services.
This would increase the number of states that can participate in the Certified Community Behavioral Health Clinic demonstration program which increases access to community mental health services to include all 24 states that applied.
- Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations.
Crisis intervention teams (CIT) is a model for community policing that brings together law enforcement, mental health providers, medical centers, and individuals with mental illness to improve responses to people in crisis. CIT programs are shown to enhance communication, connect individuals with resources, and ensure officers receive the necessary training.
- All positive behavioral health screens should be followed by standardized tools used to measure patient outcomes.
Standardized tools must be tied to behavioral health screening to monitor patient health outcomes so that treatment plans can be adjusted accordingly.

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

Likely Under the Jurisdiction of Health, Education, Labor, and Pensions:

- HHS should create the Inter-Departmental Serious Mental Illness Coordinating Committee, which will evaluate the effect on public health of federal programs related to serious mental illness that includes data about health outcomes and other social outcomes such as employment, homelessness, and incarceration rates.

This position would provide a valuable role in evaluating the health and social impact of existing federal programs targeting individuals with serious mental illness.

- Congress should extend the National Health Service Corps to include Veterans' Administration Hospitals.

Veterans' Administration Hospitals are ineligible to apply to become National Health Service Corps sites, a program that provides financial assistance to providers and sites in underserved communities.

- Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide.

Zero Suicide is a program that prevents all suicide deaths within any health setting. Given that individuals in elderly care and university settings are particularly vulnerable to suicide, these principles should be applied to these settings as well.

- Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth.

A substantial evidence base supports benefits of medication assisted treatment for women both during and after pregnancy.

- Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region.

Fetal alcohol syndrome is a completely preventable disorder that can be addressed through individual and community level training and education. While the CDC currently funds six PICs, these services should be available to individuals in every region.

Possibly Under the Jurisdiction of Health, Education, Labor, and Pensions:

- The Indian Health Services, a division of the HHS, must develop a strategy to address the high incidence of suicide and untreated substance use disorders in Native American communities.

Native American communities experience disproportionately high rates of suicide and substance use disorders in comparison to the general population.

- Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands.
The VA cannot currently meet care demands because of provider shortages. Contracting with providers external to the agency is a potential solution.
- The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs.
The VA cannot currently meet care demands because of provider shortages. Additional funding to the Department of Veterans Affairs to hire more providers is a potential solution.

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

Likely Under the Jurisdiction of Health, Education, Labor, and Pensions:

- Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals.
The extreme shortage of mental health and substance use disorder providers across the country requires increased funding to support financial incentive programs, such as the National Health Service Corps, to drive individuals into pursuing careers in mental health care.
- Congress should appropriate additional funds to the Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations.
Providers must be able to meet the specific needs of minority populations who are disproportionately impacted by these conditions.

- Medical training programs must include discussions of safe-prescribing practices based on the CDC Guideline for Prescribing Opioids for Chronic Pain, including the use of opioid treatment alternatives when appropriate.

Given the growing numbers of substance use disorders and overdoses due to opioid use disorder, medical training programs must emphasize the importance of safe-prescribing practices. The evidence base supporting the use of medication assisted treatment demonstrates that opioid treatment alternatives must be a component of this training.

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

Likely Under the Jurisdiction of Health, Education, Labor, and Pensions:

- Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools.

Research indicates that it is more productive and cost-effective to proactively engage students that have demonstrated behavioral issues rather than to punish and discard them.

- Unemployment and homeless rates among individuals identified as living with a mental illness or substance use disorder should be tracked.

We must understand the scope of this issue because unemployment and homelessness are problems that disproportionately affect those with mental illnesses or substance use disorders.

- The Occupational Safety and Health Administration should develop a national psychological health and safety in the workplace standard—similar to physical health and safety standards—to help organizations achieve measurable improvement in the psychological health of employees.

Addressing mental health in the workplace is essential to maintain and restore wellness among the nation's workforce and increase productivity.

- Titles I and II of the Americans with Disabilities Act (ADA) must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness.

Employment discrimination against people with mental illness is still common, particularly against those with serious mental illness.

- Expand eligibility for supplemental security income and supplemental security disability income to include people with substance use disorders.

The regressive exclusion of benefits for people disabled by substance use disorders is not in line with modern science.

Possibly Under the Jurisdiction of Health, Education, Labor, and Pensions:

- Medicaid coverage must be extended to cover evidence-based housing support programs.

Research overwhelmingly demonstrates that supportive housing improves individual outcomes, enhances communities, and saves public dollars.

- Congress should increase funding for the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs.

Our wounded warriors with invisible scars of war deserve this evidence-based practice that integrates veterans with mental illnesses and traumatic brain injuries back into the workforce.

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

Likely Under the Jurisdiction of Health, Education, Labor, and Pensions:

- Congress should direct NIH to allocate more funding to the NIMH, NIDA, and NIAAA for critically-needed mental health research.

The opioid epidemic and rising suicide rates make it imperative that federal health research dollars are spent solving the most dire public health crisis our nation faces.

- Congress should continue to appropriate funding to the NIMH Research Domain Criteria (RDoC) initiative.

We must move to a diagnostic system that classifies brain diseases according to biologically valid markers rather than one that designates them by a cluster of symptoms.

- Congress should appropriate funding to the NIMH for research on the determinants of self-directed violence.

Effective programs that reduce suicide and self-harm are scant partly because there is not a solid evidence base on the upstream variables that contribute to self-directed violence.

- The CDC should establish a broad and coordinated behavioral health surveillance system that tracks prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses.

A unified system is needed to track the many different variables that contribute to the public health crisis of suicides and drug overdoses.

- Brain health research funding should be contingent upon the use of open science principles to increase data sharing across disciplines and institutional boundaries.

The findings of brain health research must be accessible to all so that the scientific community can close the knowledge gap between our understanding of the mind and the rest of the body.

- Federal research grants for behavioral health treatments should include a translational research component on the financial, ethical, logistic, and regulatory aspects impacting dissemination of therapies into clinical and community settings.

Research must take into account all of the potential corollary effects of any treatment modality so that the treatment is efficacious, cost-effective, practical, and does no harm to those receiving the treatment.

U.S. Senate Committee on Indian Affairs

These are the specific recommendations for the Senate Committee on Indian Affairs within the following categories:

III. Vulnerable Populations

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

Likely Under the Jurisdiction of Indian Affairs:

- The Indian Health Services, a division of the HHS, must develop a strategy to address the high incidence of suicide and untreated substance use disorders in Native American communities.

Native American communities experience disproportionately high rates of suicide and substance use disorders compared to the general population.

U.S. Senate Committee on Judiciary

These are the specific recommendations for the Senate Committee on Judiciary within the following categories:

- I. Access to Services
- II. Prevention and Early Intervention
- V. Social Determinants

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

Likely Under the Jurisdiction of Judiciary:

- Congress should increase the highest limit on the number of patients eligible providers can treat with medication assisted treatment from 250 to 500.

This arbitrary limit creates a barrier for individuals to access medication assisted treatment, which is the standard of care for substance use disorders.

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

Possibly Under the Jurisdiction of Judiciary:

- Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations.

Crisis intervention teams (CIT) is a model for community policing that brings together law enforcement, mental health providers, medical centers, and individuals with mental illness to improve responses to people in crisis. CIT programs are shown to enhance communication, connect individuals with resources, and ensure officers receive the necessary training.

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

Possibly Under the Jurisdiction of Judiciary:

- Titles I and II of the Americans with Disabilities Act must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness.

Employment discrimination against people with mental illness is still common, particularly against those with serious mental illness.

U.S. Senate Committee on Veteran's Affairs

These are the specific recommendations for the Senate Committee on Veteran's Affairs within the following categories:

III. Vulnerable Populations**V. Social Determinants**

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

Likely Under the Jurisdiction of Veteran's Affairs:

- Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands.

The VA cannot currently meet care demands because of provider shortages. Contracting with providers external to the agency is a potential solution.

- The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs.

The VA cannot currently meet care demands because of provider shortages. Additional funding to the Department of Veterans Affairs to hire more providers is a potential solution.

Possibly Under the Jurisdiction of Veteran’s Affairs:

- Congress should extend the National Health Service Corps to include Veterans’ Administration Hospitals.

Veterans’ Administration Hospitals are ineligible to apply to become National Health Service Corps sites, a program that provides financial assistance to providers and sites in underserved communities.

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

The extreme shortage of mental health and substance use disorder providers across the country requires increased funding to support financial incentive programs, such as the National Health Service Corps, to drive individuals into pursuing careers in behavioral health care.

Likely Under the Jurisdiction of Veteran’s Affairs:

- Congress should increase funding for the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs.

Our wounded warriors with invisible scars of war deserve this evidence-based practice that integrates veterans with mental illnesses and traumatic brain injuries back into the workforce.

U.S. House of Representatives Appropriations Committee

These are the specific recommendations for the House of Representatives Committee on Appropriations within each of these six categories:

- I. **Access to Services**
- II. **Prevention and Early Intervention**
- III. **Vulnerable Populations**
- IV. **Behavioral Health Workforce**
- V. **Social Determinants**
- VI. **Research**

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

Possibly Under the Jurisdiction of Appropriations:

- Payment obstacles that hinder the integration of behavioral health care into all other medical settings, including primary care, should be removed.

Evidence shows that the integration of behavioral health care into other medical settings improves health outcomes and reduces costs.

- Evidence-based programs aimed at care coordination following early diagnosis, such as the NIMH's RAISE project, should be further funded and disseminated nationwide.

Care coordination starting from the moment of diagnosis is shown to be cost-saving and medically effective.

- Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities.

The IMD exclusion prohibits mental health and substance use disorder facilities with more than 16 beds from receiving federal Medicaid financing in Medicaid fee for service. A recent revision of the Medicaid managed care final rule allows federal financial participation for 15 days or less in a given month in an IMD. This rule must be removed completely for both Medicaid fee for service and managed care because it currently prohibits individuals from access evidence based and medically necessary treatment.

- Congress should incentivize states to prioritize the behavioral health diagnosis and treatment of individuals with co-occurring developmental disability, mental illness, and substance use disorder, through the continuation of programs like Money Follows the Person and the Balancing Incentive Payment Program.

These programs increase access to community based services and long term care for individuals with disabilities and comorbid conditions.

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

Possibly Under the Jurisdiction of Appropriations:

- Congress should expand upon the provisions of the Excellence in Mental Health Act that were included in the Protecting Access to Medicare Act of 2014 and implement alternative payment models that incentivize coordination between community-based services.

This would increase the number of states that can participate in the Certified Community Behavioral Health Clinic demonstration program which increases access to community mental health services to include all 24 states that applied.

- Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models.

Home visiting programs provide families with health, social, and child development services that are shown to improve health and behavioral outcomes.

- Congress should enact legislation requiring all providers to provide, and all health plans to reimburse for, evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Behavioral health screenings, such as SBIRT and adverse childhood experience assessment, are critical components of prevention and early intervention.

- Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development in mental wellness programs, such as social and emotional learning, early warning sign identification, and trauma-informed approaches.

An evidence base supports the education of teachers and other school personnel on mental health conditions in children.

- Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports.

An evidence base supports the adoption of prescription drug monitoring programs, naloxone training, and MAT therapy for substance use disorder and overdose prevention.

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

Possibly Under the Jurisdiction of Appropriations:

- HHS should create the Inter-Departmental Serious Mental Illness Coordinating Committee, which will evaluate the effect on public health of federal programs related to serious mental illness that includes data about health outcomes and other social outcomes such as employment, homelessness, and incarceration rates.

This committee would perform a valuable role in evaluating the health and social impact of existing federal programs targeting individuals with serious mental illness.

- Congress should extend the National Health Service Corps to include Veterans' Administration Hospitals.

Veterans' Administration Hospitals are ineligible to apply to become National Health Service Corps sites, a program that provides financial assistance to providers and sites in underserved communities.
- Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region.

Fetal alcohol syndrome is a completely preventable disorder that can be addressed through individual and community level training and education. While the CDC currently funds six PICs, these services should be available to individuals in every region.
- Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands.

The VA can not currently meet care demands because of provider shortages. Contracting with providers external to the agency is a potential solution.
- The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs.

The VA can not currently meet care demands because of provider shortages. Additional funding to the Department of Veterans Affairs to hire more providers is a potential solution.
- Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth.

A substantial evidence base supports benefits of medication assisted treatment for women both during and after pregnancy.
- Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide.

Zero Suicide is a program that prevents all suicide deaths within any health setting. Given that individuals in elderly care and university settings are particularly vulnerable to suicide, these principles should be applied to these settings as well.

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

Possibly Under the Jurisdiction of Appropriations:

- Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals.

The extreme shortage of mental health and substance use disorder providers across the country requires increased funding to support financial incentive programs, such as the National Health Service Corps, to drive individuals into pursuing careers in behavioral health care.

- Congress should appropriate additional funds to the Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations.

Providers must be able to meet the specific needs of minority populations who are disproportionately impacted by behavioral health disorders.

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

Possibly Under the Jurisdiction of Appropriations:

- Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools.

Research indicates that it is more productive and cost-effective to proactively engage students that have demonstrated behavioral issues rather than to punish and discard them.

- Medicaid coverage must be extended to cover evidence-based housing support programs.

Research overwhelmingly demonstrates that supportive housing improves individual outcomes, enhances communities, and saves public dollars.

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

Possibly Under the Jurisdiction of Appropriations:

- Congress should direct NIH to allocate more funding to the NIMH, NIDA, and NIAAA for critically-needed behavioral health research.

The opioid epidemic and rising suicide rates make it imperative that federal health research dollars are spent solving the most dire public health crisis our nation faces.

- Congress should continue to appropriate funding to the NIMH Research Domain Criteria (RDoC) initiative.

We must move to a diagnostic system that classifies brain diseases according to biologically valid markers rather than one that designates them by a cluster of symptoms.

- Congress should appropriate funding to the NIMH for research on the determinants of self-directed violence.

Effective programs that reduce suicide and self harm are scant partly because there is not a solid evidence base on the upstream variables that contribute to self-directed violence.

- The CDC should establish a broad and coordinated behavioral health surveillance system that tracks prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses.

A unified system is needed to track the many different variables that contribute to the public health crisis of suicides and drug overdoses.

- Brain health research funding should be contingent upon the use of open science principles to increase data sharing across disciplines and institutional boundaries.

The findings of brain health research must be accessible to all so that the scientific community can close the knowledge gap between our understanding of the mind and the rest of the body.

- Federal research grants for behavioral health treatments should include a translational research component on the financial, ethical, logistic, and regulatory aspects impacting dissemination of therapies into clinical and community settings.

Research must take into account all of the potential corollary effects of any treatment modality so that the treatment is efficacious, cost-effective, practical, and does no harm to those receiving the treatment.

U.S. House of Representatives Education and the Workforce Committee

These are the specific recommendations for the House of Representatives Committee on Education and the Workforce within the following categories:

- I. Access to Services
- II. Prevention and Early Intervention
- III. Vulnerable Populations
- V. Social Determinants

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

Possibly Under the Jurisdiction of Education and the Workforce:

- Guidance on the implementation of multi-tier systems of supports for behavioral health services must be developed and disseminated by the Department of Education.

Multitiered systems of support is an evidence based model that integrates academic and behavioral instruction and intervention within the school setting.

- Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations.

Crisis intervention teams (CIT) is a model for community policing that brings together law enforcement, mental health providers, medical centers, and individuals with mental illness to improve responses to people in crisis. CIT programs are shown to enhance communication, connect individuals with resources, and ensure officers receive the necessary training.

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

Likely Under the Jurisdiction of Education and the Workforce:

- Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development in mental wellness programs, such as social and emotional learning, early warning sign identification, and trauma-informed approaches.

An evidence base supports the education of teachers and other school personnel on mental health conditions in children.

- Congress should amend the Head Start Act so that HHS must give priority to the implementation of evidence-based trauma-informed programs, age-appropriate positive behavioral interventions and supports, early childhood mental health consultation, and prevention of suspension and expulsion.

These programs delivered in community settings are shown to improve health and behavioral outcomes.

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

Likely Under the Jurisdiction of Education and the Workforce:

- Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide.

Zero Suicide is a program that prevents all suicide deaths within any health setting. Given that individuals in elderly care and university settings are particularly vulnerable to suicide, these principles should be applied to these settings as well.

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

Possibly Under the Jurisdiction of Education and the Workforce:

- Medical training programs must include discussions of safe-prescribing practices, including the use of opioid treatment alternatives when appropriate.

Given the growing numbers of substance use disorders and overdoses due to opioid use disorder, medical training programs must emphasize the importance of safe-prescribing practices. The evidence base supporting the use of medication assisted treatment demonstrates that opioid treatment alternatives must be a component of this training.

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

Possibly Under the Jurisdiction of Education and the Workforce:

- Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools.

Research indicates that it is more productive and cost-effective to proactively engage students that have demonstrated behavioral issues rather than to punish and discard them.

U.S. House of Representatives Energy and Commerce Committee

These are the specific recommendations for the House of Representatives Committee on Energy and Commerce within each of these six categories:

- I. **Access to Services**
- II. **Prevention and Early Intervention**
- III. **Vulnerable Populations**
- IV. **Behavioral Health Workforce**
- V. **Social Determinants**
- VI. **Research**

I. Access to Service: Individuals continue to struggle to access medically necessary mental health and addiction care. Poor implementation of the Mental Health Parity and Addiction Equity Act results in frequent care delays, restrictions, and denials of often lifesaving treatment. There is little continuum of care for mental illness and substance use disorder treatment. Despite the transition towards integrated care, valued based payment, and electronic health records for physical health care, these reforms largely ignore behavioral health services. The sustainable solutions below to these barriers are essential to addressing inadequate access to mental health and substance use disorder care.

Likely Under the Jurisdiction of Energy and Commerce:

- HHS, DOL, and state regulatory agencies should strongly enforce the federal parity law by conducting random audits of health plans on an annual basis, and all regulatory agencies—both state and federal—should scrutinize all consumer complaints for possible violations of the federal parity law.

Random audits ensure that health plans remain in compliance with MHPAEA. Given the lack of awareness of MHPAEA, consumers rarely use the word parity when making a complaint.

- Congress must require all health plans to report on how they design and apply medical management criteria and protocols for both behavioral healthcare and medical/surgical care to federal regulators.

It is impossible to determine compliance with MHPAEA without reporting this critical information regarding the design and application of medical management practices used for both behavioral health and general health.

- Congress must remove the 190-day lifetime limit on inpatient psychiatric hospital care in Medicare.

This is an arbitrary restriction that is not in place for other medical inpatient care, and it is especially harmful to individuals between the ages of 22 and 64 who are dual eligible for Medicaid and Medicare; these individuals are often the sickest of the sick in terms of their behavioral health status and may become homeless or incarcerated because of this Medicare restriction.

- Payment obstacles that hinder the integration of mental health and substance use disorder care into all other medical settings, including primary, should be removed.

Evidence shows that the integration of mental health and substance use disorder care into other medical settings improves health outcomes and reduces costs.

- Evidence-based programs aimed at care coordination following early diagnosis, such as the NIMH's RAISE project, should be further funded and disseminated nationwide.

Care coordination starting from the moment diagnosis is shown to be cost-saving and medically effective.

- CMS should extend eligibility for the Medicare and Medicaid EHR Incentive Program to include all mental health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities.

Of mental health and substance use disorder providers, only psychiatrists are eligible for this program, hindering the dissemination of electronic health records across the wider behavioral health provider community.

- The HITECH Act must be amended to extend financial incentive eligibility for electronic health record use to behavioral health providers.

Mental health and addiction treatment providers are not included as providers eligible for HITECH Act technical assistance.

- HHS must finalize the update of federal regulation "42 CFR part 2" so that substance use disorder information can be incorporated into health records while protecting patient privacy.

This rule was issued at a time of great concern for the privacy of individuals with substance use disorders but now inhibits the integration of behavioral health information into electronic health records that facilitate care coordination.

- Congress should amend MHPAEA to specify that insurance plans cannot exclude benefits for residential treatment for substance use disorders or eating disorders if they cover benefits for sub-acute inpatient medical and surgical care.

Insurance plans sometimes include blanket exclusions of residential treatment, which is a critically important form of care for people with certain mental health conditions or addiction.

- Guidance on the implementation of multitiered systems of supports for mental health services must be developed and disseminated by the Department of Education.

Multitiered systems of support is an evidence based model that integrates academic and behavioral instruction and intervention within the school setting.

- Congress should pass the Mental and Behavioral Health Care Bump Act, which requires Medicaid to reimburse states for 90 percent of the cost of providing new mental and behavioral health services in excess of states' certain spending.

Low reimbursement rates for behavioral health providers severely limit our ability to build and maintain an adequate workforce to treat those with mental illnesses and substance use disorders.

- Congress should incentive states to prioritize the behavioral health diagnosis and treatment of individuals with co-occurring developmental disability, mental illness, and substance use disorder, through the continuation of programs like Money Follows the Person and the Balancing Incentive Payment Program.

These programs increase access to community based services and long term care for individuals with disabilities and comorbid conditions.

Possibly Under the Jurisdiction of Energy and Commerce:

- Congress should increase the highest limit on the number of patients eligible providers can treat with medication assisted treatment from 250 to 500.

This arbitrary limit creates a barrier for individuals to access medication assisted treatment, which is the standard of care for substance use disorders.

- Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities.

The IMD exclusion prohibits mental health and substance use disorder facilities with more than 16 beds from receiving federal Medicaid financing in Medicaid fee for service. A recent revision of the Medicaid managed care final rule allows federal financial participation for 15 days or less in a given month in an IMD. This rule must be removed completely for both Medicaid fee for service and managed care because it currently prohibits individuals from access evidence based and medically necessary treatment.

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

Likely Under the Jurisdiction of Energy and Commerce:

- Congress should expand upon the provisions of the Excellence in Mental Health Act that were included in the Protecting Access to Medicare Act of 2014 and implement alternative payment models that incentivize coordination between community-based services.

This would increase the number of states that can participate in the Certified Community Behavioral Health Clinic demonstration program which increases access to community mental health services to include all 24 states that applied.

- All programs operated or supported by SAMHSA should incorporate the best available science, use evidence-based practices, and measure their effectiveness and efficiency through the adherence to clearly identified goals.

By requiring evidence-based standards and evaluation metrics, SAMHSA will ensure the effectiveness of programs receiving federal funding.

- Evidence-based home visiting programs should be a mandated benefit of health plans and be integrated into all collaborative care models.

Home visiting programs provide families with health, social, and child development services that are shown to improve health and behavioral outcomes.

- Congress should enact legislation requiring all providers to provide and all health plans to reimburse for evidence-based mental health screening during annual well-child exams and adult annual physical exams. This should include an adverse childhood experience (ACE) component in addition to Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Behavioral health screenings, such as SBIRT and adverse childhood experience assessment, are critical components of prevention and early intervention.

Possibly Under the Jurisdiction of Energy and Commerce:

- Congress should continue to prioritize state law enforcement crisis intervention training through additional appropriations.

Crisis intervention teams (CIT) is a model for community policing that brings together law enforcement, mental health providers, medical centers, and individuals with mental illness to improve responses to people in crisis. CIT programs are shown to enhance communication, connect individuals with resources, and ensure officers receive the necessary training.

- Congress should amend the Elementary and Secondary Education Act to fund teacher and principal training and professional development on mental health conditions in children.
An evidence base supports the education of teachers and other school personnel on mental health conditions in children.
- Congress should amend the Head Start Act so that the HHS secretary is required to prioritize programs that support evidence-based trauma-informed programs, age-appropriate positive behavioral interventions and supports, early childhood mental health consultation, and prevention of suspension and expulsion.
These programs delivered in community settings are shown to improve health and behavioral outcomes.
- All positive behavioral health screens should be followed by standardized tools used to measure patient outcomes.
Standardized tools must be tied to behavioral health screening to monitor patient health outcomes so that treatment plans can be adjusted accordingly.
- Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports.
An evidence base supports the adoption of prescription drug monitoring programs, naloxone training, and MAT for substance use disorder and overdose prevention.

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

Likely Under the Jurisdiction of Energy and Commerce:

- HHS should create the Inter-Departmental Serious Mental Illness Coordinating Committee, which will evaluate the effect on public health of federal programs related to serious mental illness that includes data about health outcomes and other social outcomes such as employment, homelessness, and incarceration rates.
This position would provide a valuable role in evaluating the health and social impact of existing federal programs targeting individuals with serious mental illness.

- Congress should extend the National Health Service Corps to include Veterans' Administration Hospitals.
Veterans' Administration Hospitals are ineligible to apply to become National Health Service Corps sites, a program that provides financial assistance to providers and sites in underserved communities.
- The Indian Health Services, a division of the HHS, must develop a strategy to address the high incidence of suicide and untreated substance use disorders in Native American communities.
Native American communities experience disproportionately high rates of suicide and substance use disorders in comparison to the general population.
- Facilities serving the elderly and universities should develop suicide prevention plans based on Zero Suicide.
Zero Suicide is a program that prevents all suicide deaths within any health setting. Given that individuals in elderly care and university settings are particularly vulnerable to suicide, these principles should be applied to these settings as well.
- Pregnant women with opioid use disorder should be connected with appropriate medication assisted treatment during pregnancy and remain in treatment after they have given birth.
A substantial evidence base supports benefits of medication assisted treatment for women both during and after pregnancy.
- Congress should appropriate federal funding to the Centers for Disease Control and Prevention to sponsor Fetal Alcohol Syndrome Disorder Practice and Implementation Centers (PICs) in every region.
Fetal alcohol syndrome is a completely preventable disorder that can be addressed through individual and community level training and education. While the CDC currently funds six PICs, these services should be available to individuals in every region.

Possibly Under the Jurisdiction of Energy and Commerce:

- Reimbursement for licensed mental health providers external to the agency should be made available in cases where the VA is incapable of meeting care demands.
The VA cannot currently meet care demands because of provider shortages. Contracting with providers external to the agency is a potential solution.

- The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs.

The VA cannot currently meet care demands because of provider shortages. Additional funding to the Department of Veterans Affairs to hire more providers is a potential solution.

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

Likely Under the Jurisdiction of Energy and Commerce:

- Congress should increase funding for the National Health Service Corps scholarship and loan repayments program to increase the supply of behavioral health professionals.

The extreme shortage of mental health and substance use disorder providers across the country requires increased funding to support financial incentive programs, such as the National Health Service Corps, to drive individuals into pursuing careers in behavioral health care.

- Congress should appropriate additional funds to the Minority Fellowship Program designed to increase providers' knowledge of issues related to prevention, treatment, and recovery support for mental and substance use disorders among racial and ethnic minority populations.

Providers must be able to meet the specific needs of minority populations who are disproportionately impacted by behavioral health disorders.

- Medical training programs must include discussions of safe-prescribing practices based off of the CDC Guideline for Prescribing Opioids for Chronic Pain, including the use of opioid treatment alternatives when appropriate.

Given the growing numbers of substance use disorders and overdoses due to opioid use disorder, medical training programs must emphasize the importance of safe-prescribing practices. The evidence base supporting the use of medication assisted treatment demonstrates that opioid treatment alternatives must be a component of this training.

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

Likely Under the Jurisdiction of Energy and Commerce:

- Federal Title I education funds should be used to replace zero tolerance policies with social emotional learning programs, such as the Responsive Classroom from the Center for Responsive Schools, and executive function training programs like the ACTIVATE program in all schools.

Research indicates that it is more productive and cost-effective to proactively engage students that have demonstrated behavioral issues rather than to punish and discard them.

- Unemployment and homeless rates among individuals identified as living with a behavioral health disorder should be tracked.

We must understand the scope of this issue because unemployment and homelessness are problems that disproportionately affect those with mental illnesses or substance use disorders.

- The Occupational Safety and Health Administration should develop a national psychological health and safety in the workplace standard—similar to physical health and safety standards—to help organizations achieve measurable improvement in the psychological health of employees.

Addressing mental health in the workplace is essential to maintaining and restoring wellness among the nation's workforce and increasing productivity.

- Titles I and II of the Americans with Disabilities Act (ADA) must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness.

Employment discrimination against people with mental illness is still common, particularly against those with serious mental illness.

- Expand eligibility for supplemental security income and supplemental security disability income to include people with substance use disorders.

The regressive exclusion of benefits for people disabled by substance use disorders is not in line with modern science.

- Medicaid coverage must be extended to cover evidence-based housing support programs.

Research overwhelmingly demonstrates that supportive housing improves individual outcomes, enhances communities, and saves public dollars.

Possibly Under the Jurisdiction of Energy and Commerce:

- Congress should increase funding for the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs.

Our wounded warriors with invisible scars of war deserve this evidence-based practice that integrates veterans with mental illnesses and traumatic brain injuries back into the workforce.

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

Likely Under the Jurisdiction of Energy and Commerce:

- Congress should direct NIH to allocate more funding to the NIMH, NIDA, and NIAA for critically-needed behavioral health research.

The opioid epidemic and rising suicide rates make it imperative that federal health research dollars are spent solving the most dire public health crisis our nation faces.

- Congress should continue to appropriate funding to the NIMH Research Domain Criteria (RDoC) initiative.

We must move to a diagnostic system that classifies brain diseases according to biologically valid markers rather than one that designates them by a cluster of symptoms.

- Congress should appropriate funding to the NIMH for research on the determinants of self-directed violence.

Effective programs that reduce suicide and self harm are scant partly because there is not a solid evidence base on the upstream variables that contribute to self-directed violence.

- The CDC should establish a broad and coordinated behavioral health surveillance system that tracks prevalence rates, types of treatment being used, availability of care, and comorbidities with other illnesses.

A unified system is needed to track the many different variables that contribute to the public health crisis of suicides and drug overdoses.

- Brain health research funding should be contingent upon the use of open science principles to increase data sharing across disciplines and institutional boundaries.

The findings of brain health research must be accessible to all so that the scientific community can close the knowledge gap between our understanding of the mind and the rest of the body.

- Federal research grants for behavioral health treatments should include a translational research component on the financial, ethical, logistic, and regulatory aspects impacting dissemination of therapies into clinical and community settings.

Research must take into account all of the potential corollary effects of any treatment modality so that the treatment is efficacious, cost-effective, practical, and does no harm to those receiving the treatment.

U.S. House of Representatives Judiciary Committee

These are the specific recommendations for the House of Representatives Committee on Judiciary within the following categories:

- I. Access to Services**
- II. Prevention and Early Intervention**
- V. Social Determinants**

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

Likely Under the Jurisdiction of Judiciary:

- Congress should increase the highest limit on the number of patients eligible providers can treat with medication assisted treatment from 250 to 500.

This arbitrary limit creates a barrier for individuals to access medication assisted treatment, which is the standard of care for substance use disorders.

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

Possibly Under the Jurisdiction of Judiciary:

- Congress should continue to prioritize state law enforcement of crisis intervention training through additional appropriations.

Crisis intervention teams (CIT) is a model for community policing that brings together law enforcement, mental health providers, medical centers, and individuals with mental illness to improve responses to people in crisis. CIT programs are shown to enhance communication, connect individuals with resources, and ensure officers receive the necessary training.

- Congress should require states to strengthen prescription drug monitoring programs in order to receive funding, incentivize training of family and first responders in naloxone, and incentivize the use of medication assisted treatment in all healthcare settings through additional funding and supports.

An evidence base supports the adoption of prescription drug monitoring programs, naloxone training, and MAT therapy for substance use disorder and overdose prevention.

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

Possibly Under the Jurisdiction of Judiciary:

- Titles I and II of the Americans with Disabilities Act must be interpreted and enforced in ways that limit discrimination and maximize employment opportunities for individuals with mental illness.

Employment discrimination against people with mental illness is still common, particularly against those with serious mental illness.

U.S. House of Representatives Veterans' Affairs Committee

These are the specific recommendations for the House of Representatives Committee on Veterans' Affairs within the following categories:

III. Vulnerable Populations

V. Social Determinants

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

Likely Under the Jurisdiction of Veterans' Affairs:

- Reimbursement for licensed mental health providers external to the agency should be made available in cases where the Veterans Administration is incapable of meeting care demands.

The VA can not currently meet care demands because of provider shortages. Contracting with providers external to the agency is a potential solution.

- The number of behavioral health professionals in the Veterans Health Administration should be increased through the appropriation of additional funding to the Department of Veterans Affairs.

The VA can not currently meet care demands because of provider shortages. Additional funding to the Department of Veterans Affairs to hire more providers is a potential solution.

Possibly Under the Jurisdiction of Veterans' Affairs:

- Congress should extend the National Health Service Corps to include Veterans Administration Hospitals.

The extreme shortage of mental health and substance use disorder providers across the country requires increased funding to support financial incentive programs, such as the National Health Service Corps, to drive individuals into pursuing careers in behavioral health care.

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

Likely Under the Jurisdiction of Veterans' Affairs:

- Congress should increase funding for the evidence-based Compensated Work Therapy, Supported Employment Program of the Department of Veterans Affairs.

Our wounded warriors with invisible scars of war deserve this evidence-based practice that integrates veterans with mental illnesses and traumatic brain injuries back into the workforce.

U.S. House of Representatives Ways and Means Committee

These are the specific recommendations for the House of Representatives Committee on Veterans' Affairs within the following categories:

- I. Access to Services
- V. Social Determinants

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

Likely Under the Jurisdiction of Ways and Means:

- CMS should extend eligibility for the Medicare and Medicaid EHR Incentive Program to include all behavioral health professionals providing care at psychiatric hospitals, mental health treatment facilities, and substance use treatment facilities.

Of mental health and substance use disorder providers, only psychiatrists are eligible for this program, hindering the dissemination of electronic health records across the wider behavioral health provider community.

- Congress must eliminate the IMD exclusion, which prevents Medicaid from reimbursing many inpatient mental health facilities.

The IMD exclusion prohibits mental health and substance use disorder facilities with more than 16 beds from receiving federal Medicaid financing in Medicaid fee-for-service. A recent revision of the Medicaid managed care final rule allows federal financial participation for 15 days or less in a given month in an IMD. This rule must be removed completely for both Medicaid fee-for-service and managed care because it currently prohibits individuals from access evidence based and medically necessary treatment.

Possibly Under the Jurisdiction of Ways and Means:

- HHS, DOL, and state regulatory agencies should strongly enforce the federal parity law by conducting random audits of health plans on an annual basis, and all regulatory agencies—both state and federal—should scrutinize all consumer complaints for possible violations of the federal parity law.

Random audits ensure that health plans remain in compliance with MHPAEA. Given the lack of awareness of MHPAEA, consumers rarely use the word parity when making a complaint.

- Congress should amend MHPAEA to specify that insurance plans cannot exclude benefits for residential treatment for substance use disorders or eating disorders if they cover benefits for sub-acute inpatient medical and surgical care.

Insurance plans sometime include blanket exclusions of residential treatment, which is a critically important form of care for people with certain behavioral health conditions.

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

Likely Under the Jurisdiction of Ways and Means:

- Expand eligibility for supplemental security income and supplemental security disability income to include people with substance use disorders.

The regressive exclusion of benefits for people disabled by substance use disorders is not in line with modern science.

- Medicaid coverage must be extended to cover evidence-based housing support programs.

Research overwhelmingly demonstrates that supportive housing improves individual outcomes, enhances communities, and saves public dollars.

Final Thoughts

As of today, too many of our fellow citizens are being forced to live in denial, and it's causing untold suffering. Each life is affected by mental illness and addiction in a different way. Every life and every family that's devastated by the denial of mental health and addiction treatment is not a political statement but a stark reminder of what's at stake when we allow inaction at best, and discrimination at worst, to prevail.

Ultimately, The New Frontier is a set of challenges, not promises. We developed this Roadmap to Equality: A Legislative Guide to Mental Health and Addiction, not only to give you valuable resources and insights, but also to ask for your help. I'm calling on those of you in this new Congress and administration, which includes some of my former colleagues, to support the whole health of every American. I'm personally asking you to follow through on the legislative promises we made back in 2008, and to secure the progress we will make in the coming months and years, so that someday soon we can all celebrate the achievements that we have made together, for our friends, our loved ones, our country and ourselves.

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