STATE POLICY PLATFORM FOR ADDRESSING THE U.S. MENTAL HEALTH & ADDICTION CRISIS

Invest in Youth Mental Health

Fifty percent of mental illness begins by age 14 and 75% begins by the time the brain is fully developed in the mid-20s. The pandemic has significantly worsened the collecive mental health of youth, prompting the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association to declare a national emergency in children's mental health, and, most recently, the U.S. Surgeon General to issue a public health advisory on the same topic. To help our young people, we must come together to prioritize prevention, early identification, and early treatment in schools and primary care settings.

States should:

- **Integrate mental health screenings into school physicals.** Children's mental health and physical health are closely connected— identifying potential issues early on can help them get the services and support they need before challenges worsen. Illinois adopted this approach by enacting Senate Bill 565.
- **Prioritize Social-Emotional Learning (SEL) and Multi-Tiered Systems of Support in schools.** Decades of research have shown the importance of incorporating SEL into classrooms and school cultures. It's been proven to help "children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy toward others, establish and maintain positive relationships, and make responsible decisions." States should also help schools adopt Multi-Tiered Systems of Support, which incorporate prevention, early intervention, and connections to community-based mental health services to meet students' unique needs.
- **Incorporate mental health and substance use education into school curricula.** States such as Virginia, New York, and Florida have worked to integrate mental health content into health classes. For example, students can be taught to identify signs of suicidal ideation or behavior, and attend school-sponsored Youth Mental Health First Aid trainings. New York has even made it a *requirement* for schools to incorporate this type of content into current cirriculum. Appendix C of Mental Health America's (MHA) report, "Addressing the Youth Mental Health Crisis: The Urgent Need for More Education, Services, and Supports," includes a full list of states' progress incorporating mental

health and substance use education. Some have enacted specific legislation to further enhance mental health education, the details of which can be found at this Healthy Schools Campaign briefing.

- **Reimburse schools for student mental health services.** Many mental health services can be effectively provided in school settings, either by onsite clinicians or through telehealth. States must ensure schools can be reimbursed for these services by allowing schools to bill Medicaid for:
    - *Services provided to any Medicaid-eligible student, not just a student with an Individualized Education Plan (IEP)*. Fourteen states, including Michigan, have done this. Early results show significant increases in mental health staffing: Michigan saw mental health staff increase by over 70%, while reimbursement increased by more than $6 million. MHA's report details Michigan's experience and other states' use of Medicaid expansion beyond students with IEPs.
    - *Telehealth services provided to a student while at school*. Twenty-seven states and the District of Columbia have allowed schools to serve as originating sites (the location of the person receiving telehealth services). The most common services reimbursed are therapy services, and the most common modality is live video. Texas has maximized the use of telehealth to provide school-based mental health services through their Texas Child Mental Health Care Access Through Telemedicine (TCHATT) program, which is anticipated to provide coverage for an additional 1.33 million students.

Break Down Silos That Separate Mental Health from Physical Health

Primary care is the most common contact point Americans have with a health system. More than half of people see their primary care provider in a given year. And, for many, primary care is where a mental health need is first identified. As primary care providers are increasingly incentivized to coordinate care, integration with mental health will be vital.

States should:

- **Require reimbursement for Collaborative Care model (CoCM).** Require insurers to reimburse for CoCM, which has been shown (across more that 90 randomized control trials) to be effective in improving outcomes related to depression and anxiety, medication use, mental health quality of life, and patient satisfaction when compared to usual care. Though the majority of commercial insurers reimburse for CoCM, only 17 state Medicaid agencies have mandated coverage of CoCM codes. In a 2018 letter to state Medicaid directors, CMS identified CoCM as an evidence-based approach to

integrate mental and physical health care, and listed potential Medicaid payment strategies that states can use to implement the model.

- **Pursue integration in Medicaid through Section 1115 waivers.** One in five Medicaid beneficiaries have a mental health or substance use disorder (MH/SUD). Medicaid demonstration waivers currently allow states to test experimental, pilot, or demonstration projects. For example, California, Massachusetts, New York, Oregon, Texas, and Washington have all implemented delivery system reform demonstrations that integrate mental health and substance use disorder care with primary care.
- **Train primary care doctors to screen and identify MH/SUDs.** Primary care doctors are often best situated to identify mild to moderate needs, suggest evidence-based treatment, and/or make referrals to care. For children and adolescents, this includes early developmental screening, social-emotional screening, and screening for adverse childhood experiences (ACES). States can encourage adoption of validated screening tools for MH/SUDs in primary care settings, including the PHQ9 for major depressive disorder and the SBIRT for substance use.
- **Require specialized protocols for treating MH/SUDs in emergency rooms.** Hospitals are another common contact point for those struggling with MH/SUDs, particularly at more acute levels. In fact, nearly half of all emergency room (ED) visits in the U.S. are categorized as relating to substance use disorders. Hospital departments and staff, especially emergency rooms, should have systemized ways to identify and treat MH/SUDs. Some EDs are even integrating peer navigators or recovery coaches into post-overdose care.
- **Support value-based payment models that reward good outcomes.** State Medicaid programs can drive change by encouraging value-based payment models (VBPs) that pay for improved outcomes rather than just volume of services. VBPs can take a variety of forms, but they ultimately encourage multi-disciplinary care teams that break down silos between mental health/addiction and physical health. They often result in physical health care savings stemming from successful treatment of MH/SUDs. For more information on opportunities related to addiction payment reform, visit the Alliance for Addiction Payment Reform, which works to advance pilots in a number of states, including Ohio and North Carolina.
- **Implement a statewide Zero Suicide program.** States can operationalize the seven elements of safe and effective suicide care that make up the Zero Suicide framework. Organizations that used this approach found a 60-80% reduction in suicide rates among those in care. California has adopted a Zero Suicide framework that includes integration with counties and schools.

Increase Access to High-Quality, Affordable Treatment

The COVID-19 pandemic has exacerbated existing cracks within our health care system. As mental health and addiction challenges worsen, access to evidence-based care remains a major barrier for those seeking help. States can directly address long-standing disparities in access to MH/SUD treatment for racial and ethnic groups, and advance policy and clinical interventions that confront these inequities. State legislators and regulators have a great deal of authority to pursue the necessary policies and changes.

States should:

- **Aggressively enforce mental health and addiction parity laws.** States should require commercial and Medicaid-managed care plans to demonstrate they are not unlawfully denying care—and, thus, complying with the Mental Health Parity and Addiction Equity Act of 2008—by submitting parity compliance analyses to state regulators. Nearly half of states have already put in place such parity reporting requirements. Regulators must conduct detailed investigations and market conduct examinations of plans to ensure they are complying with the law.
- **Require health plans to cover the full continuum of MH/SUD care and follow national clinical standards when making coverage decisions.** Unfortunately, many health plans do not cover the full continuum of mental health and addiction treatment, leaving large gaps for individuals to navigate alone. Plans also frequently use flawed criteria to conduct utilization review, resulting in life-threatening denials of care. To ensure proper coverage, states should enact The Kennedy Forum's Jim Ramstad Model State Legislation, which requires all insurers to follow generally accepted standards of MH/SUD health care when making coverage decisions, and use criteria consistent with these standards. By putting these critical requirements in place, states can improve access to mental health and addiction care at a time of rapidly escalating need. California has done this through Senate Bill 855, and Illinois and Oregon recently enacted requirements as well.
- **Prohibit prior authorization requirements for lifesaving addiction treatment.** Medication-assisted treatment (MAT), which combines medications to reduce cravings and counseling, is an essential, life-saving treatment for opioid and alcohol use disorders that can help people recover from these illnesses. Unfortunately, MAT is severely underutilized. Increasing access to MAT must be a critical component of strategies to address the alarming increase in fatal overdoses, which recently surpassed 100,000 in a 12-month period for the first time ever. Prior authorization and fail-first requirements, particularly for medications, can inhibit access and result in overdose and death. States

should prohibit health plans from imposing such requirements and should place MAT medications on lower cost-sharing tiers, as Illinois has done.

- **Increase the number of diverse providers.** There simply are not enough mental health and addiction providers to meet the current demand. States must utilize multiple strategies to increase provider networks, with an emphasis on providers who are equipped to serve the needs of diverse communities. Needed actions include:
    - *Ensuring telehealth reimbursement for MH/SUD services.* Telehealth usage has expanded dramatically during the pandemic. Now, state policymakers must make expansions permanent by requiring reimbursement of telehealth services at parity with in-person services, and allowing out-of-state telehealth providers to treat state residents. Nineteen states have fully implemented telehealth parity.
    - *Funding loan forgiveness programs for new mental health and addiction providers.* States can provide grants and loan forgiveness to mental health and addiction providers located in particular areas.
    - *Enforcing parity laws and raising Medicaid rates to increase reimbursement for mental health and addiction services.* Without adequate reimbursement, there will never be an adequate pipeline of providers who choose to enter the field—when other areas of health care pay significantly more.
    - *Reimbursing the full range of providers, including peers.* States can take action to ensure commercial health plans and Medicaid reimburse for the full range of mental health and addiction providers. This includes certified peer support specialists, who are an essential part of the provider continuum and help to advance individuals' recovery.

Advance Equity by Addressing Political Determinants of Health

Improving mental health requires meaningfully addressing all factors that contribute to wellbeing, including the ways in which certain communities are impacted by racism, biases, and systemic inequities. Prevention efforts within these communities are critical for keeping people out of crisis care and/or the criminal justice system. Even with effective services, however, crises will still occur, and states should be prepared to respond to people with appropriate care.

States should:

- **Build a comprehensive crisis response system for MH/SUD and suicide prevention through 9-8-8.** A lack of a statewide, comprehensive coordinated crisis response system results in inconsistent and patchwork care; unnecessary emergency room visits; hospitalizations, arrests, and detentions that cause undue harm topeople in crisis; and

unnecessary burdens on state and local services. States should collaborate with the National Suicide Prevention Lifeline to implement 9-8-8 as a complete crisis call hub capable of connecting individuals to appropriate, non-punitive care. States can take advantage of the myriad federal assistance resources associated with 9-8-8 planning to invest in infrastructure and capacity expansion by the time 9-8-8 goes live in July 2022. Planning efforts must ensure:

  - 9-8-8 call centers are equipped to handle the anticipated influx in calls, including funding to train call center staff to effectively answer a wide range of MH/SUD and suicidal risk calls.
  - Community-based care and inpatient care can adequately meet the needs of those diverted from hospital emergency departments and jails.
  - Mobile crisis outreach teams are funded and equipped to collaborate with local MH/SUD providers and other emergency response systems.
  - Statewide availability of effective crisis stabilization programs.
  - 9-1-1 and 9-8-8 systems operate in a complementary fashion.
  - Health plans are covering the crisis continuum of care.
  - Specialized crisis response systems for youth and in schools.
  - For more information on what a comprehensive crisis system might entail, see Well Being Trust's Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System.

- **Prioritize public health strategies for mental health and substance use disorders.** States must adopt a public health approach to MH/SUDs, including mobile outreach campaigns to reach people in need, and expansion of fentanyl testing strip distribution and needle exchange programs. States such as New Jersey have built out Harm Reduction Centers (HRCs), also known as Syringe Access Programs. HRCs are community-based programs that bridge gaps in health services for people who use drugs and connect them to critical health services such as health screenings, pregnancy testing and prenatal care, nutrition counseling, reproductive counseling, vaccinations, wound care, and mental health and addiction treatment. HRCs offer access to sterile injection equipment and a place to discard used equipment to prevent blood borne diseases such as HIV and Hepatitis C. They also provide naloxone (to reverse opioid overdose), pre-exposure prophylaxis (for those at risk of HIV from sex or injection drug use), education about preventing overdoses, and recovery resources.
- **Support the use of contingency management (CM).** This evidence-based, psychosocial intervention gives individuals tangible monetary or non-monetary rewards to reinforce positive behaviors such as treatment adherence and reduced drug use. Both the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration have recognized CM as highly effective. CM is particularly needed for

SUDs such as methamphetamine use disorder, which currently has limited effective medications in use. Currently, the state of California is planning to increase the use of CM.

- **Invest in supportive services.** Addressing underlying community conditions such as affordable housing, reliable transportation, employment, and other supportive services can make the path to recovery much easier for those with MH/SUDs. Many studies show that supportive housing successfully interrupts the cycle between institutionalization and homelessness, and that people with histories of incarceration or institutionalization significantly reduce their use of those systems after moving into supportive housing. One large study found that individuals placed in supportive housing spent 115 fewer days in homeless shelters, 75 fewer days in psychiatric hospitals, and almost eight fewer days in prison or jails compared to groups without supportive housing. States should:
    - Increase investment in supportive housing.
    - Expand the use of state-funded rental subsidies for individuals with serious mental illness who are homeless or unstably housed.
    - Invest in supported employment programs.
- **Decriminalize mental health and substance use disorders.** People in an active mental health crisis are more likely to encounter police than to get medical attention. Nearly 2 million people living with a mental illness—including many veterans with PTSI or other mental health conditions—are booked into jails each year. When in jail, individuals with mental health disorders stay almost twice as long as other individuals facing similar charges. Jails and prisons should not be default mental health facilities. Instead, states should:
    - *Expand efforts to divert people with MH/SUDs away from the criminal justice system and into appropriate community-based MH/SUD care*, including diverting youth with mental health conditions from juvenile justice systems. The Council of State Governments Justice Center highlights individual programs as well as systems-wide strategies states can take to improve diversion.
    - *Build networks of community-based, continuous, and integrated support services to help individuals reenter their communities after incarceration.* States can also ease the transition for those exiting the criminal justice system by automating Medicaid enrollment so that there is no gap in access to MH/SUD care. Missouri, Ohio, New Mexico, and Rhode Island have all automated Medicaid enrollment for those leaving the criminal justice system.
    - *Train law enforcement and emergency responders to appropriately respond to individuals with mental health conditions*. Establish formalized diversion programs among law enforcement (e.g. citations in lieu of arrests) and expand

crisis triage centers and crisis stabilization units. Los Angeles County's Alternative Crisis Response Project is a partnership with law enforcement, fire/EMS, other health and human services providers, and suicide prevention lines that establishes a county-wide non-police crisis response system that connects to both 9-1-1 and 9-8-8 lines.