National Alliance on Mental Illness

STATE LEGISLATION REPORT

Trends in State Mental Health Policy

2020-2021

LEGISLATIVE REVIEW

About NAMI

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Acknowledgements and Gratitude

This report was prepared by NAMI's state affairs team, Stephanie Pasternak, Samira Schreiber and Kathryn Gilley, with contributions from Brandon Graham, Jessica W. Hart, Jodi Kwarciany, Shannon Scully, Jennifer Snow and Hannah Wesolowski. NAMI is grateful to NAMI State Organization executive directors and public policy leaders for providing information on their legislative priorities and accomplishments that serve as the basis for this report. We are also grateful to Jessica Cruz (NAMI California), Sue Abderholden (NAMI Minnesota) and Luke Russell (NAMI Ohio) for providing insights into their advocacy strategy for the spotlights in this report.

Additional thanks are extended to NAMI staff members who helped to edit (Luna Greenstein and Margot Harris) and to provide key facts and figures (Elizabeth Stafford, Zahira Correa, and Jessica Walthall), and to Pamela Krikorian, the designer of this report.

Finally, we deeply appreciate NAMI grassroots advocates who communicate with legislators to make mental health a priority in state legislatures across the country.

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National Alliance on Mental Illness

NAMI STATE LEGISLATION REPORT

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2020–2021 Legislative Review

Introduction

Overview

The COVID-19 pandemic brought about an unprecedented crisis in the U.S. that disrupted our daily lives and caused extreme stress, isolation, trauma and loss. At the outset of the pandemic in 2020, many states' legislative sessions were cut short, and state legislators had to prioritize the most urgent policy actions needed to support their residents through the immediate crisis. Fortunately, the enormous impact of the pandemic on mental health was not overlooked, and in fact, mental health came into national focus like never before.

Figures from the first two years of the pandemic highlight the U.S. mental health crisis. Well over 41% of adults reported symptoms of anxiety or depression in January 2021, compared to a rate of 1 in 10 in January 2019. The social and economic stressors of the pandemic were not felt equally across demographics, and children and young people have been one of the groups disproportionately affected. The proportion of youth emergency department visits that were due to mental health-related reasons increased for children aged 5–11 and 12–17 years by approximately 24% and 31%, respectively, from 2019 to 2020.

The demand for mental health services has always far exceeded the supply, and this disparity has only been exacerbated by the pandemic.

Lawmakers responded to these alarming numbers by passing a significant amount of mental health-focused legislation in 2020 and 2021. However, even the increased attention did not change the fact that most people struggle to access mental health care. The demand for mental health services has always far exceeded the supply, and this disparity has only been exacerbated by the pandemic.

The NAMI Alliance's advocacy has never been more important. For over 40 years, NAMI has been shaping public policies that help individuals with mental illness and their families live healthy and fulfilling lives. What started with a small group of families gathered around a kitchen table in Wisconsin in 1979 has grown into a grassroots alliance of more than 600 local NAMI Affiliates (NAs) and 49 NAMI State Organizations (NSOs).

NAMI organizations bring the real-life experiences of individuals and families affected by mental illness to the policymaking table. It is mental health advocates' collective goal to create systemic change that ensures people with mental health conditions get help early, get the best possible care and are diverted from criminal justice system involvement.

The policies and funding for many key mental health services and supports are decided at the state-level. NSOs represent the voices of those affected by mental illness at their statehouses by sharing the challenges and discrimination that people with mental health conditions and their families face and fighting for needed

changes to state law. During this time, NSOs were incredibly effective in making sure that states invested more in mental health and prioritized policy changes that made mental health care more accessible for everyone.

Because of the unique nature of the issues addressed and the focus of state legislators during this time, this report is a showcase of significant state mental health legislation that was enacted during the height of the COVID-19 pandemic, in calendar years 2020 and 2021. The report explains key trends in mental health policy and offers lessons from NSO leaders who played an important role in shaping some of these policies.

State legislators and agency officials, NSOs and other mental health advocates should use this report to understand the many policy options that exist to improve conditions for people with mental illness and their families and identify best practices in policy to replicate in their state.

Structure of Report

The report is divided into three main sections based on the topic area pillars of the NAMI 2020–2025 Strategic Plan:

Section 1: "People Get Help Early"
Section 2: "People Get the Best Possible Care"
Section 3: "People Get Diverted from Criminal Justice System Involvement"

Within each section, bill analysis is framed around several "areas of focus." There are 10 areas of focus in total, which all represent issues of critical importance to NAMI's mission that also saw significant legislative action in 2020-2021. In each area of focus, key trends and highlight bills are identified and briefly analyzed. ***Note:*** these areas of focus are not exhaustive of the many activities happening in the mental health policy space.

Find all the bills referenced in this report online here.

Bills are organized into mini-tables within each trend area and are also listed in this resource for reference. Bills that fit more than one section or area of focus are only listed in the area that the bill's content is primarily focused on.

Other special components of the report include "Understanding the Issue" features that provide a deeper dive on a complex mental health policy issue and "Advocacy Spotlights," which showcase an NSO's involvement with a key piece of legislation and illustrate how other advocates may replicate their success.

Methodology

The content of this report is focused on major mental health legislation that was in enacted in either 2020 or 2021 (vetoed bills were not included). The research for this report was conducted primarily using legislative tracking software (Quorum). Additionally, NAMI National collected NSOs' 2020-2021 state legislative summaries (when available) to inform the analysis of major legislation.

State budget and appropriations bills were excluded due to the vast differences in how states fund and administer their mental health services and programs across state agencies and county/local entities. There are a few exceptions in which budget bills are mentioned in this report to discuss a specific provision from that bill. Finally, bills that did not meet one of the "Areas of Focus" for this report, or bills that were not primarily mental health-focused, were also excluded.

Note that mental health policy spans many issues, all of which are important and worthy of policymakers' attention. However, in the interest of creating an accessible, brief and usable document for advocates and other interested parties, the report's scope had to remain limited and, therefore, this report is not comprehensive. The areas of focus are not intended to provide a complete list of state legislation passed on a given topic; rather, they are intended to provide overall trends and highlights of state legislation.

Even within these limits, more than 440 state mental health bills were collected for consideration in this report. Upon further refinement, around 330 bills were included in the final report.

REPORT NAVIGATION KEY

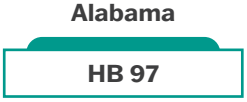
The top right corner of each page features a set of interactive links allowing you to navigate easily to different sections of this report.

Click or tap a number to navigate to the beginning of each report section.

Click or tap the hamburger menu to navigate to the interactive Table of Contents.

STATE BILL REFERENCE LINKS

Summary tables of exemplary state bills also include links to the entire bill language.



Click or tap a bill button to review the entire bill online. (Control or command + clicking will open links in a new window or tab in most browsers.)

1

People Get Help Early

Early identification and treatment of symptoms is crucial to any health condition, and mental health is no different. Early signs of a mental health condition can present at any age, but research reinforces the importance of access to timely and evidence-based care that can help a person get and stay well. NAMI believes that public policies and practices should promote greater awareness and early identification of mental health conditions.

It is especially critical that states step up to meet the growing need for youth mental health treatment amid a well-documented youth mental health and suicide crisis. Identifying and providing early supports for young people experiencing mental health conditions will ensure that they can lead healthy and fulfilling lives. In addition to early intervention and suicide prevention strategies, mental health education and support in school is crucial to ensuring that young people get help early. School mental health programs can raise awareness and destigmatize mental health conditions, provide pathways for students seeking help and assist school officials in identifying students who are struggling and connecting them to mental health care.

In this section, we review key trends in legislation in two areas of focus:

1. ***Early Intervention***
2. ***School Mental Health***

The legislation covered in this section aims to enhance early identification and treatment of mental health conditions, prevent the risk of suicide for both youth and adults, and leverage school settings to improve students' overall mental health.

Early Intervention

Early diagnosis and treatment of people experiencing mental health conditions can greatly reduce the escalation of symptoms and the risk of a person experiencing crisis. On average, it takes approximately 11 years to receive mental health treatment after symptoms first occur. That delay is harmful and unsustainable — like any health condition, early intervention is key to preventing symptoms from becoming worse and helping a young person stay engaged socially and in school, work or other activities. While 75% of all mental health conditions develop by age 24, early intervention is critical at any age, regardless of when symptoms first arise.

The years of the pandemic, however, exacerbated mental health struggles across the country, particularly for children and adolescents. In 2021, the U.S. Surgeon General issued a rare advisory, focused on the nation's youth mental health crisis. In early 2021, emergency department visits in the U.S. for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019. Nearly one in five young people reported that the pandemic had a negative impact on their mental health. With the increase in youth experiencing symptoms of mental health conditions, providing avenues to intervene early has taken on more urgency.

States must also recognize that certain factors are associated with higher risk of suicide, and policy efforts can be made to protect individuals at risk. Although having a mental health condition is a risk factor for suicide, anyone experiencing hopelessness or despair due to a variety of stressors can be at-risk for suicide.

What does early intervention look like?

Early intervention generally refers to recognizing the signs and symptoms of common mental health challenges and intervening before someone's condition worsens. Early intervention policies occur at the individual, community and systems levels. Strategies include:

- Developing and coordinating comprehensive mental health care services available to youth
- Enhancing mental health screening opportunities
- Increasing the number of educational programs, advertising materials and trainings on mental health conditions and suicide prevention
- Expanding access to mental health services and supports for children and young adults

Trends in 2020/2021 Early Intervention Legislation

Mental Health Screenings

Mental health screenings help with the early detection and intervention of a mental health condition. The primary strategy to increase mental health screenings in legislation during 2020 and 2021 was requiring insurance coverage of such exams, like New Jersey's requirement for depression screenings of adolescents (A 3548) and California's action to require Adverse Childhood Experience (ACEs) screenings for children (AB 428). Another strategy has been to engage providers to proactively offer screenings, such as Virginia's bill that focused on encouraging providers to administer both prenatal and postpartum depression screenings (HB 42). Relatedly, several states took efforts to implement mental health screenings in school settings (see the School Mental Health section on page 14 for more information).

Examples of 2020-2021 Addressing Mental Health Screenings

STATE | BILL NUMBER	YEAR	DESCRIPTION
California AB 428	2021	An act that expands insurance coverage of Adverse Childhood Experiences (ACEs) screenings for all health plans that provide pediatric and preventative care coverage.
Connecticut SB 2	2021	An act that establishes a youth suicide prevention training program, requires certain licensed health care professionals to complete mental health and suicide screening and prevention training and permits minors to receive more than six outpatient mental health treatment sessions without the consent of a parent or guardian, among other provisions.
New Jersey A 3548	2021	An act that requires insurance coverage to include adolescent depression screenings for ages 12-18.
Virginia HB 42	2020	An act that requires the state's Board of Medicine to annually communicate to relevant practitioners the importance of prenatal/ postnatal/other depression screening. The bill would encourage practitioners to screen every patient who is pregnant or who has been pregnant within the previous five years and provide practitioners with information on factors that may increase depression.
Washington SB 6191	2020	An act that adds to the voluntary, biannual healthy youth survey to include questions related to adverse childhood experiences (ACEs) to help assess the prevalence of ACEs throughout the state, with results used to help inform school and community decision-making and improve services for students.

Access to Child and Adolescent Mental Health Treatment

When children and adolescents need mental health intervention and treatment, they and their families often face significant barriers in accessing those resources. Policymakers have worked to alleviate some of the most common barriers that children, youth and families face, including costs, bureaucracy, lack of information about mental health care and gaps in services. This has been addressed by providing free therapy sessions to expand access (CO HB 21-1258), giving adolescents the ability to initiate a mental health evaluation without parental consent (WA HB 2883) and making information about children's mental health services readily available in key settings, such as emergency rooms (CT HB 6510).

Some states engaged in a system-level effort with studies or task force/work group activity to evaluate needs, fill in gaps in services and better coordinate resources for children and youth (AR HB 1689; VA HJ 51; and WA HB 2737).

See page 14 for more about mental health treatment in school settings.

Examples of 2020-2021 Legislation Addressing Access to Child and Adolescent Mental Health Treatment

STATE | BILL NUMBER	YEAR	DESCRIPTION
Arkansas HB 1689	2021	An act that creates the Arkansas Legislative Study on mental and behavioral health. The purpose of this study is to assess the strengths and weaknesses of mental and behavioral health resources, including studying the suicide rate among school-aged children and mental health screening and suicide prevention measures for children in grades K-12.
Colorado HB 21-1258	2021	An act that establishes a temporary program to facilitate youth mental health services by giving three free therapy sessions to any school-aged youth in Colorado who wants them. This bill appropriates $9 million for this effort.
Connecticut HB 6510	2021	An act that requires the provision of information on children's mental health services in hospital emergency rooms. The bill requires the Department of Children and Families to develop documents for mental health regions in the state that describe behavioral and mental health evaluation and treatment resources available to children, among other provisions.

Examples of 2020-2021 Legislation Addressing Access to Child and Adolescent Mental Health Treatment *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Florida CS/CS/HB 945	2020	An act that implements a coordinated system for children's mental health care, including development of a model protocol for mobile response teams (MRTs) to provide 24/7 immediate, onsite behavioral health services; directs the Department of Children & Families (DCF) and the Agency for Health Care Administration (AHCA) to identify children and adolescents who are the highest users of crisis services and collaborate to address their needs; requires the development of plans promoting a coordinated system of care for certain services; tests provider network databases maintained by Medicaid managed care plans; requires pre-training for foster parents on how to contact MRTs; requires verification of use of certain strategies and outreach before a student is removed from school, school transportation or school-sponsored activities under specified circumstances; and requires DCF and AHCA to assess quality of care provided in crisis stabilization units.
Maryland HB 0776	2021	An act that requires the State Department of Education to perform a thorough study, analysis and evaluation of the Infant and Early Childhood Mental Health Consultation Project to evaluate the project's services, capacity, and integration with existing programs and requires the department to report on progress, findings and recommendations.
Virginia HJ 51	2020	An act that directs the Departments of Education, Behavioral Health and Developmental Services, and Social Services to jointly study the feasibility of developing an early childhood mental health consultation program available to all early care and education programs serving children from birth to five years of age.
Washington HB 2737	2020	An act that updates the state's children's mental health workgroup. This bill ensures that the workgroup is renamed the Children and Youth Behavioral Health Work Group (CYBHWG) and amends the duties of the group as well as modifies the parent representative requirements, including the addition of a foster parent representative.
Washington HB 2883	2020	An act that expands adolescent behavioral health care access through family-initiated treatment by allowing adolescents aged 13-17 to initiate an evaluation for treatment without parental consent and allowing parents/caregivers to initiate an evaluation for treatment for adolescents without consent but only if the service is medically necessary.

Suicide Prevention

States have explored several legislative strategies to help reduce the risk of suicide, particularly focused on raising awareness of existing resources and providing additional support to vulnerable populations. Strategies include sharing information on suicide crisis resources in highly visible public areas, such as highways (MD SB 0810). States have also acted to provide support when individuals are or may be at an elevated risk for suicide, such as if they recently purchased a firearm (DE HB 55), have made a recent suicide attempt (TN SB 0615) or are part of a demographic known to be at elevated risk for suicide, like emergency first responders (NV AB 315).

Examples of 2020-2021 Legislation Addressing Suicide Prevention

STATE | BILL NUMBER	YEAR	DESCRIPTION
California AB 2112	2020	An act that authorizes the State Department of Public Health to establish the Office of Suicide Prevention to provide information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs and reporting on progress to reduce rates of suicide.
Delaware HB 55	2021	An act that creates a statewide "Gun Shop Project." This bill provides suicide prevention education materials and training for retailers and consumers of licensed weapons.
Florida CS/SB 7012	2020	An act that broadens the Statewide Office for Suicide Prevention to act as a clearinghouse for suicide prevention resources and disseminate best practices on suicide prevention, increases the scope of the office to include veterans and servicemembers, and establishes the First Responders Suicide Deterrence Task Force. The act also creates the Suicide Prevention Coordinating Council to develop strategies for preventing suicide. The act also defines coordinated specialty care (CSC) programs for early psychosis as a coordinated system of care and requires the state to report annually on any gaps in availability or access to this care in the state.
Maryland SB 0810	2020	An act that authorizes the State Highway Administration to post information on suicide prevention, including a hotline number, on electronic signs along any highway within a five-mile radius of a high suicide risk zone, as identified by the administration.

Examples of 2020-2021 Legislation Addressing Suicide Prevention *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Nevada AB 315	2021	An act that assists first responders both during their course of employment and within three months of retirement by providing access to information and counseling relating to mental health with an emphasis on suicide prevention.
Oregon SB 563	2021	An act that creates a Youth Suicide Intervention and Prevention Advisory Committee to advise the Oregon Health Authority on strategies to address suicide intervention and prevention for children and youth ages 5-24.
Tennessee SB 0615	2021	An act that establishes that, if a health care provider knows that a person under the provider's care has been admitted to a health care facility and has threatened or attempted suicide or to inflict serious bodily harm, then the provider must ensure that the person is provided access to or contact information for a qualified mental health professional or mental health counseling resource. This must be provided to the patient prior to discharge. If a health care provider violates this law, they will be considered to have committed professional misconduct and subject to discipline by the health care provider's licensing authority.

School Mental Health

With the growing mental health crisis for youth, schools provide an avenue to reach children where they are. School-aged children generally spend over one-third of their waking hours in school settings, and schools and teachers can serve as trusted resources for mental health information. Schools provide a safe and appropriate setting to receive mental health education, and they can help normalize and raise awareness of mental health conditions. Moreover, adolescents are increasingly expecting schools to fill this need. A national poll conducted by NAMI of U.S. adolescents aged 12-17 found that seven in 10 teenagers believe schools should offer mental health education, and 68% of adolescents say schools should communicate treatment options that may be available.

The COVID-19 pandemic has negatively contributed to student mental health concerns. Students reported that their mental health had been worsening even before the pandemic. In 2019, 36.7% of high school students reported experiencing persistent feelings of sadness and hopelessness, a 40% increase from 2009. In 2021, 44% of high school students reported feeling persistently sad or hopeless.

While schools are an important resource to improve awareness of mental health conditions and resources, as well as connect children to care, schools can also be a source of stress for children and adolescents. Policies that recognize and adapt to these stressors can serve to improve youth mental health.

What does school mental health look like?

- Including mental health education in school curricula
- Providing information about mental health resources to students
- Implementing policies for training of school personnel, recognizing mental health as reason for an excused absence and other strategies to improve student mental health
- Providing mental health services and screenings in school settings or a direct connection to care in the community
- Directing state agencies to coordinate the response to the youth mental health crisis

Trends in 2020/2021 School Mental Health Legislation

Student Identification Card Requirements

Suicide is the 2nd leading cause of death for youth aged 10-14 and the 3rd leading cause among those aged 15-24. Many states have taken action to provide youth with mental health and suicide prevention resources. A common trend seen across many states was legislation requiring the National Suicide Prevention Lifeline number (now known as the 988 Suicide & Crisis Lifeline as of July 2022) and other suicide prevention resources to be printed on student identification cards. This was mostly directed at middle school, high school and higher education institutions, where students are more likely to receive a student identification card. Washington's HB 1373 addressed what mental health and suicide prevention resources must be provided on a school district's website.

Examples of 2020-2021 Legislation Addressing Student Identification Cards

Please note that all references to the National Suicide Prevention Lifeline (NSPL) in the chart below refer to the 988 Suicide and Crisis Lifeline. The transition to 988 occurred on July 16, 2022, after these legislative actions.

STATE | BILL NUMBER	YEAR	DESCRIPTION
Arizona SB 1446	2020	An act that requires any school district or charter school governing board with students in grades 9-12 or institutions of higher education that issue identification cards to include contact information for local or national suicide prevention resources, local crisis centers or emotional support services.
Arkansas HB 1770	2021	An act that requires student identification cards of public school, public charter school or a two- to four-year institution of higher education to include the following information: national domestic violence hotline, national sexual assault hotline and National Suicide Prevention Lifeline.
Illinois HB 1778	2021	An act that amends the School Code and Mental Health Early Action Act on Campus. If a school district (grades 6-12) or public college issues an identification card, the district shall provide contact information for the National Suicide Prevention Lifeline, the Crisis Text Line and the local suicide prevention hotline on the identification card. ***This bill is built on similar efforts, such as HB 0597 and SB 2014, both passed earlier in 2021.***
Kentucky SB 42	2020	An act that requires any public school or public charter school with students in grades 6-12 or institutions of higher education that issue identification cards to include contact information for national crisis hotlines specializing in domestic violence, sexual assault and suicide.

Examples of 2020-2021 Legislation Addressing Student Identification Cards *(Continued)*

Please note that all references to the National Suicide Prevention Lifeline (NSPL) in the chart below refer to the 988 Suicide and Crisis Lifeline. The transition to 988 occurred on July 16, 2022, after these legislative actions.

STATE | BILL NUMBER	YEAR	DESCRIPTION
Maryland HB 405	2021	An act that requires higher education institutions to provide contact information for Maryland's helpline or an on-campus crisis center that operates 24/7 on student identification cards.
Michigan HB 5482	2020	An act that requires any public school with students in grades 6-12 that issues identification cards to include a local, state or national suicide prevention hotline telephone number that is available 24/7 on the card. The act also directs the Department of Health and Human Services to develop model informational materials regarding suicide prevention services, suicide, depression and anxiety, and to make these available to any school or school district upon request. The bill encourages any school with students in grades 6-12 to display this information on the school website and in the school counselors' and principal/chief administrator's office.
Nebraska LB 528	2021	An act that requires that newly issued school identification cards include any one of the following numbers: a national suicide prevention hotline, a local suicide prevention hotline or a crisis text line, among other provisions.
Nevada SB 249	2021	An act that requires mental health resources, including the National Suicide Prevention Lifeline, to be included on school identification cards for grade school and college/university students. The act also adds behavioral health to the list of conditions that may excuse a child's absence from school.
New Jersey S 550	2021	An act that requires public schools with students in grades 7-12 and higher education institutions that issue student identification cards, to include the New Jersey Suicide Prevention Hopeline and a crisis text line on student ID cards. The act also allows the designated schools to include other mental health resource information on the student ID cards.
South Carolina SB 0231	2021	An act that requires public schools and public and private institutions of higher learning to include the National Suicide Prevention Lifeline number on their student identification cards.

Examples of 2020-2021 Legislation Addressing Student Identification Cards *(Continued)*

Please note that all references to the National Suicide Prevention Lifeline (NSPL) in the chart below refer to the 988 Suicide and Crisis Lifeline. The transition to 988 occurred on July 16, 2022, after these legislative actions.

STATE | BILL NUMBER	YEAR	DESCRIPTION
Texas SB 279	2021	An act that requires the inclusion of the National Suicide Prevention Lifeline information on each student identification card issued by a public school with grades six or higher or by a public institution of higher education.
Washington HB 1373	2021	An act that promotes student access to information about behavioral health resources. Public schools' website home page must list contact information for a suicide prevention organization, depression or anxiety support organization, eating disorder and substance abuse support organization.

See page 22 for more about social emotional learning (SEL).

Mental Health Education and Social Emotional Learning in Schools

To raise awareness of the importance of mental health, promote healthy coping mechanisms and encourage help-seeking behaviors, states have passed legislation adding instruction on mental health to their standard health education curriculums (AZ SB 1376; CA SB 224; NJ A 4454; OK HB 1568; and SC HB 3257).

In 2021, California joined the growing list of states requiring mental health instruction with the passage of SB 224. The law will ensure that middle and high school students who are required to receive health education will learn about mental health as part of that curriculum. To learn more about SB 224 and how NAMI California's advocacy helped pass this bill, check out the Advocacy Spotlight on page 19.

In addition to mental health education (also referred to as mental health literacy), some states worked to create or strengthen their schools' social emotional learning (SEL) programs (NJ S 2486 and VA HB 753). SEL is distinctly different from mental health education, but both efforts complement one another to support students' well-being. To better understand SEL and its role in schools, please see the Understanding the Issue overview on page 22.

Examples of 2020-2021 Legislation Addressing Mental Health Education or SEL in Schools

STATE | BILL NUMBER	YEAR	DESCRIPTION
Arizona SB 1376	2021	An act that directs the State Board of Education to require all health education instruction to include mental health and to consult with mental health experts and advocacy organizations on the development of mental health instruction.
California SB 224	2021	An act that expands mental health instruction in California public schools. This bill requires that each school district, county office of education, state special school and charter school of students in grades 7-12 that requires a health education course to graduate includes mental health instruction.
New Jersey S 2486	2021	An act that establishes the Clayton Model Pilot Program in the Department of Education to provide school-based social emotional learning to students in grades K-5 at certain public schools.
New Jersey A 4454	2021	An act that requires school districts to include instruction on diversity and inclusion, including mental health conditions and physical disabilities, in their K-12 curriculum as part of implementation of the New Jersey Student Learning Standards in Comprehensive Health and Physical Education.
Oklahoma HB 1568	2021	An act that creates Maria's Law to require that schools include mental health instruction in any health education curriculum. The State Board of Education will develop a list of mental health resources for students and revise the state's academic standards to include mental health.
South Carolina HB 3257	2020	An act that directs the Board of Education to develop age-appropriate standards and concepts that address mental, emotional and social health.
Virginia HB 753	2020	An act that requires the Department of Education to establish a uniform definition of social emotional learning (SEL) and develop guidance standards for SEL for all public students in grades K-12, to be available to each local school division no later than July 1, 2021. The bill also requires a report by Nov. 1, 2021, on the resources needed to successfully support local school divisions with the implementation of a statewide SEL program.

Advocacy Spotlight

NAMI CALIFORNIA

Breaking Stigma in California by Bringing Mental Health Education to Youth

In 2019, more than 45% of youth between the ages of 12-17 in California experienced moderate to severe psychological distress, which can interfere with their academic and social functioning. In 2020, one in six high school students in the state reported that they considered suicide in the past year. Unfortunately, far too many students and school staff don't have access to comprehensive information on mental health conditions and how to get help. NAMI California worked to change that, advocating for legislation that establishes a mental health curriculum to increase student awareness around mental illness and reduce the stigma around getting care.

Eight years ago, NAMI California started this effort by working on legislation to promote mental health awareness programming. A key first step was a law that created a committee that would make recommendations on future mental health curricula. Using those recommendations, NAMI California continued to turn its advocacy into action by helping write a subsequent bill that required mental health education in schools. As a result of their work, Governor Gavin Newsom signed SB 224 into law on Oct. 8, 2021.

When discussions around a mental health curriculum first started, NAMI California Executive Director Jessica Cruz said, "Stigma was the big thing." But the conversation evolved. During the summer of 2020, there was a significant focus on how the pandemic impacted kids, teachers and parents. As a result, "It was the right time to bring it around again," said Cruz.

"Everyone assumes mental health education is just talking about feelings and having surface-level conversations. Now, we need to have the harder conversations after the easy conversations are out of the way," said Jessica Cruz, Executive Director, NAMI California.

After similar legislation passed in New York (A 3887) in 2016, NAMI California first began discussing and planning this effort, including gathering input from NAMI New York State's then-Executive Director. NAMI California also leveraged relationships with various organizations and groups who supported mental health education as a top priority in California schools. This included organizations like Mental Health America of California, Children and Family Alliance of California, California Department of Education, California Student Government Association, California Mental Health Advocates for Children and Families and others. NAMI California also worked with their Youth Advisory Council and student associations to amplify youth

> ***"Everyone assumes mental health education is just talking about feelings and having surface-level conversations. Now, we need to have the harder conversations after the easy conversations are out of the way."***

Jessica Cruz,
Executive Director, NAMI California

Advocacy Spotlight

NAMI CALIFORNIA

NAMI California Youth Advisory Group Members

voices. They brought youth advocates to meet with legislators and share their stories of why mental health education is needed.

SB 224 will bring much-needed mental health instruction to public middle and high schools in California (grades 7-12). Now, a mental health curriculum will be included in health education courses wherever health education courses are required to graduate. These courses will bring the discussion of mental health to the next level by focusing on serious mental illness through defining signs and symptoms of common mental health challenges. Depending on student age and development level, the course instruction includes defining conditions, such as depression, suicidal thoughts and behaviors, schizophrenia, bipolar disorder, eating disorders, anxiety and post-traumatic stress disorder. The courses will also help promote mental wellness and be appropriate for students of any age, race, ethnicity, gender, sexual orientation and cultural background.

With more mental health discussions happening with the COVID-19 pandemic, NAMI California was able to use its reputation to its advantage to drive the conversation about mental health education and reducing stigma for youth. They faced some opposition about creating another mandate in a heavily regulated environment. But that's exactly where NAMI California is prepared to help advise their communities on implementing education for their students on mental health, within the state's mandated requirements under this bill.

Ultimately, this legislation was personal to NAMI California's Executive Director, Jessica Cruz. When asked the bottom line on why this bill is important, she responded: "It matters for my kids. My kids started 5th and 8th grade and whatever is taught in their health class can help them change their perspective on mental illness. It can help with compassion and access to resources from trusted individuals. This can change how our children, teachers, schools and parents think about serious mental illness."

The work is not done yet. NAMI California partnered closely with the California Department of Education (CDE). Having this strong relationship helped in their advocacy efforts and now there is an opportunity to continue

Advocacy Spotlight

NAMI CALIFORNIA

these conversations on evaluating the impact and to expand mental health education to more students in the future, including private schools, schools without a required health curriculum piece and how to expand this to grades K-6 in addition to 7-12.

Keys to Success

Looking back at the passage of SB 224, NAMI California shared the following advice for other mental health advocates:

Leverage existing relationships and resources in your community. Forming coalitions can be an effective way of making change happen. It is always important to build relationships and support efforts that can help gain momentum for your issue.

Amplify the voices of those being impacted. When possible, engage individuals who will be directly impacted by the legislation and ask them to share their experiences and story.

Use other states as a model. Sometimes other states have passed the same or similar legislation. NAMI California saw what worked in New York and reached out to the NAMI NYS Executive Director for insight and help in getting SB 224 to pass in California.

Understanding the Issue

SOCIAL EMOTIONAL LEARNING

Across the U.S., state legislatures and school districts are increasingly looking to new strategies to help students of all ages overcome many of the effects of the pandemic and increase students' success both at school and in their everyday life. Adolescence is a time for young people to have a healthy start, yet the number of adolescents reporting poor mental health is increasing. Building relationships can help youth build important connections that help their mental health and growth into healthy adulthood.

One strategy is Social Emotional Learning. Social Emotional Learning, or SEL, is defined by the Centers for Disease Control and Prevention (CDC) as "developing the skills to recognize and manage emotions, learning to set and achieve a positive goal, learning to appreciate the perspectives of others, establishing and maintaining positive relationships and making responsible decisions." In short, SEL is the essential knowledge, skills, attitudes and mindsets that individuals need to thrive.

In practice, SEL often consists of dedicated classroom time with regular reinforcement of these lessons throughout the day. It may also include activities like daily greetings, journaling about feelings, positive affirmations, daily reflection, SMART goals, mindfulness and check-ins. For older students, SEL may also include activities like goal setting, mentoring, creating a classroom charter or using a mood meter. Estimates suggest that schools and school systems spend about $640 million on SEL-related initiatives each year. However, SEL can take place in a variety of settings beyond schools, including in the home or at after-school programs, and SEL programs are helpful for people across all stages of life. Importantly, there is no one-size-fits-all-approach to SEL; school districts can tailor programs based on community needs and challenges.

Understanding the Issue

SOCIAL EMOTIONAL LEARNING

SOCIAL EMOTIONAL LEARNING

The primary focus of social emotional learning is **skills and competencies that promote life skills**, such as:

- Self-awareness
- Self-management
- Responsible decision-making
- Social awareness
- Relationship skills

SEL supports emotional development and regulation and can improve student success in school, including improved attitudes and engagement.

MENTAL HEALTH EDUCATION

The primary focus of mental health education is **mental health literacy**, such as understanding:

- Types of mental health conditions
- Prevalence (how common)
- Signs and symptoms
- Treatment options (e.g., therapy, medications)
- Available resources, including peer supports
- Stigma and its impact

Mental health education supports knowledge of mental health conditions and impacts, as well as decreasing stigma and increasing help-seeking behaviors and self-efficacy.

While SEL is not mental health education, such programs help promote mental wellness. About 1 in 6 school-aged youth (aged 6-17) experience a mental health condition each year. These youth, or even their peers without mental health conditions, may have other difficulties in their ability to try new things, make new friends or take on new responsibilities and routines. These challenges may cause them to withdraw or act out, hampering their ability to participate in and benefit from their classroom experiences and affecting their mental health. Poor mental health in youth may increase the risk of drug use, experiencing violence, and higher-risk sexual behaviors. Because many habits and traits are established in early years, it is critical to help youth develop strong mental wellness.

By building students' skills and social connections, children may feel more comfortable, more valued, better cared for in school and home settings, and motivated to achieve. A meta-analysis of 213 school-based, universal SEL

Understanding the Issue

SOCIAL EMOTIONAL LEARNING

programs involving over 270,000 kindergarten through high school students found that participants had significantly improved social and emotional skills, attitudes, behavior and academic performance. Other studies point to SEL programs supporting students' long-term success.

While SEL programs have grown in popularity, they also face challenges. For example, SEL programs teach important skills, yet they cannot address the social forces that negatively impact the health and wellness of students. They are also not mental health treatment — for which the demand is high in schools everywhere. Others have misconstrued SEL with political ideologies, although people are often more supportive once SEL programs are more fully explained beyond the name.

NAMI believes that all people with mental health conditions deserve access to supports that promote wellness. Since children spend much of their productive time in educational settings, schools offer a unique opportunity for strengthening mental wellness for students and their families.

Additional Resources on Social Emotional Learning

- Committee for Children's one-pager on how Social-Emotional Learning Can Promote Mental Wellness: Essential in Times of Crisis
- What Is SEL and Why SEL Matters (video)
- More Than Just Okay (video)

School Personnel Training on Mental Health

Teachers and other school staff are with students for much of their awake hours. They are often a trusted adult resource for students, and if given the proper training, they can also be pivotal in helping with early detection of mental health conditions. A common theme seen across state legislation during 2020 and 2021 is to implement more mental health and suicide prevention training for school staff (AL HB 97; MN HF 2; NC S 476; OK SB 21; RI SB 31; VA HB 74/SB 619; and VA HB 1419/SB 171).

Examples of 2020-2021 Legislation Addressing School Personnel Training on Mental Health

STATE | BILL NUMBER	YEAR	DESCRIPTION
Alabama HB 97	2021	An act that requires mental health awareness be included in the annual training session for employees of each K-12 school.
Minnesota HF 2	2021	An act that appropriates $265,000 to continue the online, evidence-based suicide prevention training (called Kognito) that can be taken by all school staff, among other provisions.
North Carolina S 476	2020	An act that requires the Board of Education to develop a school-based mental health plan for the state to establish minimum requirements for each school district to develop a school-based plan to promote student mental health, develop a model mental health training program for personnel in schools with any students in grades K-12, and create a model suicide risk referral protocol for personnel in schools with any students in grades 6-12. The act also establishes timelines and annual requirements for school personnel training on mental health and suicide risk referral protocol.
Oklahoma SB 21	2021	An act that requires the State Board of Education to adopt policies regarding suicide awareness trainings for staff and the reporting of student drug abuse. Beginning with the 2022-2023 school year, the board of education of each school district may provide training to address suicide awareness and prevention to students in grades 7-12.
Rhode Island SB 31	2021	An act that creates the "Nathan Bruno and Jason Flatt Act" requiring the training of teachers, students and all school personnel regarding suicide awareness and prevention, and the establishment of a conflict resolution process between teachers or school personnel and students.

Examples of 2020-2021 Legislation Addressing School Personnel Training on Mental Health
(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Virginia HB 74 SB 619	2020	An act that mandates each school board adopt and implement policies that require each teacher and other relevant full-time personnel, as determined by the school board, to complete a mental health awareness training or similar program at least once and requires each school board to provide such training.
Virginia HB 1419 SB 171	2020	An act that requires school resource officers and school security officers to receive training specific to the role and responsibility of a law enforcement officer working with students in a school environment. The training must include information on a variety of issues, such as mediation and conflict resolution (including de-escalation techniques, such as physical alternatives to restraint); awareness of cultural diversity and implicit bias; working with students with disabilities, mental health needs, substance use disorders, or past traumatic experiences; and student behavioral dynamics, including current child and adolescent development and brain research.

School Policies Promoting Healthy School Environments

Beyond trainings for staff, it's important for school districts to examine their existing policies to ensure they promote a safe and healthy environment for students to thrive. For example, some states have amended their school absence policies to explicitly include mental/behavioral health reasons as a valid excuse for absence from school (NV SB 249*; UT HB 81; and VA HB 308), a strategy NAMI supports. These updated policies recognize that mental health symptoms and treatment are an acceptable reason for absence from school and encourage students to take care of themselves and treat their mental health the same as their physical health.

States have also worked to eliminate or reduce the use of isolation and restraints in schools (IL HB 0219; VA HB 894; and WI SB 527). Restraints refer to restricting someone's ability to move their torso, arms or head freely by using physical maneuvers, mechanical restraints or other equipment. Seclusion or isolation is confinement in an area without the ability to leave. NAMI supports the elimination of restraints and seclusion in schools, as these practices have no mental health benefit and often cause harm and trauma to the students and school staff involved.

* *NV SB 249 also included a student identification card requirement.*
See our Suicide Prevention trend on page 12 for summary.

Examples of 2020-2021 Legislation Addressing School Policies Promoting Healthy School Environments

STATE | BILL NUMBER	YEAR	DESCRIPTION
Florida CS/SB 590	2021	An act amending that amends existing law to require public and charter schools to make a "reasonable attempt to notify" a parent or guardian before a student is removed from school for an involuntary mental health evaluation. This bill requires all school safety officers to undergo crisis intervention training, among other provisions.
Illinois HB 0219	2021	An act that creates regulations for the State Board of Education around the use of isolation, time outs and restraints in schools across Illinois.
Illinois HB 2400	2021	An act that amends the School Safety Drill Act to require the involvement of school-based mental health professionals and inclusion of trauma-informed approaches in law enforcement drills in school settings, among other provisions.
Iowa SF 2360	2020	An act that establishes and develops guidelines for teachers to respond to incidents of classroom violence, establishes a grant program and fund for creation of therapeutic classrooms and provides claims reimbursement to school districts for costs relating to therapeutic classrooms. Includes appropriations.
Minnesota HF 7	2021	An act that invests $1.5 million in one-time funding to create a mental health awareness program at each Minnesota State College for the 2022/2023 academic year as part of an omnibus higher education bill.
Texas SB 168	2021	An act that amends the Education Code to require schools to establish a policy pertaining to notification, announcement, content and outcome/impact reporting of active shooters. The act also requires schools to use trauma-informed policies and best practices if they conduct an active shooter exercise.
Utah HB 81	2021	An act that adds mental or behavioral health as a valid excuse for a school age child's absence from school.
Virginia HB 308	2020	An act that requires the Department of Education to establish and distribute guidelines for the granting of excused absences due to mental or behavioral health and requires that absences be excused if they meet those guidelines.

Examples of 2020-2021 Legislation Addressing School Policies Promoting Healthy School Environments *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Virginia HB 894	2020	An act that updates teacher licensure rules to add a requirement that institutions of higher education provide instruction in education preparation programs on positive behavior interventions and supports, crisis prevention and de-escalation, the use of physical restraint and seclusion and alternative methods to reduce the use of restraints and seclusion. The act requires every person seeking initial licensure as a teacher who has not received such instruction to receive training on these topics.
West Virginia SB 658	2021	An act that requires law enforcement officers and others to use the Handle with Care Program to notify trained public school personnel of a child who has been exposed to a traumatic event.
Wisconsin SB 527	2021	An act that increases transparency, including clarifying notification timelines and internal procedures, for physical restraint and seclusion of students in schools. The act limits school personnel from using restraint or seclusion unless they have received training on de-escalation and positive behavioral interventions, except for limited emergency circumstances. The act also requires a review of individualized education programs (IEPs) within 10 days of restraint or seclusion being used on a student with an IEP for the second time in a school year to assess changes needed to ensure the IEP includes positive behavioral interventions and supports to address behavior(s) of concern.

Mental Health Screenings & Services in Schools

There is a growing need for programs and services that promote positive mental health and provide early intervention and treatment among children and youth, and schools can provide an important setting to offer these services. A successful tool used to identify and support the mental health needs of students is mental health screenings, which some states have encouraged in school settings through legislation. For example, New Jersey legislation encourages written depression screenings for students grades 7-12 (A 970) and Utah legislation empowers local school districts to implement evidence-based and age-appropriate screenings to their students (HB 323).

In an effort to increase students' access to mental health care, some states have sought to implement national standards for ratios of school mental health

professionals to students (KY SB 8 and DE HB 100), which include a recommended ratio of at least one counselor per 250 students and at least one school psychologist per every 500 students. Other states have sought to increase students' access to mental health care by creating processes for identifying students in need (CA SB 309 and GA HB 855), easing Medicaid billing for services provided in schools (MN HF 2) and offering more interventions though a Multi-Tiered System of Support framework (NH HB 1558) or school-based mental health consultation program (WI AB 644).

Examples of 2020-2021 Legislation Addressing Mental Health Screenings and Services in Schools

STATE | BILL NUMBER	YEAR	DESCRIPTION
California SB 309	2021	An act that develops a new protocol for addressing student mental health concerns by identifying students who might need help and connecting them with counselors or other mental health services. Teachers, parents, counselors and students will be among those who help write the protocols, among other provisions.
Delaware HB 100	2021	An act that sets a ratio of one school counselor/school social worker per 250 students and one school psychologist per 700 students in public elementary schools and designates funds for the hiring of school mental health professionals.
Georgia HB 855	2020	An act that directs the State Board of Education to develop guidance for local school systems that receive state funds to assess students in foster care upon enrollment in a new school. Assessments are meant to determine if trauma has had or will have an adverse effect on the student's educational performance and to include that assessment in the evaluation process for determining eligibility for special education and related services.
Kentucky SB 8	2020	An act that amends Kentucky's school safety laws to expand school personnel by requiring designation of a school safety coordinator for each school district and at least one counselor or school-based mental health services provider per 250 students. The act also makes changes to school resource officer training and requirements.
Kentucky HB 312	2020	An act that changes requirements around placement and enrollment in schools for children in foster care and promotes information sharing between school districts and local agencies to promote educational stability. The act also requires caseworkers to work with new schools to share information on the child's unique needs and prior experiences that may impact their education.

Examples of 2020-2021 Legislation Addressing Mental Health Screenings and Services in Schools *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 2	2021	An act that calls on the Department of Education and Department of Human Services to work with stakeholders to develop a strategy for schools to bill Medical Assistance for services provided through an Individualized Education Program or Family Serviced plan. This is an education omnibus bill to look on how to reduce administrative burdens for schools in billing Medical Assistance, among other provisions.
New Hampshire HB 1558	2020	An act that outlines a multi-tiered system of supports for mental health and wellness to address students' social, emotional and behavioral health. The act requires the Department of Education to develop multi-tiered system of supports through: creating a plan to promote the system of supports; providing technical assistance and professional development for local school districts; aligning federal funds with these supports, and more.
New Jersey A 970	2021	An act that encourages public schools to conduct written screenings for depression of students in grades 7-12 via an electronic screening tool. The act also appropriates $750,000 in grant awards to school districts for implementation.
Utah HB 323	2020	An act that requires the Board of Education to develop a process for local education agencies (LEAs) to seek approval to implement evidence-based and age-appropriate mental health screenings to students. The act further allows LEAs, upon approval by the board, to administer the screening with parental consent and, if a screening indicates a potential mental health condition, notify parents of the results and any resources available.
Virginia HB 1508 SB 880	2020	An act that establishes minimum staffing ratios for school counselors of one full-time equivalent school counselor position per 325 students in grades K-12.
Wisconsin AB 644	2020	An act that requires the Department of Health Services (DHS) to create and administer a school-based mental health consultation pilot program. The aim is to assist participating school-based providers in providing enhanced care to students with mental health care needs, to provide referral support for those students and to provide additional services. The act also requires DHS to hire a public health nurse to oversee implementation of the pilot program. Includes appropriations.

State Review Bodies to Examine Student Mental Health

To improve services and supports provided to students, several states have worked to assess the mental health needs of students through taskforces, coalitions and councils. Notably, Utah has helped to encourage greater collaboration between the state's youth-serving systems with HB 288. The law creates the Education and Mental Health Coordinating Council to develop recommendations for how state and local education systems and mental health providers can collaborate to best meet the needs of youth in their state.

Examples of 2020-2021 Legislation Addressing State Review Bodies to Examine Student Mental Health

STATE | BILL NUMBER	YEAR	DESCRIPTION
Connecticut HB 6402	2021	An act that requires higher education institutions to establish a mental health coalition to assess the presence of mental health services and programs by Jan. 1, 2022.
Illinois HB 0212	2021	An act that amends the Children's Mental Health Act of 2005. The Children's Mental Health Partnership will make recommendations for youth to receive mental health education and have access to mental health care in school settings in consultation with the Department of Education.
Utah HB 288	2021	An act that creates and establishes duties for the Education and Mental Health Coordinating Council. This council will provide guidance to the legislature and other state leaders on how to meet youths' behavioral needs, including mental health and substance use conditions.

2

People Get the Best Possible Care

While about one in five adults had a mental illness in 2020, less than half (46.2%) received mental health services. NAMI believes that all people with mental health conditions deserve accessible, affordable and comprehensive health care, but there are currently numerous barriers to a person getting the help they need. Financial barriers, including inadequate or nonexistent health insurance coverage, lack of available providers, geographic and racial disparities, discrimination, stigma and social determinants of health all affect a person's access to treatment.

To receive the best possible care, people should have access to a full range of mental health and substance use services, regardless of ability to pay. Every person should receive timely care when and where they need it regardless of age, gender, race or ethnicity, national origin, religion, disability, language, socio-economic status, sexual orientation or gender identity.

In this section, we review key trends in state legislation in five areas of focus:

1. ***Mental Health and Substance Use Parity***
2. ***Medication Access***
3. ***Mental Health Service Expansion***
4. ***Telehealth Expansion***
5. ***Inclusive and Culturally Competent Care***

The legislation covered in this section is aimed at expanding and ensuring access to effective treatment options and quality and affordable care.

Mental Health and Substance Use Parity

There is no health without mental health, yet health insurance covers mental health care differently than other kinds of medical services, creating barriers to affordable, accessible mental health care and reinforcing stigma around mental illness and seeking mental health treatment. In recent years, federal legislation, including the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and the 2010 Affordable Care Act (ACA), created and expanded requirements for many insurance plans to equitably cover mental health and substance use treatment as compared to medical/surgical treatment.

Mental health and substance use (MH/SUD) care should be covered at the same levels as care for other health conditions.

Parity is the concept that mental health and substance use (MH/SUD) care should be covered at the same levels as care for other health conditions. While the federal and state parity laws have resulted in significant improvements in equitable coverage, disparities remain. Parity requirements do not apply to all insurance plans, and though the law mandates equitable coverage if MH/SUD care is covered, only certain plans must provide MH/SUD benefits. Additionally, states often do not have the tools and resources to adequately enforce parity.

Moreover, parity laws don't adequately address low reimbursement levels among mental health providers compared to other medical specialty providers. Mental health and substance use services are often reimbursed at a lower rate than medical services, compounding mental health workforce shortages and further limiting patients' access to care.

Even with the federal laws in place, out-of-network treatments and out-of-pocket costs for mental health care are growing more commonplace. Between 2016 and 2020, the average out-of-pocket cost for an inpatient mental health admission rose by almost 12%, compared to a 6% increase in out-of-pocket costs averaged across all types of inpatient admissions. In 2017, individuals were 5.7 times more likely to use an out-of-network provider for outpatient mental health services and 5.2 times more likely to use an out-of-network provider for inpatient mental health treatment than for outpatient and inpatient medical/surgical treatment, respectively. Fortunately, some states are taking action to close the gaps in mental health parity and ensure compliance with federal laws.

What does mental health and substance use parity look like?

At its core, parity means that insurance carriers' policies treat mental health and substance use care equitably to medical/surgical care. State laws to strengthen mental health parity have included strategies such as:

- Enhancing state-level enforcement of federal parity laws
- Strengthening state parity laws
- Clarifying medical necessity rules for insurance coverage of MH/SUD care

Key Terms Used in Following Bill Trends:

MHPAEA
refers to The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008)

EHB
means Essential Health Benefits, or benefits that are required to be covered by insurers

ACA
means Affordable Care Act (2010)

Trends in 2020/2021 Mental Health and Substance Use Parity Legislation

Parity Enhancement and Enforcement

Several states in 2020 and 2021 enacted legislation to enforce compliance with existing mental health and substance use parity laws. States have responsibility for enforcing compliance with MHPAEA within certain insurance plans, and policymakers have worked to pass laws specifying how insurers are to comply with this federal act (AZ SB 1523; IN HB 1092; KY SB 50; MD HB 0455/MD SB 0334; NV AB 181; OH SB 284; OK SB 1718; PA HB 1439; and PA HB 1696).

Most legislation is based on the Kennedy Forum's model parity bill. This model bill, endorsed by NAMI and other mental health advocacy organizations, requires insurers to proactively report to state regulators on key measures demonstrating their compliance with MHPAEA and empowers state regulators to examine and penalize plans for parity violations.

Requiring insurance coverage of mental health wellness exams as preventative care, similar to annual physicals, is another form of parity that contributes to early identification and intervention of mental health conditions. Colorado passed a requirement that annual mental health exams be included as part of mandatory health insurance coverage of preventative care services (CO HB 21-1068). These exams can help diagnose a possible mental health condition in its earliest stage.

Examples of 2020-2021 Legislation Addressing Parity Enhancement and Enforcement

STATE | BILL NUMBER	YEAR	DESCRIPTION
Arizona SB 1523	2020	An act that directs health care insurers to comply with the MHPAEA for commercially insured group and individual policies and outlines related requirements. The bill also implements mental health and substance use disorder coverage for minors, including creation of the Children's Behavioral Health Services Fund, which provides $8 million for behavioral health services for uninsured and/or underinsured children.
Colorado HB 21-1068	2021	An act that adds a requirement, as part of mandatory health insurance coverage of preventative health care services, that health plans cover an annual mental health wellness examination of up to 60 minutes. The examination is performed by a qualified mental health care provider, and the coverage must be comparable to coverage for a physical health examination and follow parity requirements.
Florida CS/HB 701	2021	An act that requires health insurers and health management organizations to provide written notice to covered individuals outlining the federal and state requirements for coverage of behavioral health care services. The bill also requires the Department of Financial Services (DFS) to provide a report to the Legislature by Jan. 31, 2022, which must include information on the complaints received by the Division of Consumer Services related to behavioral health care services.
Indiana HB 1092	2020	An act that expands the state's Medicaid program to include more behavioral health providers (licensed clinical social workers, marriage and family therapists, mental health counselors and licensed clinical addiction counselors) for outpatient treatment services. The act requires health maintenance organizations and insurers to submit annual reports demonstrating compliance with MHPAEA, including an analysis for each non-quantitative treatment limitation, and requires the State Department of Insurance to submit a report on enforcement activity to the legislature annually.
Kentucky HB 50	2021	An act that requires insurers to handle treatment for a mental health condition in the same manner as treatment for a physical health condition. This bill prevents insurers from imposing harsher restrictions or limitations on mental health treatment than they would for physical health conditions.

Examples of 2020-2021 Legislation Addressing Parity Enhancement and Enforcement

(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Maryland **HB 0455** **SB 0334**	**2020**	An act that requires certain health insurance plans to submit a report to the Maryland Insurance Commissioner to demonstrate the carrier's compliance with MHPAEA and requiring certain insurers to identify five health benefit plans with the highest enrollment for each product offered in certain markets and conduct analyses on medical necessity criteria used in those plans and their application of non-quantitative treatment limitations.
Montana **SB 216**	**2021**	An act that revises laws related to requiring health insurance issuers to provide parity compliance reporting, requiring a description of the process used to select medical necessity criteria and identification of non-quantitative treatment limitations.
Nevada **AB 181**	**2021**	An act that requires certain insurers, and other organizations providing health coverage, to submit information demonstrating mental health parity and addiction equity compliance, and providing penalties, among other provisions.
New Hampshire **HB 1639**	**2020**	An act that clarifies prior authorization procedures under group health insurance policies and managed care and requires reimbursement parity for coverage of mental illness and supports for individuals with co-occurring MH/SUD.
Ohio **SB 284**	**2020**	An act that requires the Superintendent of Insurance and Medicaid Director to proactively enforce MHPAEA, evaluate all behavioral health complaints for parity violations and adopt rules necessary to enforce MHPAEA.
Oklahoma **SB 1718**	**2020**	An act that requires all in-state health plans to comply with MHPAEA. The bill removes the exclusion of small employers from the requirement to provide mental health/substance use disorder benefits; prohibits health insurance plans from imposing stricter non-quantitative treatment limitations (NQTLs) on mental health and substance use disorder benefits than physical health benefits; and requires that insurance companies submit annual reports demonstrating compliance with MHPAEA (including an analysis for each NQTL).

Examples of 2020-2021 Legislation Addressing Parity Enhancement and Enforcement

(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Pennsylvania HB 1439 HB 1696	2020	Complementary acts that require health insurers to verify that they have completed and fully documented analyses of their efforts to provide mental health and substance use disorder coverage that is comparable to physical health services with respect to cost sharing, in- and out-of-network coverage and other treatment limitations. The bills also require insurers to make documentation available to the Insurance Department, upon request, to demonstrate compliance with the 2008 MHPAEA, and documentation must also be made available to policyholders and providers upon request.
Texas HB 2595	2021	An act that requires development of a parity complaint portal, educational materials and parity law training regarding benefits for mental health conditions and substance use disorders to be made available through the portal. This bill also designates October as mental health condition and substance use disorder parity awareness month.
Virginia SB 280	2020	An act that requires the Virginia Bureau of Insurance to make an annual report on mental health and substance use disorder benefits available to the public.
Washington HB 2338	2020	An act that updates the definition of "mental health treatment" to include certain inpatient and outpatient services used to treat disorders covered by the diagnostic categories listed in the most current diagnostic and statistical manual of mental disorders. This definition includes disability insurance that is necessary to treat mental health and substance use disorders.
West Virginia SB 160	2021	An act that gives the Insurance Commissioner authority to promote a legislative ruling related to mental health parity.
West Virginia SB 291	2020	An act that requires state-regulated insurance plans to provide mental health and substance use disorder benefit coverage at parity with medical/surgical benefit per federal law. The bill specifies key insurer compliance and reporting requirements in addition to providing reimbursement for behavioral health screening/preventive services. It requires health plans to reimburse for out-of-network coverage at the same reimbursement and coverage levels as in-network care when in-network care is unavailable.

Medical Necessity Standards

Far too often, mental health and substance use care is denied by health insurers for not being "medically necessary," but these decisions are not based on nationally recognized standards of care, giving plans a great deal of flexibility in making coverage determinations. California, Illinois and Oregon have set an example for other states by passing legislation that requires the criteria that insurers use to make decisions about what MH/SUD care is medically necessary (and thus reimbursable) to be evidence-based and follow generally accepted standards of care (CA SB 855; CA SB 221; IL HB 2595/SB 0471; and OR HB 3046).

Examples of 2020-2021 Legislation Addressing Medical Necessity Standards

STATE | BILL NUMBER	YEAR	DESCRIPTION
California SB 855 SB 221	2020/ 2021	An act that amends the Illinois insurance code to require every insurer that amends, delivers, issues or renews a policy after Jan. 1, 2022, to ensure plan coverage of medically necessary treatment of mental, emotional, nervous or substance use conditions. The bill also requires insurers to use nationally recognized standards of care in coverage determinations and prohibits them from limiting mental health and substance use disorder coverage to short-term or acute treatment. SB 221 is an act that builds on SB 855 by codifying regulations to ensure that, if a patient is undergoing a course of treatment for an ongoing mental health or substance use disorder (MH/SUD), they must get a follow up appointment within 10 business days of the prior appointment. Additionally, if there is a shortage of providers in the area, the bill requires the plan to arrange coverage outside of the plan's contracted network.
Illinois HB 2595 SB 0471	2021	An act that amends the Illinois insurance code to require certain new plan amendment, delivery, issuance or renewal after Jan. 1, 2022, to ensure plan coverage of medically necessary treatment of mental, emotional, nervous or substance use conditions. This bill also requires insurers to apply criteria and guidelines from the most recent versions of treatment criteria, as developed by the nonprofit professional association for the relevant clinical specialty, when conducting utilization review of covered health care services and benefits for the diagnosis, prevention and treatment of mental, emotional and nervous disorders or conditions in children, adolescents and adults.
Oregon HB 3046	2021	An act that strengthens parity protections and ensures insurer networks are providing sufficient access to a range of mental health and substance use disorder (MH/SUD) professionals. This bill also requires a detailed analyses of compliance with mental health parity requirements; to report specified data to Department of Consumer and Business Services and Oregon Health Authority; and to follow generally accepted standards of care in medical necessity determinations for behavioral health care.

Medication Access

Every individual is unique and deserves a mental health treatment plan tailored to their specific needs and medical history. For many people with mental health conditions, though certainly not all, medication is a critical part of their recovery and condition management. Unfortunately, accessing the right psychiatric medication is not always straightforward. Health insurance plans may limit access to certain drugs, through formulary limitations or utilization management techniques, like step therapy (also known as "fail-first") or prior authorization. These barriers can force people to go without needed treatment or pay large out-of-pocket costs to access the medications they need.

Often, policies aimed at controlling costs by making patients pay more or restricting access to certain medications have the opposite effect: Research shows that access restrictions on mental health medications leads to increased hospitalizations, emergency department visits and incarcerations. Not only do these negative outcomes lead to higher costs, but they can have a devastating impact on the affected individuals and their families.

What does improving medication access look like?

Administrative burdens, high out-of-pocket costs, and delayed access to the appropriate medication can significantly delay or derail a person's health and well-being. People with mental health conditions deserve to be able to access the medications that work best for them without barriers. Strategies for improving medication access can include, but are not limited to:

- Lowering out-of-pocket costs for patients
- Enhancing timely access to medications
- Reducing utilization controls, like step therapy and prior authorization

Trends in 2020/2021 Medication Access Legislation

Drug Pricing and Transparency

One of the most common barriers to needed mental health care that people report is the cost of care. Reducing what individuals pay out-of-pocket for their medications is a common strategy for improving access to mental health medication.

One way that states have addressed out-of-pocket costs is through greater drug price transparency. This allows consumers to compare prices and make more informed decisions regarding their health care (NH HB 1280 and VA HB 2007). While these measures are not mental health-specific, they benefit people with mental

health conditions who use medication to manage their illness, as well as medications they may take for co-occurring physical health conditions. Data suggests that people with mental health conditions are at greater risk of having chronic physical illnesses — conditions that can often benefit from medication.

Examples of 2020-2021 Legislation Addressing Drug Pricing and Transparency

STATE | BILL NUMBER	YEAR	DESCRIPTION
Illinois HB 2174	2020	An act that increases prescription drug affordability by requiring minimum drug coverage standards for certain health plans.
New Hampshire HB 1280	2020	An act that increases the affordability of prescription drugs by establishing a wholesale drug importation program, creating a prescription drug affordability board, clarifying the pricing of generic prescription drugs, clarifying the procedure for prior authorization for prescription drugs and establishing the prescription drug competitive marketplace.
Virginia HB 2007	2021	An act that requires prescription drug price transparency. This bill directs the Department of Health to contract with a nonprofit data services organization to collect, compile and make available on its website information about prescription drug pricing. It requires every health carrier, pharmacy benefits manager and drug manufacturer to report information about prescription drug prices.

Barriers to Medication Access

The CDC found that in 2019, 15.8% of adults had taken prescription medication for their mental health. Many individuals with a mental health condition use medication to help alleviate their symptoms, and the pandemic created unique challenges for people to remain on their treatment regimen. Because of this, some states created emergency prescription refill laws to authorize pharmacies and pharmacists to dispense early refills of certain medications during emergency situations (GA SB 391 and NJ S 2344) or to administer medications, like a long-acting injectable, that require health care professional oversight (CO HB21-1275).

Step therapy, another barrier to medication access, is an insurance practice that may request or require patients to demonstrate unsuccessful treatment on one or more insurer-preferred medications before they receive coverage for the

medication that their physician recommends. This practice is sometimes referred to as "fail first." Step therapy can be a danger to the health and well-being of the person taking the medication, and it can often result in a worsening of symptoms and undermining the decisions made between individuals and their health care providers. Policymakers have passed legislation that would clarify the step therapy procedures and allow for consumers to request exemptions (AR SB 99; LA HB 263; ME LD 1268; NE LB 337; and SD SB 155).

Another technique imposed by insurers is prior authorization — a process by which a provider must receive insurer approval before a certain drug or service can be offered. Several states passed legislation to limit when prior authorization can be applied to psychiatric medications or clarified prior authorization procedures (GA SB 80; ME LD 1268; MN HF 33; TX HB 2822; and VA HB 2008/SB 1269).

Recognizing the unique nature of psychiatric medications, some states have regulatory or statutory protections for mental health medications, exempting them from common utilization controls. Oregon's HB 3045 was a significant highlight in legislation that extended open access to certain psychiatric medications in the state's Medicaid program.

Examples of 2020-2021 Legislation Addressing Barriers to Medication Access

STATE | BILL NUMBER	YEAR	DESCRIPTION
Arkansas SB 99	2021	An act that requires insurers to base step therapy protocols on appropriate clinical practice guidelines or published peer-reviewed data developed by independent experts with knowledge of the conditions. This bill also ensures that patients have access to a process for requesting a step therapy protocol exemption when the patient's physician deems it appropriate.
Colorado HB 21-1275	2021	An act that makes a pharmacist eligible for reimbursement under the medical assistance program for certain medically necessary pharmacist services. This bill allows pharmacists that dispense or administer extended-release injectable medications for the treatment of mental health or substance use disorders to seek reimbursement for those medications.
Georgia SB 80	2021	An act that aims to require health care insurance companies to detail the services or medications that require prior authorization.

Examples of 2020-2021 Legislation Addressing Barriers to Medication Access *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Georgia SB 391	2020	An act that requires health insurers to provide coverage for early refills of a 30-day supply of prescription medications under certain emergency situations. The prescription cannot be a Schedule II controlled substance and must, in the professional judgment of the pharmacist, be essential for a chronic condition and/or create undesirable health consequences/cause physical or mental discomfort due to an interruption in the use of the prescription.
Illinois HB 0711	2021	An act that creates the Prior Authorization Reform Act to set requirements concerning: disclosure and review of prior authorization requirements; denial of claims or coverage by a utilization review organization; and the implementation of prior authorization requirements or restrictions.
Louisiana HB 263	2020	An act that provides insurance coverage guidelines for step therapy or fail first protocols, as well as for override and appeals processes.
Maine LD 1268	2021	An act that provides greater access to treatment for serious mental illness by prohibiting an insurance carrier from requiring prior authorization or step therapy protocols.
Minnesota HF 33	2021	An act that requires the Department of Human Services (DHS) to hold a public hearing before removing a medication from the preferred drug list or the list of medications that do not require prior authorization. This health and human service omnibus bill ensures that the DHS Commissioner provides adequate notice before the hearing, among other provisions.
Nebraska LB 337	2021	An act that creates guardrails on the practice of step therapy. This bill provides a clear and transparent process for health care providers to request a step therapy override exception; provides certain circumstances when a health care provider can override the step therapy protocol; and establishes timelines for when an insurance company or pharmacy benefit manager must respond following a request for a step therapy override exception.
New Jersey S 2344	2020	An act that requires Medicaid and health insurance coverage for certain refills of prescription drugs during a state of emergency.

Examples of 2020-2021 Legislation Addressing Barriers to Medication Access *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Oregon HB 3045	2021	An act that defines a mental health drug and adds mental health drugs prescribed in the last year to the list of drugs for which the Oregon Health Authority may not require prior authorization. Specifies that a claims history must be made available on mental health drugs showing that the recipient has been in a course of treatment within the last year or that the prescriber has specified that the prescription be "dispensed as written."
South Dakota SB 155	2020	An act that creates step therapy protocols for certain prescription drugs, including processes for a step therapy override exemption.
Texas HB 2822	2021	An act that prohibits Medicaid managed care organizations (MCOs) from implementing prior authorization protocols that require physicians to obtain approval before dispensing preferred antipsychotic medications to individuals living with a serious mental illness (SMI).
Virginia HB 2008 SB 1269	2021	An act that ensures no additional prior authorization is required when a carrier has approved prior authorization for any drug prescribed for treatment of a mental health condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as long as: the drug is a covered benefit, issued for fewer than three months and the prescriber performs an annual review of the patient to evaluate the drug's efficacy.

Mental Health Service Expansion

Despite the clear need for a broad continuum of mental health care, many people lack access to these services. More than 50% of people with a mental illness did not receive treatment in 2020.

Across the U.S., there is a growing demand for mental health and substance use disorder care. At the same time, there is a significant shortage of mental health providers. More than 150 million people live in a designated Mental Health Professional Shortage Area. The lack of providers exacerbates unmet needs and leaves more people without options for mental health care. Lack of coverage for certain types of providers, including peer support specialists, are one barrier to meeting the demand. Providers also face many barriers to providing care, although some restrictions and requirements were eased during the COVID-19 public health emergency.

Additionally, there are ongoing challenges in translating evidence-based treatment models into practice. Barriers, like how we pay for mental health care, keep important services, like crisis care and first episode psychosis programs, from being available to everyone who needs them.

What does mental health service expansion look like?

Expanding mental health services can be accomplished through a broad array of policy options. Increasing funding, providing additional mental health services, reducing barriers for the workforce and adding insurance benefits can all expand access to services. More examples of what mental health service expansion can look like include:

- Implementing and expanding mental health crisis services and evidence-based models of care
- Increasing funding for the mental health care continuum
- Reducing barriers that impede the growth and availability of the mental health workforce
- Bolstering insurance coverage of mental health services
- Enhancing recovery supports so individuals can lead full and satisfying lives

Trends in 2020/2021 Mental Health Service Expansion Legislation

Mental Health Funding and Treatment Options Expansion

During the pandemic, demand for mental health care skyrocketed, far exceeding the available supply. To increase treatment capacity and ensure continued availability of mental health services, states increased funding, including dedicating the use of federal COVID relief funding to behavioral health programs and providers. For example, Wisconsin appropriated funds to expand their behavioral health services, which included increasing bed capacity, aid for school mental health, farmer mental health assistance programs, among other provisions (WI AB 68). Colorado created a new Behavioral and Mental Health Cash Fund to be used for mental health treatment, substance use treatment and other behavioral health services (CO SB 21-137).

See page 48 for more about Certified Community Behavioral Health Clinics (CCBHCs).

States also sought to expand outpatient treatment by expanding Certified Community Behavioral Health Clinics (CCBHCs), a community-based treatment model for mental health and substance use care (MN HF 2128; See our Understanding the Issue on page 48 to learn more).

While the transition to the 988 Suicide & Crisis Lifeline occurred after the period of legislation included in this report, several states focused efforts on improving crisis services and access — both in anticipation of the 988 transition in 2022, as well as to address growing crisis needs stemming from the pandemic (MI HB 4051; MN HF 2128 and SD SB 2).

Note: While a comprehensive analysis of all state spending packages was not possible, a few bills are provided here as examples.

Examples of 2020-2021 Legislation Addressing Mental Health Funding and Treatment Options Expansion

STATE | BILL NUMBER	YEAR	DESCRIPTION
Colorado SB 21-137	2021	An act that extends, modifies and finances behavioral health programs throughout state government, including dedicating $550 million of American Rescue Plan Act (ARPA) COVID-19 Fiscal Recovery Funds to behavioral health. This bill creates a new Behavioral and Mental Health Cash Fund to be used for mental health treatment, substance use treatment and other behavioral health services allowable under ARPA.

Examples of 2020-2021 Legislation Addressing Mental Health Funding and Treatment Options Expansion *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Michigan HB 4051	2020	An act that establishes a statewide, 24/7 mental health telephone access line called the Michigan Crisis and Access Line. The crisis/access line will refer and connect individuals requiring mental health or SUD services to mental health professionals, including community mental health services programs and prepaid inpatient health plans.
Minnesota HF 11	2020	An act that is a broad human services omnibus bill that includes an increase in funds for Consumer Directed Community Supports: post-arrest community-based service coordination; youth and adult psychiatric residential treatment facility services; children's mental health crisis response services; intensive rehabilitative mental health services requirements/provider standards; covered services and state certification for Certified Community Behavioral Health Clinics (CCBHCs) and officer-involved community-based care coordination; children's mental health respite grants; state-operated services for individuals with complex behavioral needs; adult mental health outpatient treatment; and housing support.
Minnesota HF 33	2021	An act that provides First Episode Psychosis grants and criteria on how funding for first episode psychosis programs can be used. The bill also pays for housing. This health and human services omnibus bill allows funding and criteria for travel expenses if these are barriers to participating in a first episode program, among other provisions.
Minnesota HF 2128	2021	An act that expands Certified Community Behavioral Health Clinics (CCBHCs). This omnibus health and human services policy and finance bill requires the Department of Human Services to consult with key stakeholders, including CCBHC providers, when developing or making changes to the certification process and clarifies that CCBHCs may collaborate with existing mobile crisis teams and may coordinate with other entities to provide other mandated services, among other provisions.
Mississippi SB 2610	2020	An act that allows the Department of Finance and Administration to add a new position, the Coordinator of Mental Health Accessibility, to oversee mental health systems and facilities, interview employees in the mental health system, access services of the mental health system necessary to provide assessment and recommendations, among other provisions.

Examples of 2020-2021 Legislation Addressing Mental Health Funding and Treatment Options Expansion *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Montana HB 701	2021	An act that adds a section to a marijuana tax bill that will provide millions of dollars for mental health promotion and care and appropriates funding for mental health grant opportunities, among other provisions.
South Dakota SB 2	2020	An act that requires the Department of Social Services to support each county in the development and maintenance of a statewide centralized resource information system accessible to any resident of the state, including information for and referrals to resources for a person in a crisis and assistance for mental health conditions and substance use disorders.
Wisconsin AB 68	2021	An act that appropriates funds to expand mental health systems in Wisconsin. This act increases psychiatric bed capacity, authorizes funds to make a grant to renovate existing mental health facilities in Marathon County, and provides additional funding for mental health and developmental disabilities services/facilities, farmer mental health assistance programs, mental health and school climate training programs and grants and aid for school mental health programs, among other provisions.

Understanding the Issue

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

About one in five adults has a mental illness, but many find it far too difficult to access the care they need. Across the country, people need more access to quality, affordable mental health care. Luckily, a federal demonstration program has shown that there is a way to better address the needs of people with mental illness.

Certified Community Behavioral Health Clinics, or CCBHCs, are health care centers specifically designed to improve community mental health services by providing a wide range of evidence-based mental health and substance use disorder care regardless of an individual's ability to pay. They also offer primary care services and help patients manage multiple complex health needs, which too often are otherwise left untreated and lead to poor health outcomes for people with mental health conditions. CCBHCs must provide coordinated care — meaning organizing care activities between different services, providers, and facilities to help serve the whole person — and offer a comprehensive range of nine types of services like 24/7 mobile crisis teams, health screenings and assessments and peer and family supports.

CCBHCs began as a demonstration program established by Congress in the 2014 Excellence in Mental Health Act, first operating in eight states before further expanding across the U.S. thanks to repeated extensions and expansion grants. They are funded through enhanced Medicaid reimbursements based on anticipated costs of care. Unlike other types of reimbursement, anticipated costs allow CCBHCs to provide a wide array of services and coordination. It also allows CCBHCs to hire a range of behavioral health professionals, some of which are not traditionally eligible for reimbursement from insurance providers but are nonetheless critical parts of a care team.

Understanding the Issue

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

They can also receive additional payments related to the quality of care provided.

CCBHCs have been shown to improve access to a comprehensive range of treatment and recovery support services. For example, through 24/7 crisis care, CCBHCs can help connect someone in crisis to immediate care instead of traditional outcomes for people in crisis, like hospitalization or jail. CCBHCs have dramatically expanded patients' access to timely and quality behavioral health services in the community, helping people get care when and where they most need it. Moreover, their funding mechanism is more sustainable — meeting providers' actual costs rather than focusing on only billable services. This improves the quality of care and allows CCBHCs to provide robust services to their patients.

NAMI believes that all people with mental health conditions deserve accessible, affordable and comprehensive health care. CCBHCs are a promising model of care that have the potential to significantly improve the quality of community mental health and substance use services. However, CCBHCs are still not available in every state and the program is not yet permanent. NAMI applauded Congress' nationwide expansion of CCBHCs in 2022 in the Bipartisan Safer Communities Act, which will enable more states and communities to benefit from an increase in access to critical addiction and mental health services.

For more information, see NAMI's policy position on CCBHCs.

Workforce Licensure, Reimbursement and Expansion

Although the need for mental health and substance use professionals is high, there is a significant shortage of these professionals throughout the US. About 37% of the US population lives in an area with a shortage of psychologists, counselors and social workers. In an effort to increase the mental health and substance use workforce, states have passed legislation to help incentivize professionals to join this field. In Minnesota, an agency can bill for work being provided by individuals doing their practicum and internship and they can be paid for their work (MN HF 33). Several states have also modified education and licensure requirements and/or relaxed rules to allow for providers located out-of-state to serve their residents (IA HF 2627; MS HB 208; NJ A 3901; and NJ 4246). Notably, Alaska passed legislation (SB 134) to submit a state plan amendment for Medicaid that covers licensed professional counselors, an important segment of the workforce to expand access to care.

Another strategy to further strengthen the behavioral health workforce is to expand access to peer support. A peer support specialist is someone with direct lived experience of a mental illness and/or substance use disorder who receives specialized training to support the treatment and recovery of others. Peer support specialists have been found to be beneficial to both the individual receiving support and the specialist providing it. In 2020 and 2021, two states passed legislation to formalize a peer support specialist certification program (CA SB 803 and NV AB 96).

Examples of 2020-2021 Legislation Addressing Workforce Licensure, Reimbursement and Expansion

STATE | BILL NUMBER	YEAR	DESCRIPTION
Alaska SB 134	2020	An act that adds licensed professional counseling services to the list of optional benefits/reimbursable services offered by Alaska's Medicaid program. Alaska will submit a state plan amendment to the U.S. Department of Health and Human Services for approval.
California SB 803	2020	An act that establishes a peer support specialist certification program within the state's Medicaid program, Medi-Cal.

Examples of 2020-2021 Legislation Addressing Workforce Licensure, Reimbursement and Expansion *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Iowa HF 2627	2020	An act that allows jurisdictions to approve an out of state professional or occupational license, registration or certificate without the need for reapplying; recognizes three years of work experience as a substitute for any education, training and work experience requirements; and waives initial licensing fees for first time applications of families earning less than 200% of the federal poverty level. This bill creates a uniform standard of review for denial of licensure based on a person's conviction history, among other provisions.
Minnesota HF 33	2021	An act that expands who can be a mental health practitioner to include someone in the process of completing a practicum or internship as part of their undergraduate or graduate level program in social work, psychology or counseling. This health and human services omnibus bill ensures that a mental health agency can bill for the work being provided by people doing a practicum or internship and the intern can be paid for their work, among other provisions.
Mississippi HB 208	2021	An act that removes the requirement that a psychologist complete a one-year fellowship after they receive their Ph.D. to be licensed.
Nevada SB 69	2021	An act that requires supervisors of peer support specialists and peer recovery support specialists who provide peer recovery support services under certain conditions to be certified.
Nevada AB 96	2021	An act that expands access to peer support counseling for public safety personnel.
New Jersey A 3901	2020	An act that permits professional and occupational licensing boards to reactivate licensures for retired individuals during a state of emergency or public health emergency, including mental health care professionals.
New Jersey A 4246	2021	An act that permits expedited licensure in mental health professions for certain out-of-state individuals during a state of emergency or public health emergency.
South Dakota HCR 6001	2020	An act that directs the Department of Social Services to investigate implementing peer support services to improve access to mental health care, and to report to the 2021 Legislature on how to best provide peer support services across the state and the associated financial costs.

Examples of 2020-2021 Legislation Addressing Workforce Licensure, Reimbursement and Expansion *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Tennessee SB 0101	2021	An act that establishes licensure procedures and requirements for licensed professional art therapists and creates the professional art therapist advisory committee of the board of examiners in psychology to regulate the practice of art therapy.

Coverage Expansion and Enhancements

Health insurance plans play a critical role in accessing mental health services and treatment. In 2020 and 2021, states took action to improve insurance coverage in key areas that help people experiencing mental health conditions. Virginia acted to strength access to home and community-based services (HCBS), which help people covered by Medicaid receive services in their own home or community rather than in institutional settings (VA SB 902).

In the past two years, over one third of the U.S. adults received a surprise medical bill, which occurs when a person with coverage unknowingly receives treatment from an out-of-network provider, leading to higher-than-expected health care costs. Policymakers passed legislation to help reduce surprise medical bills from happening in their states (GA HB 888/SB 359; IN HB 1004; OH HB 388; and VA HB 1251/SB 172).

The postpartum period is one with heightened risk of experiencing new or worsening mental health symptoms. While individuals with pregnancy-related Medicaid coverage typically lose their benefits 60 days after the end of their pregnancy, Georgia extended Medicaid coverage to eligible women up to six months after they give birth (HB 1114) and Minnesota extended Medicaid postpartum medical assistance coverage from 60 days to 12 months (HF 33).

Other legislation passed in 2020 and 2021 relates to codifying essential health benefits from the Affordable Care Act (ACA) in state law (NJ A 5248/5506) and providing for emergency (OR SB 3) and non-emergency transportation (MN HF 33).

Examples of 2020-2021 Legislation Addressing Coverage Expansion and Enhancement

STATE | BILL NUMBER	YEAR	DESCRIPTION
Georgia HB 789	2020	An act that creates a surprise bill rating system based upon the number of certain physician specialty groups contracted with a hospital within a health insurer's network.
Georgia HB 888 SB 359	2020	An act that addresses surprise medical billing by requiring that out-of-network providers, facilities and insurers handle the payment for any services directly, without involving the patient. An arbitration process is established with rules created by the Department of Insurance and a database is created to retain insurer payments for health care services.
Georgia HB 1114	2020	An act that requires the state to apply for a federal waiver that would extend Medicaid coverage to eligible women up to six months after they give birth.
Indiana HB 1004	2020	An act that reduces surprise medical billing and increases transparency by creating stipulations around when an out-of-network provider in an in-network facility may charge more than the allowed rate and requires certain health care providers to provide a good faith estimate to individuals of the price for non-emergency health care services.
Minnesota HF 33	2021	An act that extends postpartum medical assistance coverage from 60 days to 12 months. This health and human services omnibus bill increases access to treatment for postpartum mental illnesses and substance use disorders, among other provisions.
Minnesota HF 33	2021	An act that allows the Department of Human Services to provide monthly transportation passes to meet the non-emergency medical transportation needs of recipients who live in communities with strong public transportation networks, among other provisions.
New Jersey A 5248	2020	An act that codifies provisions of the Affordable Care Act (ACA) into state law, including requiring insurance companies to cover essential health benefits (such as mental health/substance use care) and preserving protections for individuals with pre-existing conditions.
New Jersey A 5506	2020	An act that repeals existing law allowing insurance carriers to offer "Basic and Essential" health insurance plans that do not contain the 10 essential health benefits required under the ACA, such as mental health and substance use disorder treatment, maternity care and prescription drugs.

Examples of 2020-2021 Legislation Addressing Coverage Expansion and Enhancement

(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Ohio HB 388	2020	An act that requires a health plan issuer to reimburse an out-of-network provider for unanticipated out-of-network care when the care is provided to a person at an in-network facility, and the services would be covered if provided by an in-network provider.
Oregon SB 3	2021	An act that requires health benefit plans to cover emergency medical service transportation.
Virginia SB 561	2020	An act that provides workers' compensation coverage for those who develop post-traumatic stress disorder in the line of duty.
Virginia SB 902	2020	An act that permits every individual who applies for or requests community or institutional long-term services via Medicaid to choose the setting and provider of long-term care services and supports from a list of approved providers. For patients receiving services in acute care hospitals, this includes psychiatric units.
Virginia HB 1251 SB 172	2020	An act that limits surprise medical bills by limiting cost-sharing requirements for enrollees upon receiving emergency services from an out-of-network health care provider or out-of-network surgical/ancillary services from an in-network provider; also creates a dispute resolution framework.

Children/Young Adult Service Expansion

Many states acted in 2020 and 2021 to provide better health and social support services for children. Minnesota and Virginia expanded eligibility for Youth Assertive Community Treatment for ages 8-26 (HF 33 and SB 734 respectively). Virginia also acted to provide support to individuals who have aged out of the foster care system through the creation of the Fostering Futures program, available to interested individuals ages 18-21 who were in the foster care system as a minor transitioning to adulthood and self-sufficiency (SB 156).

Examples of 2020-2021 Legislation Addressing Children/Young Adult Service Expansion

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 33	2021	An act that creates an alternative pathway for children with mental illnesses needing residential treatment so they do not have to go through child protection. This health and human service omnibus bill will use state funds to pay for room and board, among other provisions.
Minnesota HF 33	2021	An act that expands the eligibility for Youth Assertive Community Treatment (ACT) to children ages 8-26 and provides intensive community-based treatment using a team-based approach modeled off adult ACT teams. This health and human services omnibus bill appropriates $1.263 million in FY 22-23 and $2.94M in FY 24-25, among other provisions.
Virginia SB 156	2020	An act that establishes the Fostering Futures program, which provides services and supports to individuals between the ages of 18 and 21 who were in foster care as a minor and are transitioning to adulthood and self-sufficiency. Includes provisions on admission for inpatient treatment in mental health facilities.
Virginia SB 734	2020	An act that establishes a work group to review the current process for approval of residential psychiatric placements for children and adolescents. The work group will identify barriers to timely approval and develop recommendations for improving the process and expediting approvals.
Washington HB 2873	2020	An act that expands access with a tool called Family Reconciliation Services to provide culturally relevant, trauma-informed services for families and/or children who are struggling. This includes family counseling, mental health services or conflict resolution training.
Wisconsin AB 192	2020	An act that provides reimbursement for mental health consultations for students up to age 21.

Telehealth Expansion

Prior to 2020, telehealth had been expanding, but access to and coverage of telehealth services ballooned during the COVID-19 pandemic. Between March and August of 2019, mental health and substance use constituted just 11% of all telehealth visits; two years later, mental health and substance use comprised 39% of all telehealth visits. While telehealth is not always the right option for every person or every condition, for many individuals, it can significantly reduce barriers to accessing care and play a vital role in a person's mental health condition management and recovery.

Compared to in-person mental health care, telehealth services can save patients significant time — they do not have to travel to and from their provider, which can benefit individuals who need childcare or have inflexible work hours. Transportation is often a barrier to mental health services in itself — many people lack access to a vehicle or public transportation, or they have co-morbid conditions that make traveling even short distances difficult. And in areas with a shortage of mental health providers, patients may have to travel even farther from their homes for in-person care. These advantages of telehealth can be particularly beneficial to rural communities; from March to August 2021, 55% of mental health and substance use disorder visits in rural areas were via telehealth, compared to 35% in urban areas. Telehealth has been shown to improve patient satisfaction and be cost effective.

What does telehealth expansion look like?

Telehealth should be treated by insurance plans, state Medicaid agencies and providers as equal to in-person health care in terms of payment, and barriers should be reduced to allow individuals to access tele-mental health if that is the best option for them. Telehealth expansion can look like:

- Ensuring parity between telehealth and in-person health care
- Covering telehealth visits with out-of-state mental health providers
- Implementing telehealth best practices for providers

Trends in 2020/2021 Telehealth Expansion Legislation

Telehealth Parity

The COVID-19 pandemic saw a focus on legislation that enabled individuals to get health care services via telehealth that they traditionally could only access in-person. In 2020 and 2021, policymakers attempted to create parity between telehealth and in-person care by addressing issues such as equitable coverage, cost-sharing and provider reimbursement. Several states required health insurers

to reimburse for mental health services provided through telehealth at the same rate as services provided in-person (IA SF 619; KY SB 150; MA S 2984; MN HF 33; and UT HB 313).

Prior to COVID, it was common for any telehealth visits to be preceded by an in-person visit or previously established relationship with a clinician to qualify for reimbursement. To accommodate social distancing concerns, legislation was passed that would prohibit plans from requiring a prior in-person visit before insurance coverage of the service (AK HB 29; CO SB 20-212; and KY SB 150).

Importantly, many of these actions were temporary. Many states modified requirements for the delivery of telehealth services and insurance coverage of these services to apply only through a set expiration date (CT HB 6001 and TN HB 8002) or when the Governor's declared state of emergency was lifted (MA S 2984). Although some of these telehealth expansions were temporary, many individuals were able to get much-needed services amidst social distancing requirements, and in many areas, efforts are ongoing to make these permanent enhancements.

Examples of 2020-2021 Legislation Addressing Telehealth Parity

STATE | BILL NUMBER	YEAR	DESCRIPTION
Alaska HB 29	2020	An act that requires health plans sold in the individual and group market to provide telehealth options for mental health benefits and prohibits plans from requiring a prior in-person visit before covering such services.
Colorado SB 20-212	2020	An act that prohibits health insurers from imposing specific requirements or limitations on HIPAA-compliant technologies used to deliver telehealth services; removes requirement that a beneficiary have a previously established relationship with a specific provider to receive medically necessary telehealth services; and prohibits imposing additional certification, location or training requirements as a condition of telehealth service reimbursement.
Connecticut HB 6001	2020	An act that modifies requirements for the delivery of telehealth services and insurance coverage of these services until March 15, 2021. Provisions of these temporary requirements include audio-only telehealth options, cost-sharing protections for patients using telehealth, prohibitions on insurance plans from reducing provider reimbursement for services provided via telehealth, and more.

Examples of 2020-2021 Legislation Addressing Telehealth Parity *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Iowa SF 619	2021	An act that requires health insurers reimburse for mental health services provided through telehealth at the same rate as services provided in person.
Kentucky SB 150	2020	An act that provides for wide-ranging COVID-19 relief measures, including the expansion of telehealth, among other provisions. Telehealth provisions waive an in-person examination requirement to initiate telehealth services, waive certain originating site requirements, require equal reimbursement for services provided by telehealth and expand options for qualified out-of-state providers to serve Kentucky residents via telehealth.
Massachusetts S 2984	2020	An act that requires insurance carriers, including MassHealth, to cover telehealth services in any case where the same in-person service would be covered, and the use of telehealth is appropriate. The bill also requires telehealth reimbursement rate parity for a temporary period and includes coverage of telehealth services that is audio-only, among other provisions.
Minnesota HF 33	2021	An act that allows for continued flexibility to use telehealth services with video and audio (phone) communication (until July 1, 2023). The health and human service omnibus bill ensures that telehealth can be used for mental health and substance use disorder services and requires that telehealth services are reimbursed at the same rate as in-person treatment, among other provisions.
Mississippi SB 2799	2021	An act that extends the duration of certain laws pertaining to the use of telemedicine and telehealth in relation to the COVID-19 pandemic for a period of 90 days following the end of both the public health emergency and the state of emergency.
Oklahoma SB 674	2021	An act that requires every health benefit plan offered in the state to provide coverage of telemedicine. No insurer may exclude a service for coverage solely because the service is provided through telemedicine and is not provided through in-person consultation or contact between a health care professional and a patient.
Tennessee HB 8002	2020	An act that requires payers to cover telehealth services as they would cover in-person care and mandates reimbursement parity for telehealth through April 1, 2022. It also requires payers to cover remote patient monitoring services if that service is covered by Medicare and relaxes originating site requirements for telehealth delivery.

Examples of 2020-2021 Legislation Addressing Telehealth Parity *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Utah HB 313	2020	An act that requires certain health plans to provide coverage and reimbursement parity for telehealth services.
Washington SB 5385	2020	An act that requires state-regulated health plans, state employee health plans and Medicaid managed care plans to provide telehealth reimbursement rate parity.
West Virginia HB 4003	2020	An act that requires any insurer in West Virginia issuing or renewing health insurance policy on or after July 1, 2020 to provide coverage of health care services provided through telehealth if those same services are covered through face-to-face consultation by the policy.
Wyoming SF 0052	2021	An act that prohibits any individual or group health insurance plan from denying coverage for a telehealth mental health or substance service if that same service would be covered in person, charging a co-payment deductible or coinsurance amount to a person receiving mental health or substance use services through remote, audio, or audio visual system, or reducing any reimbursement for audio or audio-visual system to less than what would be paid if the services were in-person.

Telehealth Standards and Rules

Beyond ensuring parity for telehealth visits, states worked on broad-based expansions of telehealth coverage and set rules and standards for telehealth delivery and billing (GA HB 307; LA HB 449, HB 530, HB 589; MD HB 1208/SB 0502; MN HF 19; MS HB 94; MS SB 2799; NJ S 2467 and A 3860; and WA SB 6061).

Audio-only telehealth options, where clinically appropriate, can help address the needs of populations that may have difficulty accessing or unable to access technologies used for audio-video telehealth. Audio-only telehealth services can help reach individuals in rural communities, individuals with disabilities and many others. Several states were able to pass legislation for audio-only telehealth coverage (MN HF 33; TN SB 0429; VA HB 5046/SB 5080; WA HB 1196; and WA SB 5325; see above section for MN HF 33 telehealth summary).

Another trend was using the availability of telehealth to help extend the available workforce in a given state (MN SF 193; NJ A 4205; TN HB 0508; and VT H 742). Minnesota, New Jersey, Tennessee and Virginia were authorized to enter the Psychology Interjurisdictional Compact (PSYPACT), which is an agreement that allows psychologists to practice across state lines either through telehealth or in person services. Because PSYPACT allows certified psychologists to practice in multiple states, this can help individuals in need of care to connect with a provider more quickly.

Examples of 2020-2021 Legislation Addressing Telehealth Standards and Rules

STATE | BILL NUMBER	YEAR	DESCRIPTION
Georgia HB 307	2021	An act that revises the "Georgia Telehealth Act" to authorize health care providers to provide telemedicine services from home and allow patients to receive telemedicine services from their home, workplace or school.
Kentucky HB 140	2021	An act that establishes minimum standards for telehealth, including ensuring that health insurance coverage does not materially increase premiums or similar benefits for services to an insured person through telehealth and prohibiting certain practices in telehealth, among other provisions.
Louisiana HB 449	2020	An act that allows psychiatric mental health nurse practitioners to perform emergency psychiatric evaluations for inpatient admission; adds behavioral health to the telehealth definitions; and authorizes the Louisiana Department of Health (LDH) to develop rules and regulations for behavioral health telehealth.
Louisiana HB 530	2020	An act that requires the issuer of a health coverage plan to display in a conspicuous manner on the issuer's internet website information for patients regarding how the patient may receive covered benefits via telehealth. Defines parameters for remote patient monitoring services which include coordination of behavioral health needs.
Louisiana HB 589	2020	An act that authorizes the Louisiana Department of Health (LDH) to review policies and procedures for Medicaid-funded telehealth services that would allow payment for services comparable to Medicare. LDH must include in its Medicaid policies and procedures an exhaustive list of covered services available via telehealth and processes by which providers submit claims for such services.

Examples of 2020-2021 Legislation Addressing Telehealth Standards and Rules *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Maryland HB 1208 SB 502	2020	An act that requires the state's Medicaid program, subject to the limitations of the state budget, to allow for the provision of mental health services through telehealth and expands the definition of telehealth for private health coverage. The bill also requires the Maryland Department of Health to submit a waiver amendment request to the federal Centers for Medicare and Medicaid Services to implement a Medicaid telehealth services pilot program focused on chronic disease management and behavioral health services, which will remain effective through June 30, 2025.
Minnesota HF 4556	2020	An act that expands coverage for telehealth services provided within a patient's residence in response to COVID-19, among other provisions. This expires on June 30, 2021.
Minnesota SF 193	2021	An act that authorizes Minnesota to enter the Psychology Interjurisdictional Compact, or PSYPACT. This agreement allows a psychologist licensed in one compact state to provide treatment via telemedicine or limited in-person treatment in any compact state.
Mississippi HB 94	2020	An act that creates the Mississippi Center for Rural Health Innovation to provide services and resources to rural health care facilities and expand telehealth in rural areas.
Mississippi SB 2799	2021	An act that extends the duration of certain laws pertaining to the use of telemedicine and telehealth in relation to the COVID-19 pandemic for a period of 90 days following the end of both the public health emergency and the state of emergency.
New Jersey S 2467	2020	An act that extends the duration of certain laws pertaining to use of telemedicine and telehealth in relation to COVID-19 pandemic for a period of 90 days following the end of both the public health emergency and the state of emergency.
New Jersey A 3860	2020	An act that authorizes any health care practitioners to provide telemedicine and telehealth services for the duration of the public health emergency declared by the Governor.
New Jersey A 4205	2021	An act concerning psychological services and enters New Jersey into the Psychology Interjurisdictional Compact. This compact regulates the day-to-day practice of telepsychology and allows for tele-psychological practice across state lines, among other provisions.

Examples of 2020-2021 Legislation Addressing Telehealth Standards and Rules *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Tennessee SB 0161	2021	An act that authorizes the Psychology Interjurisdictional Compact Act which allows for tele-psychological practice across state lines as well as temporary, in person, face-to-face services into a state in which the psychologist is not licensed to practice psychology, and to facilitate the exchange of information between compact states regarding psychologist licensure, adverse actions and disciplinary history.
Tennessee SB 0429	2021	An act that authorizes the use of HIPAA compliant audio-only conversations when providing behavioral health provider-based telemedicine services if HIPAA-compliant real-time, interactive audio, video telecommunications, or electronic technology, or store-and-forward telemedicine services are unavailable.
Tennessee HB 0508	2021	An act that authorizes unlicensed graduates and students of certain medical training programs to provide telehealth services as long as those graduates and students adhere to the same standards for the provision of telehealth services that licensed medical professionals must meet.
Vermont H 742	2020	An act that provides administrative and health care provider flexibility in responding to the COVID-19 pandemic, including expanding access to and reimbursement for telehealth services. It also allows recently retired Vermont health care professionals and licensed out-of-state professionals to deliver health care services to Vermont residents using telehealth under specific circumstances.
Virginia SB 760	2020	An act that authorizes Virginia to become a signatory to the Psychology Interjurisdictional Compact, which permits eligible licensed psychologists to practice in Compact member states if they are licensed in at least one member state including via telepsychology under certain conditions.
Virginia HB 5046 SB 5080	2020	An act that temporarily expands Medicaid coverage of telemedicine care, including use of audio-only technology. It also relaxes originating site requirements for telemedicine for all payers beginning on March 19, 2020, until July 1, 2021.
Washington HB 1196 SB 5325	2021	An act that provides health coverage of audio-only telemedicine.

Examples of 2020-2021 Legislation Addressing Telehealth Standards and Rules *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Washington HB 2728	2020	An act that allows for an expansion of mental health care telemedicine programs by implementing a sustainable funding model for the services provided through the children's mental health services consultation program and the tele-behavioral health video call center.
Washington SB 6061	2020	An act that creates training standards in providing telemedicine services. It requires health care professionals who provide clinical services through telemedicine to complete a telemedicine training, which must include information on state and federal law, liability, informed consent — as well as a question-and-answer methodology to demonstrate understanding. This bill also ensures that the telemedicine training be made available in electronic format and completed online.

Inclusive and Culturally Competent Care

Mental health care should be respectful of and tailored to each person's needs, background and lived experience. Mental health conditions don't skip any demographic group — anyone can experience mental illness, regardless of age, gender, race or ethnicity, national origin, religion, disability, language, socio-economic status, sexual orientation or gender identity. But a person's lived experience, culture, beliefs and more can affect how an individual experiences a mental health condition. The care a person receives should not only be evidence-based, but it should also reflect a person's culture and identity.

Moreover, access to appropriate mental health care is not equitable across these individuals and populations. Of individuals with a mental health diagnosis, racial and ethnic minorities receive treatment at far lower rates than white individuals – for example, just 20.8 percent of Asian adults with a mental health diagnosis receive treatment, compared to 51.8 percent of white adults. The disparities in mental health care increased during the COVID-19 pandemic, with Black, Hispanic and Asian adults being far more likely to have unmet mental health care needs than white adults.

In addition to being culturally competent, effective mental health care is inclusive of the individuals and families it is designed to serve. It is important for peers and family members with lived experience to have a voice in the way mental health services are designed and delivered.

What does inclusive and culturally competent care look like?

Mental health systems and professionals should work to address cultural stigmas and disparities within mental health care and strengthen the voices of those with lived experience. This can be accomplished by:

- Requiring peer and family representation on boards and committees
- Recruiting a more diverse mental health workforce
- Educating the mental health workforce on diversity and cultural competency/humility
- Increasing access to care among vulnerable populations

Trends in 2020/2021 Inclusive and Culturally Competent Care Legislation

Lived Experience Requirement for Advisory Bodies

Peer and/or Family Member Advisory Boards or councils that include peer and family member perspectives can help improve services and communications processes in order to provide individuals with better care. Because of its proven effectiveness, several states formed councils and committees that included peers with lived experiences to help improve their states' mental health care system.

Vermont created the Mental Health Integration Council to help ensure that all health care systems integrate mental health (H 960). This council includes individuals and family members that have received mental health services in Vermont. Kentucky established the Kentucky Eating Disorder Council, which must include peers and will oversee the development and implementation of eating disorder awareness, education, and prevention programs (SB 82).

Often the role of family members and caregivers is overlooked in system design and service delivery, and Louisiana should be commended for charging a legislative committee to better define caregiver rights for individuals who provide care to individuals with serious mental illness.

Examples of 2020-2021 Legislation Addressing Lived Experience Requirement for Advisory Bodies

STATE | BILL NUMBER	YEAR	DESCRIPTION
Kentucky SB 82	2020	An act that establishes the Kentucky Eating Disorder Council, consisting of appointed members from the Commonwealth's government, researchers, providers and peers. This council will oversee the development and implementation of eating disorder awareness, education and prevention programs.
Louisiana HCR 27	2020	An act that requests a study by the respective legislative committees to study the rights of caregivers and the establishment of a "Caregivers' Bill of Rights" for family members, legal guardians and other persons who provide care for persons with serious mental illness.

Examples of 2020-2021 Legislation Addressing Lived Experience Requirement for Advisory Bodies *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 2128	2021	An act that updates the membership of the State Advisory Council on Mental Health, including adding representatives from the Minnesota Department of Health, the American Indian Mental Health Advisory Council and a consumer-run mental health advocacy group, among other provisions.
Oregon HB 2086	2021	An act that requires the Oregon Health Authority to establish peer and community-driven programs that provide culturally specific and culturally responsive behavioral health services to people of color, tribal communities and people with lived experience.
Vermont H 960	2020	An act that establishes a system to collect and review data from each community mental health and developmental disability agency and creates the Mental Health Integration Council to ensure that all sectors of the health care system participate in mental health integration. This council is to include individuals and family members who have received mental health services in Vermont and one who has delivered peer services.

Diverse and Culturally Competent Workforce

When a person accesses care that incorporates or recognizes cultural needs and differences, it can significantly improve outcomes. Many states passed legislation to ensure that mental health professionals receive diversity and cultural competency trainings (LA HR 33; MD HB 28; MD SB 005; MN HF 33; and WA SB 5229). These trainings can help improve mental health professionals' ability to serve individuals from a variety of backgrounds.

Minnesota was a standout state with legislation to not only increase cultural competency of the existing workforce, but to make the workforce more diverse by recruiting more clinicians of color. Read more about the many provisions of HF 33 that pushed this issue forward in our Advocacy Spotlight on page 69.

Examples of 2020-2021 Legislation Addressing a Diverse and Culturally Competent Workforce

STATE | BILL NUMBER	YEAR	DESCRIPTION
Louisiana HR 33	2020	An act that requests the Louisiana Department of Health to recommend and make standards and curricula publicly available about implicit bias in the delivery of health care for use by health professional education programs and health professional licensing boards.
Maryland HB 28 SB 005	2021	An act that requires health equity and bias training as part of licensing and accreditation of health professionals
Minnesota HF 33	2021	An act that requires licensing boards for psychologists, licensed marriage and family therapists, and licensed professional clinical counselors to include members from outside of the seven county region, people of color, and underrepresented communities, among other provisions.
Minnesota HF 33	2021	An act that requires continuing education for psychologists, licensed marriage and family therapists, social workers and licensed professional clinical counselors to include at least four hours on addressing the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. The topics addressed in this omnibus health and human services bill include understanding culture, its functions and strengths that exist in varied cultures; understanding clients' cultures and differences among and between cultural groups; understanding the nature of social diversity and oppression; and understanding cultural humility, among other provisions.
Minnesota HF 33	2021	An act that creates a task force to make recommendations on recruiting diverse mental health professionals, training all mental health providers on cultural competency and cultural humility; assessing the quality of current efforts to provide culturally competent care; and increasing the number of mental health organizations owned, managed or led by someone from the Black, Indigenous and people of color communities, among other provisions.

Examples of 2020-2021 Legislation Addressing a Diverse and Culturally Competent Workforce *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 33	2021	An act that requires the Minnesota Department of Health to work with relevant licensing boards to develop a grant program for mental health professionals of color or from underrepresented communities to become supervisors, among other provisions.
Washington SB 5229	2021	An act that requires health care professions that are subject to continuing education to adopt rules requiring licensees to complete health equity continuing education training at least once every 4 years by Jan. 1, 2024.

Advocacy Spotlight

NAMI MINNESOTA

Building a Culturally Diverse and Responsive Mental Health Workforce

Communities across the country are facing significant mental health workforce shortages. This is especially true in Minnesota, where nine of the state's 11 regions are identified by the state Department of Health as facing an acute mental health workforce shortage. The impact of these workforce shortages is felt profoundly among the state's communities of color, immigrant communities and rural communities, where it's difficult to find culturally competent mental health care. NAMI Minnesota sought to tackle this issue by focusing on the disparities affecting access to care and expanding a diverse mental health workforce.

After some investigation into workforce barriers, NAMI Minnesota uncovered a concerning trend: almost half of the people who completed their coursework to become a mental health professional never became fully licensed. While this trend was true across demographics, mental health professionals of color specifically face several barriers to gaining licensure, like challenges finding a supervisor of color, being saddled with a higher student debt load than their white counterparts, challenges related to completing an unpaid practicum or internship, and navigating licensing exams that were developed with cultural assumptions from a singular perspective. Addressing these barriers through legislation was a centerpiece of NAMI Minnesota's legislative agenda in 2021.

Advocacy around the state's workforce shortage was not new for NAMI Minnesota, which has been working on this issue since 2013. That long-term focus helped NAMI Minnesota identify the problems at hand and know what solutions have already been pursued and passed. They harnessed the Mental Health Legislative Network, an advocacy circle of key mental health advocacy groups and professional associations in the state, to secure input early in the process and build support for legislative solutions that were incorporated into the omnibus health and human services bill, HF 33. They also found an important partner in the Amherst H. Wilder Foundation, a Certified Community Behavioral Health Clinic (CCBHC), that specializes in offering culturally competent mental health services to the diverse communities of St. Paul.

HF 33 incorporates short and long-term strategies to build a culturally diverse and responsive mental health workforce in the state.

HF 33 incorporates short and long-term strategies to build a culturally diverse and responsive mental health workforce in the state. In the short-term, the bill requires all continuing education requirements for clinical counselors, social workers, marriage and family therapists, and psychologists

Advocacy Spotlight

NAMI MINNESOTA

to include four hours of continuing education on cultural humility and cultural competencies so every provider can reflect on the perspectives that they bring to their work. In the long-term, it increases funding for loan forgiveness for mental health professionals serving in a rural or underserved urban community.

Additionally, a program was established to pay for culturally diverse mental health professionals to become supervisors. All the licensing boards must reflect the diversity of the state and a statewide task force was formed to create recommendations to further develop a culturally informed and responsive workforce. "We can't build our mental health system and meet the needs of all Minnesotans unless we have a robust and diverse workforce," said NAMI Minnesota Executive Director Sue Abderholden.

To build support for the legislation, NAMI Minnesota identified potential champions and key voices that could move this bill. Although Minnesota has a divided state legislature, mental health is a bipartisan issue and NAMI Minnesota works with leaders on both sides of the aisle regularly. They also engaged partners from different mental health professional associations to amplify the stories and experiences that mental health professionals face in seeking licensure, both to advocate and to pursue the right solutions for equity and inclusion.

> ***"We can't build our mental health system and meet the needs of all Minnesotans unless we have a robust and diverse workforce."***
>
> ***Sue Abderholden,***
> *Executive Director, NAMI Minnesota*

Thanks to NAMI Minnesota's efforts, the bill passed both chambers and was signed into law by Governor Tim Walz. Now the state is moving to implement the new law. Distribution of the additional funding for the loan forgiveness started in 2022, and the state is working to develop and identify new continuing education standards before 2023. In the meantime, the definition of mental health practitioner now includes someone who is an intern or on a practicum, allowing them to start billing for services before they are licensed.

For NAMI Minnesota, the work is not done. In the 2022 legislative session, they obtained funding to help community mental health providers offer supervision for free. They plan to continue to pursue major workforce priorities not included in HF 33, like alternative pathways to licensure to help people transition into the mental health workforce — a practical solution to the state's pressing problems.

Advocacy Spotlight

NAMI MINNESOTA

Keys to Success

Looking back at the passage of HF 33, NAMI Minnesota shared the following advice for other mental health advocates:

Tell Powerful Stories. Stories are incredibly effective to create policy change. Work with your advocates and partners to identify stories that highlight the problems your advocacy seeks to address.

Build Consensus. While there's typically broad support on mental health policy issues, get early input and secure agreement within your coalition to get everyone on board with the key pieces of comprehensive legislation.

Maintain the Momentum. The work continues even when the legislature is out of session. Build support, address concerns and strike compromises year-round to get the bill across the finish line.

Health Disparities and Specialized Services

Many states passed legislation to address health disparities their communities face. Maryland designated the Health Equity Resource Communities to target state resources to improve health outcomes and reduce health disparities (which includes mental health disorders). Maryland's legislation also sets up a fund to supplement mental and behavioral health programs (HB 463 and SB 172).

Many populations face unique needs or common challenges, requiring a specialized focus to provide support, particularly for at-risk populations. Some states tackled the need for specialized services for specific populations such as veterans, Native Americans and law enforcement officers (FL HB 231; WA SB 6259 and SB 6570).

Examples of 2020-2021 Legislation Addressing Health Disparities and Specialized Services

STATE | BILL NUMBER	YEAR	DESCRIPTION
Florida HB 231	2021	An act that provides behavioral health care, referral and care coordination for veterans and their families.
Maryland HB 463 SB 172	2021	An act that designates "Health Equity Resource Communities" to target state resources to improve health outcomes and reduce health disparities (including mental health disparities). This legislation sets up the Health Equity Resource Community Reserve Fund to supplement mental and behavioral health programs.
Washington SB 6259	2020	An act that establishes the Governor's Indian Health Advisory Council that examines jurisdictional issues between tribes, Urban Indian Health Providers and state agencies; adopts a biennial Indian health improvement advisory plan; provides oversight of the Indian health improvement reinvestment account; and drafts recommended legislation to address Indian health improvement needs. This bill ensures tribal self-determination and maximum participation by American Indians and Alaska Natives to render the persons administering such services more responsive to the needs and desires of tribes and communities.
Washington SB 6570	2020	An act that establishes a Law Enforcement Officer Health and Wellness Task Force to be convened by the Department of Health.

Banning of Discredited Practices

Conversion therapy is a discredited practice that is focused on changing an individual's sexual orientation or gender identity, typically targeting LBGTQI youth. Research shows that conversion therapy is harmful and can trigger depression, anxiety or self-destructive behavior, which is why NAMI strongly opposes the practice.

Across the country, states have passed policies and laws to ban conversion therapy. In 2020, Virginia joined this ever-growing list of states by passing a law that prohibits any health care provider or person who performs counseling from engaging in conversion therapy with any person 18 years or younger and creates penalties for anyone who violates this act (VA HB 386/SB 245). Additionally, Utah's Governor took regulatory action in 2020 to prohibit conversion therapy based upon the provisions of HB 399.

Example of 2020-2021 Legislation Addressing Banning of Discredited Practices

STATE | BILL NUMBER	YEAR	DESCRIPTION
Virginia HB 386 SB 245	2020	An act that prohibits any health care provider or person who performs counseling from engaging in conversion therapy with any person under 18 years of age and provides that such counseling constitutes unprofessional conduct and is grounds for disciplinary action.

People Get Diverted from Justice System Involvement

People with mental illness are overrepresented in our nation's criminal justice system, resulting from a confluence of factors like limited access to mental health care, inadequate crisis care and ongoing stigma and discrimination toward people with mental illness. Approximately 44% of people incarcerated in jails and 37% of people in state and federal prisons have a history of mental illness. More than 1 in 5 people shot and killed by police officers since 2015 had a mental health condition. These numbers show the adverse impact of an underdeveloped mental health care system that results in many people who are the most vulnerable being disconnected from mental health services and supports when they need them most.

NAMI believes that the justice system responses to people with mental illness should be minimized while ensuring that any interactions preserve health, well-being and dignity. NAMI supports public policies that divert people from justice system involvement at every possible opportunity. This includes designing and funding crisis response systems that help ensure individuals experiencing acute symptoms of a mental health condition receive a mental health response — not a law enforcement response.

For individuals that do encounter law enforcement, it is essential that states help design and support local programs to connect people to treatment instead of arrest or incarceration. For people who become involved in the justice system, states should prioritize efforts to connect and support individuals with adequate mental health services and supports during and after incarceration.

In this section, we review trends in three key focus areas:

1. ***Crisis Response***
2. ***Diversion***
3. ***Rehabilitation and Reentry***

The legislation covered in this section is aimed at ensuring that people have access to a comprehensive crisis response system, have every opportunity to be diverted from incarceration, receive quality care while in jail or prison and are supported upon reentry to the community.

Crisis Response

In too many communities, people experiencing a mental health crisis don't get the services they need. In fact, when individuals are in a mental health crisis, they frequently encounter law enforcement rather than a mental health professional.

People in a mental health crisis deserve a mental health response. Fortunately, there is a growing national consensus on the continuum of services needed to provide a mental health response and strong evidence that, when implemented, this continuum improves outcomes for individuals, families and communities, providing better care and being more cost-effective.

There are three core elements in an ideal crisis response system:

- **"Someone to Call"** 24/7 Crisis Call Centers that are fully funded to provide expertise with trained staff who can offer immediate support and connect people in crisis – and their families – with local services when they need it.
- **"Someone to Respond"** Mobile Crisis Teams that can be dispatched when a person needs more support than can be provided over the phone. Mobile crisis teams with experienced mental health and health care professionals meet people where they are, de-escalate crisis situations and connect people to additional care, if needed.
- **"Somewhere Safe to Go"** Crisis Stabilization Programs that can help stabilize a person in crisis in a home-like and welcoming environment, identify long-term treatment needs, keep a person from needing more intensive care and ensure a warm hand-off to follow-up care.

State activities around the crisis continuum of care increased after October 2020, when Congress passed the National Suicide Hotline Designation Act (S. 2661). The law created "988" as a new, three-digit dialing code for the National Suicide Prevention Lifeline (now known as the 988 Suicide & Crisis Lifeline), connecting anyone experiencing a mental health, substance use or suicidal crisis with immediate support. After the federal law's passage, states began planning for the transition to 988 nationwide on July 16, 2022, increasing both resources for call centers answering 988 contacts and also improving the other aspects of the crisis continuum.

What does providing robust mental health crisis response look like?

Mental health crisis response services are a vital part of states' broader continuum of care for people with mental illness. While crisis services are highly localized, state policymakers can help improve crisis response by:

- Defining statewide service expectations
- Offering funding mechanisms to help fill gaps in services
- Encouraging training and collaborations across emergency and provider systems to ensure a clear and consistent response for anyone in crisis

Trends in 2020/2021 Crisis Response Legislation

988 Implementation

With the passage of the federal 988 law in late 2020, states had a short timeline to prepare for the transition to 988 on July 16, 2022. While 988 is a national number, it is largely up to states to ensure there are crisis services – 24/7 local crisis call centers, mobile crisis teams and crisis stabilization options — so 988 callers receive the help they need.

Some states used the 988 State Model Bill, developed by the National Association of State Mental Health Program Directors (NASMHPD) with input from NAMI and others, to write legislation to change the way their community responds to people in mental health crisis. This model bill includes a funding mechanism for states to create a small monthly fee on all phone lines — similar to the way communities fund 911— to ensure that 988 funding is sustainable and that these emergency services will not experience any funding gaps. To protect against fee diversion, the model bill requires 988 fees to be deposited in a trust fund that can only be used in support of the 988 crisis response system in the state.

Find current information on these bills and other state legislation on 988 and crisis services at reimaginecrisis.org/map

Top highlights from this group of bills were the four states that were able pass sustainable funding through a statewide fee (CO SB 21-154; NV SB 390; VA SB 1302; and WA HB 1477). Another noticeable trend seen throughout many states was bills to study the state's current crisis care system needs, gaps and funding needs and/or establishing state 988 commissions to help oversee implementation (AL HJR 168; IN HB 1468; NE LB 247; NY S 6194B; TX SB 1; and UT SB 155).

In addition to state legislation supporting 988 implementation, Utah passed legislation in 2020 to implement a state warmline, which helps people in need of mental health support but who are not in crisis (HB 32). Such resources are a critical partner for crisis call centers to ensure that a person is connected to care appropriate for their situation.

Examples of 2020-2021 Legislation Addressing 988 Implementation

STATE | BILL NUMBER	YEAR	DESCRIPTION
Alabama HJR 168	2021	An act that creates a commission to study a 988 comprehensive behavioral health crisis communication system.
Colorado SB 21-154	2021	An act that implements the 988 National Suicide Prevention Lifeline network in Colorado and creates a 988 fee that is capped at 30 cents, a 988 Crisis Hotline Cash Fund and reporting requirements, among other provisions.
Idaho HCR 11	2021	A resolution that raises awareness of 988 and shares messaging regarding the hotline.
Illinois HB 2784	2021	An act that creates the Community Emergency Services and Supports Act to implement protocols and training for a non-law enforcement response as the primary response for 988.
Indiana HB 1468	2021	An act that establishes a framework for 988, specifying that the state's Mental Health and Addiction division has oversight and coordination of the crisis hotline, establishes a 988 trust fund and requires public schools that provide student identification cards after June 30, 2022 to include the 988 crisis hotline number on student identification cards.
Nebraska LB 247	2021	An act that creates the Mental Health Crisis Hotline Task Force of the Nebraska Legislature to develop an implementation plan for the 988 mental health crisis hotline in Nebraska.
Nevada SB 390	2021	An act that provides for the establishment of the 988 hotline, including a 988 fee capped at 35 cents, Crisis Response Account and reporting requirements, among other provisions.

Examples of 2020-2021 Legislation Addressing 988 Implementation *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
New York S 6194B	2021	An act that requires the state Office of Mental Health and others to deliver a report on the resources necessary to implement 988.
Oregon HB 2417	2021	An act that appropriates $5M for the costs associated with 988 crisis hotline centers and $10M for counties to establish and maintain mobile crisis intervention teams. This bill permits the Oregon Health Authority to establish new committees or entrust existing committees with planning and oversight and requires that committees include a variety of stakeholders including a representative with lived experience, among other provisions.
Texas SB 1	2021	An act that provides appropriations for the state budget in FY 2021, which includes a required study for Texas to determine preparedness for 988.
Utah HB 32	2020	An act that implements new mental health resources, including a state "warm line" for mental health support and information.
Utah SB 155	2021	An act that appropriates one-time funding for crisis services, beginning July 1, 2020 and ending June 30, 2021. Of the funds appropriated, $4,200 will go toward expenses relating to the Behavioral Health Crisis Response Commission, and $2,451,800 toward the statewide behavioral health crisis line and warm line. Beginning July 1, 2021 and ending June 2022, a one-time fund of $15,800 will go towards the Behavioral Health Crisis Response Commission and $1,851,800 will be used for the statewide behavioral health crisis line and warmline.
Virginia SB 1302	2021	An act that creates a crisis call center fund from a $0.12 surcharge on postpaid wireless charges and a $0.08 surcharge on prepaid wireless. Funds will be used to establish and administer crisis call centers.
Washington HB 1477	2021	An act that implements the 988 Lifeline, creating a telecommunications fee in support of 988 that starts at 24 cents and will increase to 40 cents by January 1, 2023. This legislation also includes a statewide 988 Behavioral Health Crisis Response and Suicide Prevention Line Account to manage funding, a crisis response improvement strategy (CRIS) committee to help oversee implementation and reporting requirements, among other provisions.

Crisis Services - Mobile Crisis Teams

In many communities, law enforcement continues to be the primary first responder to mental health crises. These encounters often result in people ending up in jails, in emergency departments, on the street, and in some instances harmed during the encounter, but mobile crisis teams (MCTs) provide an effective, mental health-based alternative to respond to people in crisis. Unfortunately, they are not readily available in many communities and even where they exist, their capacity can be limited.

In 2020-2021, several states worked to establish, expand and fund more MCTs to provide an alternative response to crisis where law enforcement is not required (CA AB 118; MD HB 108/SB 0286; MI SB 0637; MN HF 33; OK SB 1047; and VA HB 5043/SB 5038). Some states also identified how other emergency services systems, such as 911, can deploy MCTs (ME LD 1306 and MN HF 63).

Examples of 2020-2021 Legislation Addressing Mobile Crisis Teams

STATE | BILL NUMBER	YEAR	DESCRIPTION
California AB 118	2021	An act that establishes the Community Response Initiative to Strengthen Emergency Systems (C.R.I.S.E.S.) pilot grant program to expand the participation of community organizations in emergency response for vulnerable populations, including people experiencing a mental health crisis.
Maine LD 1306	2021	An act that amends the law regulating the provision of emergency services under the state's E-911 system to include crisis response services as part of those emergency services to be offered to individuals experiencing mental health, substance use and related emergencies.
Maryland HB 108 SB 0286	2021	An act that requires at least one-third of $5M for FY 2023-2025 to be used to award competitive grants for mobile crisis teams. This bill has requirements for mobile crisis teams, follow ups and referrals, among other provisions.
Michigan SB 0637	2021	An act that creates a Community Crisis Response Grant Program that would provide grants to assist local units of government with the implementation of alternative methods to dealing with mental health emergencies. This bill provides the necessary resources for mental health professionals to respond to behavioral health related calls, deescalate the situation and provide appropriate care.

Examples of 2020-2021 Legislation Addressing Mobile Crisis Teams *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 33	2021	An act that provides an additional $8 million for FY 2022 and FY 2023 for grants to provide adult mobile crisis services and other crisis services provisions. The health and human services omnibus bill also allows children's mobile crisis teams to provide services in an emergency room or urgent care, just like adult crisis teams.
Minnesota HF 63	2021	An act that includes provisions for additional law enforcement training requirements, including crisis intervention, de-escalation and cultural competency. The omnibus public safety bill also includes provisions requiring the 911 system to include referral to mental health crisis teams, among other provisions.
Virginia HB 5043 SB 5038	2020	An act that requires the Department of Criminal Justice Services (DCJS) and the Department of Behavioral Health and Developmental Services (DBHDS) to develop and establish a mental health awareness response and community understanding services (Marcus) alert system throughout the state by July 1, 2021. The bill requires DBHDS to establish guidelines and training programs for crisis teams, call center employees, clinical staff and Marcus alert system users by Dec. 1, 2021.

Crisis Services - Crisis Receiving and Stabilization Services

"Psychiatric boarding" refers to the practice of holding patients in emergency departments, sometimes in hallways, with minimal access to care, as the patient waits for a psychiatric bed to become available. During the pandemic, the number of people and the average time spent boarded increased dramatically. Increasing the availability of crisis receiving and stabilization services provides an alternative to hospital emergency departments and can help prevent boarding. Additionally, these services serve as a core component of a crisis continuum of care, ideally taking walk-ins, mobile crisis team referrals and law enforcement referrals.

States are making progress in developing more crisis receiving and stabilization options for their residents. Several states passed legislation formally defining crisis stabilization facilities in state law, making their role in public mental health systems clearer (AL HJR 69/SJR 34; AK SB 120; and SD SB 4). Two states, South Dakota and Oklahoma, invested new funds for these facilities (OK SB 1047; SD SB 144 and SB 186), while Nevada clarified accrediting procedures for crisis stabilization services (NV SB 156). Addressing current systemic barriers to leveraging this type of care,

Alaska's legislation also allows for law enforcement to take individuals in crisis to crisis care centers as an alternative to arrest (SB 120) and California's law allows paramedics to bypass hospitalization to directly transport individuals to specialized mental health centers (AB 1544).

More crisis stabilization facilities are just one solution to the lack of psychiatric acute care options. Some states, like Iowa (SF 524), are exploring the use of psychiatric bed tracking systems to better assess their needs, capacity and gaps. Additionally, peer-run crisis stabilization programs offer a low-cost option and provide a supportive step-down environment for individuals coming out of or working to avoid a crisis episode. Oregon (HB 2980) established many new peer respite programs in 2021.

Examples of 2020-2021 Legislation Addressing Crisis Receiving and Stabilization Services

STATE | BILL NUMBER	YEAR	DESCRIPTION
Alabama HJR 69 SJR 34	2020	An act that establishes crisis diversion centers to provide 24-hour, intensive levels of care in a centralized location with community-based resources that will allow emergency departments and law enforcement agencies the ability to transfer individuals to these centers for crisis care.
Alaska SB 120	2020	An act that establishes crisis stabilization centers for those experiencing mental health or substance use crises. The bill also authorizes police officers to take individuals to crisis stabilization centers as an alternative to arrest.
California AB 1544	2020	An act that permits local emergency medical services agencies, with approval by the Emergency Medical Services Authority, to develop programs to provide community paramedic or triage to alternate destination services. The act is intended to allow for EMS workers to bypass emergency rooms and directly transport persons to specialized services in need, including to mental health facilities or sobering centers.
Iowa SF 524	2021	An act that establishes an in-patient psychiatric bed tracking system interim study committee. This bill includes requirements for membership, areas to be examined and reporting requirements, among other provisions.

Examples of 2020-2021 Legislation Addressing Crisis Receiving and Stabilization Services
(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Nevada SB 156	2021	An act that revises requirements for state approval of crisis stabilization centers including expanding the list of acceptable accrediting organizations for these facilities.
Oklahoma SB 1047	2021	An act that appropriates funds to expand crisis services in Oklahoma. This bill increases the amount of crisis intervention training sessions offered to law enforcement, and includes $2 million to expand connectivity programs between law enforcement officers, mental health providers and Oklahomans in a mental health crisis, $7.5 million to expand the number of mental health crisis centers and urgent care centers, $2.9 million for additional mobile crisis teams to respond and diffuse crisis situations in communities, among other provisions.
Oregon HB 2980	2021	An act that establishes a new program to provide funding to four peer respite centers in the Portland metropolitan area, southern Oregon, central and eastern Oregon, and the Oregon Coast, to serve individuals experiencing a behavioral health crisis. At least one of the peer respite centers must participate in a pilot project designed specifically to provide culturally responsive services to historically under-represented communities, communities of color, or to the 9 federally recognized tribes in this state.
South Dakota SB 4	2020	An act that designates regional facilities to provide crisis stabilization services for individuals with acute "psychiatric or behavioral" symptoms.
South Dakota SB 144	2021	An act that appropriates $4.6M to the Department of Social Services to develop and build a crisis stabilization unit to serve as a regional facility for western South Dakota.
South Dakota SB 186	2021	An act that appropriates $3M to the Department of Social Services for the City of Sioux Falls to support behavioral and mental health services in crisis stabilization.

Policing Reforms

In 2020, the murder of George Floyd brought about a national dialogue on the role of law enforcement in communities. For NAMI, the dialogue took on several dimensions. NAMI committed to addressing the intersection of race, identity and mental health, and addressing head-on the impact that incidents of police violence have on the mental health of impacted communities. It also energized NAMI's longstanding commitment to police reform, including the need for policies that address biases and that reduce and prevent incidents of force. These policy changes are critical, as estimates show that people with serious mental illness are over ten times more likely to experience use of force in interactions with law enforcement than people without mental health conditions.

Note: Due to the volume of legislation in this area, this legislation trend contains two bill tables.

Several states enacted policing reforms in 2020-2021 that focused primarily on reducing use of force (CO SB20-217; IN HB 1006; LA SB 34; MN HF 1; MN HF 63; NH HB 1645; PA HB 1910; VT S 119; VT S 219; and WA HB 1054).

Examples of 2020-2021 Legislation Addressing Policing Reforms

STATE | BILL NUMBER	YEAR	DESCRIPTION
Colorado SB 20-217	2020	An act that creates a new use of force standard by limiting the use of physical force and limiting the use of deadly force when force is authorized. The act also prohibits a police officer from using a chokehold and requires annual reporting by all local police departments on all use of force incidents that result in death or serious bodily injury.
Indiana HB 1006	2021	An act that reforms policing in the state by requiring de-escalation as part of statewide use of force training and in other training curricula, creates criminal penalties for turning off a body worn camera against agency policy, creates a new standard for when chokeholds are permitted and establishes a process for hiring officers to identify bad actors in the profession, among other provisions.
Louisiana SB 34	2021	An act that requires instruction for law enforcement personnel on the duty to intervene, requires law enforcement agencies that use body cameras to adopt a policy regarding the activation and deactivation of cameras, and prohibits the use of chokeholds, carotid holds and no-knock warrants, except under specific circumstances enumerated in the bill.

Examples of 2020-2021 Legislation Addressing Policing Reforms *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 1	2020	An act that creates legislative intent about use of force requiring peace officers to exercise special care when interacting with people with physical, mental health, developmental or intellectual disabilities who may not be able to understand or comply with commands. Prohibits the use of deadly force if a person poses a threat to themselves, but no one else. Among other provisions, the bill also creates the Ensuring Police Excellence and Improving Community Relations Advisory Council, which includes a member appointed by NAMI Minnesota.
Minnesota HF 63	2021	An act that bans correctional officers from using chokeholds, prone restraints and tying a person's limbs behind their back unless use of deadly force is justified. The bill creates a duty to report excessive force or neglect by corrections officers to administration within 24 hours of witnessing the incident, among other provisions.
New Hampshire HB 1645	2020	An act that imposes numerous policing reforms including requiring psychological screening of all law enforcement officers, ban on chokeholds and required reporting on police misconduct.
Pennsylvania HB 1910	2020	An act that requires police officers to receive training on how to interact with individuals of diverse backgrounds; de-escalation, harm reduction and reconciliation techniques; and community and cultural awareness. This bill also covers the appropriate use of force, provides for mental health evaluations in certain situations, and requires child abuse awareness training for officers and magisterial district judges.
Vermont S 119	2020	An act that defines statewide standard and policy for law enforcement officers' use of force. Officers are required to take "mental impairment" into account in determining appropriate use of force.
Vermont S 219	2020	An act that requires law enforcement to comply with race data reporting requirements in order to receive state grant funding, requires roadside stop data include use of force information and prohibits police from using certain kinds of restraints.
Washington HB 1054	2021	An act that restricts the use of certain tactics and equipment used by police and other law enforcement agencies. This bill restricts law enforcement's use of neck restraints and chokeholds, military equipment or tear gas, among other provisions.

Additional trends focused on promoting greater transparency and reporting of police actions (CT HB 6004; MN HF 1; MN HF 63; and WA HB 1267), increasing training for officers on implicit bias and systemic racism (CT HB 6004; NE LB 924; NJ A 3641; PA HB 1910; VA SB 1256; and VA HB 5109), and implementing requirements for interacting with individuals with disabilities, including mental illness (MA S 2963; MN HF 1; VT S 119; and VA HB 5109).

Note: MN HF 1, MN HF 63, PA HB 1910 and VT S 119 also addressed use of force. See bill summaries on pg. 85 for more information.

Examples of 2020-2021 Legislation Addressing Policing Reforms *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Connecticut **HB 6004**	**2020**	An act that makes numerous changes related to policing standards including creating a police transparency and accountability task force, requiring behavioral health assessments for police officers at least every 5 years, adding implicit bias training to required police training, among other provisions.
Massachusetts **S 2963**	**2020**	An act that imposes numerous policing reforms including improving de-escalation practices of police officers, creating new training model for police responding to mental health crises and establishing a commission to define that training.
Nebraska **LB 924**	**2020**	An act that prohibits racial profiling in policing and requires a written policy by every law enforcement agency to attain such a goal. The bill requires certified law enforcement officers to complete a minimum of two hours of "anti-bias or implicit bias training" per year.
New Jersey **A 3641**	**2020**	An act that makes cultural diversity and implicit bias training for law enforcement officers mandatory.
Virginia **SB 1256**	**2021**	An act that requires inclusion and human rights as part of law enforcement training.

Examples of 2020-2021 Legislation Addressing Policing Reforms *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Virginia HB 5109	2020	An act that standardizes and enhances law enforcement officer training requirements. Training must address systemic and individual racism and bias-based profiling including implicit bias in interacting with persons who have mental illness, substance use disorder or developmental or cognitive disability.
Washington HB 1267	2021	An act that establishes an Office of Independent Investigation, an independent agency (separate from police agencies) to investigate deadly uses of force.

Diversion

Diversion refers to an array of informal and formal practices where alternatives to criminal penalties are made available to people with mental illness who have come into contact with the criminal legal system.

The goal of any behavioral health diversion program is to remove people with mental illness or substance use disorders from the justice system and connect them to treatment and other services. People with mental illness are booked into America's jails over 2 million times each year, so helping people avoid criminal justice system involvement is a top priority for NAMI. The overrepresentation of people with mental illness is not only extremely harmful to the individual and their family, but it is also expensive (and ultimately, ineffective) for state and local governments.

What does diversion look like?

Diversion can happen at many points: before arrest, during prosecution and upon reentry, to name a few. Some communities have begun to address diversion even before contact with any part of the justice system. These efforts implement interventions for individuals who may be "at-risk" of becoming involved with the justice system.

NAMI supports a variety of approaches to diverting individuals from incarceration into appropriate treatment (including but not limited to):

- Police-based diversion such as Crisis Intervention Team (CIT) or similar programs
- Resources and interventions to prevent youth from entering the juvenile justice system
- Court-based diversion such as specialty docket mental health courts

Trends in 2020/2021 Diversion

Mental Health Trainings and Collaborations

An effective strategy for preventing potential arrest or incarcerations for individuals with mental illness is to provide training to first responders about mental health conditions, ways to identify symptoms and techniques for successfully de-escalating mental health crisis situations. Many NAMI organizations are involved in Crisis Intervention Team (CIT) training which includes this content. Even more important than the training are the cross-system collaborations that happen through CIT and similar programs. By working together, they can develop, implement and sustain crisis response systems.

In 2020-2021, several states encouraged greater collaboration between law enforcement agencies and mental health systems through crisis intervention training and collaborations (AL SJR 33; CA AB 465; CA AB 1065; GA SR 546; MD SB 0305; MT HB 696; MN HF 1; OK SB 848; UT SB 47; and VA SB 5014). In particular, Maryland's enacted SB 0305 was notable for establishing a CIT Center of Excellence, where local communities can share best practices and receive technical assistance to create a model CIT program.

Examples of 2020-2021 Legislation Addressing Mental Health Trainings and Collaborations

STATE | BILL NUMBER	YEAR	DESCRIPTION
Alabama SJR 33	2020	A joint resolution that calls on county officials, employees and residents of Alabama to reduce the number of people with mental illness in county jails and hospitals by sharing lessons learned from around the state and participating in the Stepping Up Initiative.
California AB 465	2020	An act that requires crisis intervention programs that collaborate with law enforcement to be supervised by mental health professionals.
California AB 1065	2021	An act that creates the Mental Health Crisis Prevention Voluntary Tax Contribution Fund, allowing California taxpayers to make voluntary contributions to the National Alliance on Mental Illness (NAMI) California's sponsored Crisis Intervention Team program. The funds collected for this program will go towards aiding in the training of law enforcement officers to assist and safely engage with persons with a mental illness.
Colorado HB 21-1166	2021	An act that provides training for people who provide crisis response to people with intellectual and developmental disabilities, or co-occurring behavioral health needs. This bill aims to keep individuals with intellectual and developmental disabilities in their homes and out of psychiatric placements and jails.
Georgia SR 546	2020	A resolution that encourages local law enforcement agencies, psychiatric facilities, doctors, and therapists to purchase and freely distribute Mental Health Alert Wristbands to individuals with mental illness. The wristbands are intended to help law enforcement officers identify people who may be in a mental health crisis; they can also be worn by CIT-trained officers.

Examples of 2020-2021 Legislation Addressing Mental Health Trainings and Collaborations

(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Montana HB 696	2021	An act that revises laws related to crisis intervention teams by providing specialized training to help law enforcement officers recognize and properly respond to individuals with a mental illness or behavioral health condition, including verbal de-escalation techniques.
Maryland SB 0305	2020	An act that establishes the Crisis Intervention Team Center of Excellence in the Governor's Office of Crime Control and Prevention to provide technical support to local governments, law enforcement, public safety agencies, behavioral health agencies, and crisis service providers and to develop and implement a crisis intervention model program.
Maryland HB 1280 SB 0857	2021	An act that establishes the Maryland Behavioral Health and Public Safety Center of Excellence within the Governor's Office of Crime Prevention, Youth, and Victim Services as the statewide information repository for behavioral health treatment and diversion programs related to the criminal justice system.
Minnesota HF 1	2020	An act that requires six hours of the 16 hours of law enforcement officers' continuing education to be on mental illness crisis training within every three-year licensure cycle. This includes using scenario-based training and covering the following topics: techniques for relating to individuals with mental illnesses and the individuals' families, techniques for crisis de-escalation, techniques for relating to diverse communities and education on mental illness diversity, among other provisions.
Oklahoma SB 848	2021	An act that provides crisis intervention training and wellness strategies for law enforcement.
Utah SB 47	2021	An act that creates the Mental Health Crisis Intervention Council, to be made up of stakeholders from various agencies, who will design a statewide training for emergency services professionals.
Virginia SB 5014	2020	An act that mandates the creation of minimum crisis intervention training standards and requires all law enforcement officers to complete crisis intervention training.

Specialty Courts

Specialty courts (or problem-solving courts) can be lifechanging for people with mental illness who become justice-system involved because they focus on treatment rather than punishment. As of 2020, there are an estimated 477 adult mental health courts and 56 juvenile mental health courts, along with 3,800 drug treatment courts and 601 veterans treatment courts in the US.

Policymakers passed legislation in 2020-2021 to increase access to specialty courts. Minnesota established the Veterans Treatment Court Program (SF 2), while Virginia established behavioral health courts (SB 818) and Oklahoma clarified confidentiality requirements for cases pending before mental health courts (SB 50).

Examples of 2020-2021 Legislation Addressing Specialty Courts

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota SF 2	2021	An act that creates an alternative sentencing process for veterans who commit a misdemeanor, gross misdemeanor, or certain lower-level felonies, and establishes a Veterans Treatment Court Program. This omnibus state government financing and policy bill ensures that veterans must consent to a process to determine whether sexual trauma, traumatic brain injury, PTSD, a substance use disorder or a mental health condition resulted from their service and if it impacted the crime they are charged with. If met, veterans will be sentenced to probation instead of incarceration, among other provisions.
Oklahoma SB 50	2021	An act that establishes confidentiality requirements for cases assigned to mental health court programs.
Virginia SB 818	2020	An act that adds behavioral health courts as specialized court dockets to the existing Virginia court system. Includes guidelines for creating a behavioral health docket advisory committee and requires any community implementing a behavioral health court to convene an advisory committee. Additionally, the act gives the Supreme Court of Virginia administrative oversight of the implementation of the act.

Juvenile Justice System Reform

Seven in 10 youth in the juvenile justice system tragically have a diagnosable mental health condition. It is important to help youth with behavioral health challenges avoid contact with the juvenile justice system, particularly given that juvenile justice system involvement greatly increases the likelihood of adult justice system involvement. If youth do become engaged in the juvenile system, they must be provided with adequate support that prepares them to lead successful and healthy adult lives in the community.

Many of the legislative trends impacting the adult criminal justice system are mirrored in juvenile justice system reforms, including clarification of competency restoration proceedings (VA SB 1248 and WV SB 562), diversion programs that offer an alternative to incarceration (DC B 24-0392 and MN HF 63) and greater sentencing discretion to reduce overall sentences and increase parole and expungement opportunities (IN SB 368; NC S 562; VA SB 103; and VA HB 744).

Examples of 2020-2021 Legislation Addressing Juvenile Justice System Reform

STATE | BILL NUMBER	YEAR	DESCRIPTION
District of Columbia B 24-0392	2021	An act that requires the Criminal Justice Coordinating Council to submit reports to the Mayor and the Council to determine what factors, programs, or interventions effectively prevent District youth from entering the juvenile and criminal justice systems, and to analyze the types of school-based incidents that lead to law enforcement referrals or arrests.
Indiana SB 368	2021	An act that mandates the automatic expungement of juvenile misdemeanor records, establishes a system that determines if a minor is competent to stand trial and bars children from being held in adult prisons unless the court finds doing so to be "in the best interests of justice."
Minnesota HF 63	2021	An act that authorizes law enforcement to refer a child to diversion programming for petty offenses. This omnibus public safety bill works to ensure that if the child is successful in the diversion program, they will not end up in the juvenile justice system, among other provisions.
North Carolina S 562	2020	An act that amends the law to allow for the expungement of certain misdemeanor and felony offenses that were committed by an individual prior to the age of 18.

Examples of 2020-2021 Legislation Addressing Juvenile Justice System Reform

(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Virginia SB 103	2020	An act that amends Virginia's parole eligibility laws to extend to individuals who are serving a life sentence or sentence of more than 20 years for an offense committed as a juvenile.
Virginia HB 744	2020	An act that provides courts with discretion related to mandatory minimum sentences when sentencing a juvenile as an adult. The bill also requires courts to consider additional factors such as a juvenile's exposure to adverse childhood experiences (ACEs), trauma, or any difference between a juvenile and an adult, when sentencing a juvenile tried as an adult.
Virginia SB 1248	2021	An act that relates to juveniles and competency evaluations. Requires the appointed evaluator or the director of the community services board, behavioral health authority, or hospital to acknowledge receipt of the court order requiring a competency evaluation to the clerk of the court, as soon as practicable but no later than the close of business on the next business day after receiving the court order, or the evaluator must inform the court on the acknowledgement form if they are unable to conduct the evaluation.
West Virginia SB 562	2021	An act that addresses juvenile competency proceedings when a juvenile is found incompetent to stand trial and to provide for the least restrictive alternative.

Competency Restoration

Although not often thought of as a diversion strategy, timely access to a competency evaluation and restoration process can greatly reduce the amount of time a person with a mental illness spends in jail. In 2020 and 2021, several states took steps to improve the backlogs and issues related to competency restoration for individuals facing criminal charges (AZ SB 1266; CO SB20-181; HI HB 1620; VT S 3; VA HB 259/SB 1431; and WV SB 702).

While each state addressed different aspects of the competency system, some common themes included: improvements to evaluations and reports; shortening timeframes for someone to receive an evaluation; clarifying the professionals

See page 96 for more about competency restoration.

involved in competency proceedings; and flexibility for courts to dismiss cases or authorize release for individuals who could not be restored to competency. California and Virginia specifically added flexibility for where competency restoration services could be provided, allowing for services to be provided in a community-based setting (SB 317 and SB 683 respectively).

Note: Competency restoration is a complex process. See our "Understanding the Issue: Competency Restoration" on page 96 to learn more.

Examples of 2020-2021 Legislation Addressing Competency Restoration

STATE | BILL NUMBER	YEAR	DESCRIPTION
Arizona SB 1266	2021	An act that modifies the number of mental health experts required for competency evaluation of a defendant charged only with a misdemeanor.
California SB 317	2021	An act that authorizes good conduct credits for a person found incompetent to stand trial who is receiving treatment in a treatment facility; and makes modifications to existing procedures related to a finding of mental incompetence for misdemeanor defendants to provide for community-based treatment rather than confinement in a treatment facility.
Colorado SB 20-181	2020	An act that implements guidance and measures to improve evaluations, timeframes and reports related to an individual who may be found incompetent to proceed in a criminal case. Creates requirements for courts to set bonds for release for individuals found incompetent to proceed and allows certain charges to be dropped in cases where an individual is found incompetent to proceed.
Hawaii HB 1620	2020	An act that amends the law for individuals charged with a petty misdemeanor not involving violence or attempted violence, who is determined unfit to proceed. For these individuals, the court may suspend the proceedings and commit the individual to the custody of the Department of Health; also amends requirements for fitness determination, hearings and those appointed to complete examinations and reports.

Examples of 2020-2021 Legislation Addressing Competency Restoration *(Continued)*

STATE | BILL NUMBER	YEAR	DESCRIPTION
Indiana HB 1127	2021	An act that adds competency restoration services to the list of treatment and wraparound recovery services made available to certain persons in the criminal justice system. The bill also removes provisions that allow a delinquent child's or person's Medicaid participation to be terminated following a two-year suspension due to certain adjudications or incarcerations.
Ohio SB 2	2021	An act that makes changes to the requirements for competency evaluations and mental health treatment in criminal cases.
Utah HB 35	2020	An act that appropriates funding to operate 30 additional inpatient psychiatric beds at Utah State Hospital. The bill also requires the Forensic Mental Health Coordinating Council to study and provide recommendations to the Utah Legislature regarding the long-term need for adult beds at the facility.
Vermont S 3	2021	An act that makes changes to criminal proceedings related to insanity defense and competency to stand trial. The act clarifies which professionals may complete the independent psychiatric examination (and in which order, if someone should be evaluated for competency and sanity).
Virginia HB 259 SB 1431	2020	An act that amends Virginia law with regards to an individual who is under evaluation for competence to stand trial. If a report finds that an individual is unrestorably incompetent to stand trial and will remain incompetent for the foreseeable future, the courts may move to dispose of the case.
Virginia SB 683	2020	An act that clarifies the competency statute to allow for outpatient treatment to occur in a local correctional facility or at a location determined by a community services board or the behavioral health authority including outpatient settings.
West Virginia SB 702	2021	An act that updates outdated language, creates criteria for competency restoration treatment, establishes maximum time periods for competency restoration treatment and establishes standards for judicial oversight and management regarding the detention and conditional release of persons found guilty by reason of a mental illness.

Understanding the Issue

COMPETENCY RESTORATION

Every person who faces criminal charges has a right known as competence to stand trial (CST). CST requires that someone be able to understand the charges against them and participate in their own defense. For someone with a mental illness and/or intellectual/developmental disability who is facing criminal charges, their symptoms or behaviors might result in a judge ordering a competency evaluation and restoration services. If this happens, the criminal case will be held until the person facing criminal charges is determined competent to proceed.

Competency restoration processes vary based on state and local laws, as well as the availability of resources. In most states, competency evaluations must be conducted by at least two licensed psychologists or psychiatrists. Some states require that evaluations and restoration be conducted in a hospital setting. No matter the resources or policies that shape the CST process, CST is not the same as mental health treatment. Competency restoration services are designed to prepare someone to participate in a court proceeding, which does not require that someone is engaged in treatment or be on a path to long term recovery.

Many people with mental illness often spend more time incarcerated waiting on competency restoration services than they would have for the crime they are charged with.

Although not treatment, CST places a heavy burden on the mental health system, straining already scarce resources. In recent years, this problem has grown worse with an increasing number of referrals, creating lengthy backlogs of people waiting in jails for evaluation and restoration services for weeks and months. Many people with mental illness often spend more time incarcerated waiting on competency restoration services than they would have for the crime they are charged with. These delays often result in their

Understanding the Issue

COMPETENCY RESTORATION

mental health deteriorating further because of the inadequate mental health care available in our nation's jails.

Many states are actively working to re-think the CST system, with nearly a dozen doing so because of class action lawsuits filed against their states. The most well-known is the ***Trueblood v. Washington State Department of Social and Health Services***. In this case, a federal court determined that Washington State's CST process was taking too long, violating individuals' constitutional right to due process. In 2015, the court ordered the state to provide evaluations within 14 days and competency restoration services within 7 days.

Reforming CST and eliminating the backlogs requires a blending of policy reform and innovative practice. The following are a few solutions states can explore that begin to address this issue.

- **Increasing opportunities for diversion.** Research shows that many people with serious mental illness in jails have been charged with low level misdemeanor crimes, making those individuals ideal for diversion. Nearly half the states in the U.S. have statutes that allow for diverting people with mental health conditions. Many other states have passed laws giving judges the discretion to dismiss certain cases if someone cannot be restored within a certain period of time.

  At the local level, law enforcement and court leaders can partner with advocates and leaders from the mental health system to explore increasing opportunities for diversion. Using tools such as the Sequential Intercept Model, communities can identify where within the criminal justice system people with mental illness can be diverted.

- **Alternatives to institutional-based restoration.** Community-based competency restoration is a promising practice that allows someone to receive competency restoration services in the community instead of an institutional setting. This model allows for someone to wait for evaluation and restoration close to home and in the least restrictive setting possible. The model is also less expensive and has the benefit of beginning to connect individuals to long-term recovery support.

- **Increasing resources through Medicaid.** States should also look to opportunities within the Medicaid program to help increase the capacity of their mental health systems to serve the needs of people with mental illness, including those who are incarcerated. Policies such as the IMD exclusion place limits on where Medicaid can pay for mental health

Understanding the Issue

COMPETENCY RESTORATION

services, but states can now apply for waivers to lift this restriction. These waivers not only have the potential to increase the availability of hospital beds that are necessary in some CST cases, but to also increase the investment in the broader mental health system that can support community-based competency restoration.

More Information and Resources

- Policy Research Associates Inc.'s Competence to Stand Trial microsite with tools and resources to reform CST
- The Council of State Government Justice Center *Just and Well: Rethinking How States Approach Competency to Stand Trial* (October 2020)
- SAMHSA's webpage on Sequential Intercept Model Mapping

Rehabilitation and Reentry

NAMI believes that all people with mental health conditions who are incarcerated deserve access to quality mental health treatment. But after arrest, many individuals become disconnected from needed mental health care. In fact, less than half of people (45 %) with a history of mental illness receive mental health treatment while held in local jails. In prisons, the situation is even worse, with 63 percent of inmates with a history of mental illness not receiving any mental health treatment.

In jail or prison, the health of people with mental illness deteriorates due to the lack of or inadequate mental health services, separation from loved ones, the stressful physical environment of correctional facilities and exposure to violence and harmful practices, including solitary confinement. Worse yet, individuals with a mental illness stay in jail longer than their counterparts without mental illness, and this disparity is even worse for people of color with mental health conditions.

Of those who are incarcerated, 95% will one day be released and will face a variety of challenges as they re-enter their communities. Health care often takes a backseat as they deal with more pressing needs, like housing, food security, reconnecting with family members and finding employment. Reentry — the period of return to a community from incarceration — can be marked by heightened stress, isolation and hardship. For people with mental illness and substance use disorders (SUD), there is increased vulnerability and risk.

Due to the lack of timely access to critical services and supports for their health or mental health condition, these individuals are at a higher risk of repeated incarceration. In fact, the risk of death by suicide or opioid overdose dramatically increases in the first days and weeks after an individual is released from jail or prison. One study indicates that within the first two weeks of returning to the community, recently incarcerated individuals have a risk of death 12.7 times that of the general population. Fatal overdoses are by far the most common cause of death during this time, with a risk 129 times that of the general population.

What does successful rehabilitation and reentry look like?

For successful rehabilitation, individuals with mental health conditions who are in jail or prison should:

- Have access to sentencing and parole opportunities that take their mental health condition into account
- Be provided any needed mental health treatment including medications
- Avoid harmful practices that would worsen their mental wellbeing such as solitary confinement

Reentry begins in the weeks and months before someone is released from incarceration. It includes ensuring individuals who are soon to be released from incarceration have access to:

- Community-based mental and physical health care including medications and recovery support programs
- Safe and stable housing
- Social supports (food, employment, education)
- Community supports (family, friends, social networks)
- Opportunities to expunge their criminal record and remove collateral consequences

Trends in Reentry and Rehabilitation Legislation

Early Release and Sentencing Reform

As part of overall criminal justice reform, there are many efforts to address sentencing and the length of stay for individuals who are vulnerable. Early release programs allow someone to be released before the end of their sentence, often taking into account a person's age, health or disability status, which are similar factors in sentencing reforms.

Two states passed legislation creating new pathways for inmates to apply for early release or parole (KY HB 284 and VT S 338). Meanwhile, Louisiana legislation ensures that parole boards will be given important health information, including any psychiatric conditions, of individuals up for review (LA HB 338).

In 2021, Ohio passed a first-in-the-nation bill prohibiting the death penalty for people with serious mental illness (HB 136). Read more about NAMI Ohio's journey to pass this exemption in our Advocacy Spotlight on page 102.

Examples of 2020-2021 Legislation Addressing Early Release and Sentencing Reform

STATE | BILL NUMBER	YEAR	DESCRIPTION
Kentucky HB 284	2020	An act that creates new opportunities for individuals on probation, probation with an alternative sentence, or conditional discharge, to receive probation program credits. An individual can receive credit towards their sentence if they: receive a high school equivalency diploma or college degree or complete vocation or technical educational program; successfully complete a drug treatment program; or complete work for time credit.
Louisiana HB 338	2020	An act that requires reports given to the parole committee to include information related to an individual's physical, mental and psychiatric condition.
Ohio HB 136	2021	An act that amends the Ohio criminal code to prohibit using the death penalty in sentencing for aggravated murder when the offender has a serious mental illness (defined as schizophrenia; schizoaffective disorder; bipolar disorder; or delusional disorder) at the time of the offense. The law also allows individuals previously sentenced to death to petition for re-sentencing of life imprisonment if serious mental illness was a factor at the time of the offense.
Vermont S 338	2020	An act that creates new avenues for granting parole to individuals who have yet to meet their minimum sentence, more opportunities for individuals to reduce their sentences, and removes requirements for individuals to participate in correctional programming in order to earn good time. The law also requires state stakeholders to draft recommendations, which include recommendations regarding the availability of mental health and substance use assessments and their impact on case plans.

Advocacy Spotlight

NAMI OHIO

Achieving a Historic Death Penalty Exemption for People with Mental Illness

It is a fundamental failure of our mental health system that over 2 million times each year people with mental illness are booked into our nation's jails, and that people with serious mental illness (SMI) – especially people of color with SMI – are disproportionately represented among those who have been on death row or executed. NAMI Ohio sought to change this terrible reality.

Due to their symptoms, people with SMI are frequently unable to control their impulses, unable to participate in their own defense and incapable of ***intending*** to cause a death – the exact reasons the U.S. Supreme Court ruled that it is cruel and unusual punishment to execute children under the age of 18 or individuals with intellectual disabilities. However, the Court has not yet ruled if this also applies to the death penalty for people with SMI. Most states do list mental illness as a factor that should be taken in consideration against the death penalty, but no state had ever banned the use of the death penalty for people with serious mental illness.

NAMI opposes the death penalty for people with serious mental illness.

NAMI Ohio began their advocacy to reform this policy by reaching out to different organizations across the state to form the Ohio Alliance on Mental Illness Exclusion (OAMIE), a coalition solely focused on eliminating the death penalty in Ohio for people with SMI. The large coalition consisted of mental health and non-mental health organizations and was divided into two parts: a small core team who met every two weeks for years to share updates and strategy, as well as a larger group of organizations who were regularly updated and activated whenever there was a call to action, like filling the room at a hearing or making targeted calls to key legislators, using a website to share messaging, news, and easily accessible materials.

Public engagement was also a part of OAMIE's strategy. They set up meetings for the bills' sponsors with the editorial boards of the large Ohio newspapers resulting in four major local papers endorsing the bill. Leaders also identified spokespeople who were well-respected in the state. Whenever there were hearings, spokespeople were asked to testify and all the written testimony was reviewed beforehand to make sure the messages were strong, concise and not repetitive.

After years of advocacy by NAMI Ohio and OAMIE, the bill, HB 136, passed both the Ohio House and Senate and was signed into law by Governor Mike DeWine in 2020, effective April 12, 2021. With the Governor's signature, Ohio became the first state in the country to pass legislation to ban the death

Advocacy Spotlight

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penalty for individuals who at the time of their offense have schizophrenia, schizoaffective disorder, bipolar disorder, or delusional disorder and are convicted of aggravated murder. Instead of the death penalty, if an individual with SMI is found guilty, they will be sentenced to life imprisonment without the possibility of parole.

HB 136 supporters Megan Testa of Ohio Psychiatric Physicians Association, Bob Spada, former State Senator and NAMI Ohio Board President, and Evelyn Lundberg Stratton, former Justice of Ohio Supreme Court, gathered at the Ohio Statehouse.

The law also requires that individuals who were previously sentenced to death – who prove that they had SMI at the time of the offense – be resentenced to life imprisonment without parole, with the first person taken off death row by this law in June 2021. There is now an effort underway to get individuals with SMI on death row re-sentenced.

Keys to Success

Looking back at the passage of HB 136, NAMI Ohio shared the following advice for other mental health advocates:

Build a Strong Coalition. Organize your coalition around a single priority issue to be most effective. NAMI Ohio assembled a diverse coalition who supported the idea of banning capital punishment for people with SMI, including traditional mental health partners and other organizations focused on justice and health systems.

Identify Influential Champions. Leveraging influential people within your state can be an effective way to advance a policy initiative. Identify key individuals and ask them to be spokespeople with the media, engage the legislature and testify at hearings.

Be Persistent. Policy change can take years to achieve. Meet regularly within your coalition and with your legislative champions to share updates and strategize during the journey towards bill passage.

Successful Reentry

Reentry — the period of return to a community after incarceration — can be marked by heightened stress, isolation and hardship. For people with mental illness and substance use disorders (SUD), there is increased vulnerability and risk, which makes planning critical to reducing cycling back into incarceration. States have worked to facilitate a successful transition back into the community by ensuring people who are incarcerated have assistance with basic necessities prior to release such as obtaining identification cards (VA 1467), obtaining health insurance and connection to community-based health care providers (WA SB 5118 and WA SB 5304) and providing transition specialists to support and coordinate their return to the community (CO HB 21-1130).

So-called "collateral consequences" can follow individuals long after incarceration. They include additional civil penalties that accompany a criminal conviction and most often impact a person's ability to regain employment, participate in civic life (voting rights) or access resources like student loans or financial assistance. Fortunately, states can act to remove collateral consequences, for example, Iowa enacted a measure to restore voting rights to individuals with certain convictions (SF 2348).

The state of Louisiana was notable for enacting a trio of bills aimed at strengthening reentry, including requiring several state agencies to issue a report on barriers to successful reintegration (HCR 14), offering more flexibility for individuals to meet the conditions of their parole (SB 77) and helping connect individuals to vocational licensing and certification programs (SB 354).

Examples of 2020-2021 Legislation Addressing Successful Reentry

STATE | BILL NUMBER	YEAR	DESCRIPTION
Colorado HB 21-1130	2021	An act that improves access to behavioral health care within the state's transition specialist program. This bill expands the community transition specialist program by redefining "high-risk individual" to allow more individuals to access program services among other provisions.
Iowa SF 2348	2020	An act that restores voting rights to certain convicted persons and includes effective date provisions.

Examples of 2020-2021 Legislation Addressing Successful Reentry

(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Louisiana HCR 14	2020	An act that requires the Louisiana Departments of Public Safety and Corrections, Health and Education to collaborate and produce a report that identifies solutions and resources necessary to address the barriers to successful reintegration for individuals who are incarcerated. Requires that the report be produced prior to the 2021 legislative session and that it include consideration for transportation, family support, employment, mental health, substance use treatment, housing, community apathy and education.
Louisiana HB 77	2020	An act that directs the Louisiana Department of Public Safety to create rules to allow for flexibility for parolees who are required to complete check-ins as a condition of their parole. Rules will include requirements for parole officers to schedule meetings with an individual at a time and location that accommodates an individual's work schedule and create opportunities to meet via technology instead of in person.
Louisiana SB 354	2020	An act creating a program that will issue a card to an individual who is re-entering the community that includes a list of vocational licensing and certification programs completed by an individual while they were incarcerated. Requires the Louisiana Department of Corrections to identify a transition specialist at each state correctional facility to issue these documents.
New Jersey SCR 53	2020	An act that creates a 15-member commission to assess opportunities for women who are re-entering the community from incarceration, and their experience while being incarcerated. Among other issues it is tasked to address, the commission must look at the mental health and wellbeing of women while incarcerated and access to mental health care upon release.
Washington SB 5118	2021	An act that supports successful reentry by requiring the secretary to send written notice of a planned release to the person's health care insurance provider, including the person's current and expected location and contact information. If the person does not have health insurance, the secretary shall assist the person in getting coverage.

Examples of 2020-2021 Legislation Addressing Successful Reentry
(Continued)

STATE | BILL NUMBER	YEAR	DESCRIPTION
Washington SB 5304	2021	An act that allows people incarcerated in a state hospital or other institution to apply for medical assistance during confinement; reinstates suspended medical assistance upon release; assures contact and release information is given to Managed Care Organizations (MCOs); requires the Health Care Authority (HCA) to apply for a Medicaid waiver to cover services to a person confined in a correctional institute, state hospital or other facility; and creates a workgroup to study how to expand the cost-effective strategies of this program to other populations and settings to enhance recovery, reduce recidivism and improve safety.
Virginia HB 1467	2020	An act that requires the sheriff, superintendent or administrator of a jail or prison to provide the assistance needed for an individual to obtain a government-issued identification card, birth certificate or social security card. Requires the correctional facility to pay for the costs of obtaining identification if the individual does not have the funds in their account to cover the costs.

Access to Care While in Custody

Strengthening access to health care and other services for people who are incarcerated helps to both improve individuals' mental health and reduce the likelihood of re-incarceration. In 2020 and 2021 legislation, several states passed jail treatment standards or guidance for people with mental illness, with a particular focus on access to mental health services, including medication, during incarceration and upon release (MN HF 63; TX SB 49; and VA HB 1874). Washington also enacted a law to track the criminal justice system involvement for people with behavioral health needs (SB 5157).

A notable highlight for policy promoting health services for justice-involved individuals is New York's S 6601B, which added access to medical or mental health care as part of the state's civil rights code for a person under arrest or in the custody of law enforcement.

Examples of 2020-2021 Legislation Addressing Access to Care and Other Supports While in Custody

STATE | BILL NUMBER	YEAR	DESCRIPTION
Minnesota HF 63	2021	An act that requires the Department of Corrections to develop guidance for jail facilities on: screening, assessment, treatment of people with mental illnesses and substance use disorders, suicide prevention plans and training, verification of medications in a timely manner, well-being checks, discharge planning (including providing medication at discharge) and use of solitary confinement and mental health checks, among other provisions.
New Jersey S 2055	2020	An act that allows an individual who is incarcerated to be eligible for student financial aid if they have been a resident of New Jersey for 12 months and to receive approval from the Department of Corrections to enroll in an eligible institution. Related appropriations legislation provided $625,000 in FY 2020 to provide need based financial assistance to incarcerated individuals enrolled in eligible institutions.
New York S 6601B	2020	An act that amends the New York Civil Rights Laws to include the right of someone who is under arrest or in the custody of law enforcement to receive medical or mental health services. Obligates law enforcement, peace officers or the agency to provide necessary assistance and treatment and allows for an individual to take civil action against an agency if they are not provided care and suffer injury or exacerbation of their condition.
Texas SB 49	2021	An act that updates procedures and programs regarding defendants with a mental illness or intellectual disability. This bill directs the Commission on Jail Standards to require that a prisoner with a mental illness is provided with prescription medication deemed necessary by a qualified medical or mental health professional.
Virginia HB 1874	2021	An act that relates to requiring behavioral health services standards in local correctional facilities.
Washington SB 5157	2021	An act that establishes performance measures to track criminal justice involvement of clients of the public health system who have behavioral health needs and improvement targets related to these measures. This bill also requires contractors to implement performance improvement projects related to reducing client involvement with criminal justice systems where there is an identifiable behavioral health need.

Solitary Confinement

Solitary confinement is the placement of an individual in a locked, highly restrictive, isolated cell with no human contact or rehabilitative services provided. It can cause extreme psychological distress, worsen symptoms of mental illness and, in the long-term, leave people unable to function in correctional settings and unprepared to reenter the community. Fortunately, policymakers passed laws in 2020 and 2021 restricting the practice of solitary confinement, especially for high-risk populations like people with mental illness, as well as requiring more frequent assessments of individuals placed in solitary confinement (CO HB 21-1211; CT SB 10509; and MT HB 658).

Examples of 2020-2021 Legislation Addressing Solitary Confinement

STATE | BILL NUMBER	YEAR	DESCRIPTION
Colorado HB 21-1211	2021	An act that prohibits a local jail with a bed capacity of over 400 beds from involuntarily placing an individual in restrictive housing if the individual meets various conditions. The act requires a medical or mental health professional to assess any individual placed in restrictive housing within 24 hours of placement, and to screen and document certain information regarding each individual with a mental illness or substance use disorder.
Connecticut SB 1059	2021	An act that establishes the Correction Accountability Commission and enhances correction ombuds services; restricts the use of isolated confinement and restraints; increases transparency around restrictive housing and the use of restraints and seclusions; creates policy for social contacts for an incarcerated person; and provides worker's compensation benefits for correction officers, among other provisions.
Montana HB 658	2021	An act that revises requirements related to mental health appraisals for inmates with mental illness being held in restrictive housing including making initial and updated appraisals meet timeframes recommended by American Correctional Association standards.

Conclusion

More than 8 in 10 people agree that elected officials need to do more to improve mental health care and treatment.

Help NAMI Advocate for Change on Capitol Hill.

Learn more at NAMI.org/Advocacy

Find your NAMI State Organization at NAMI.org/FindSupport

NAMI
National Alliance on Mental Illness

Mental health was front and center in states' policymaking in 2020 and 2021, following a trend in recent years (but certainly accelerated by concerns related to the COVID-19 pandemic). Progress was made on a wide variety of issues, but a few clear priorities emerged across the states. First, addressing the needs of youth was a clear focus, with state lawmakers moving to require more mental health trainings for school personnel, increased awareness and formal education on mental health and suicide prevention and more mental health services provided in or connected to schools.

At the same time, advocates continued to fight for equitable mental health benefits in insurance plans, primarily through strengthened implementation of both federal and state parity requirements. Policymakers also raced to make telehealth options more available, which allowed many people to stay connected to their mental health care provider amid social distancing concerns, and even enabling some people to access mental health care for the very first time.

Finally, sparked by federal action to create "988", a national number to aid people experiencing mental health, suicidal or substance use-related crises, state advocates brought clear attention to the need to build comprehensive behavioral health crisis care systems. Fueled by a common desire to reduce justice system involvement for people with mental illness, efforts included increasing capacity not only for crisis call centers but also for in-person crisis services such as mobile crisis teams and crisis stabilization programs.

It is worth noting that while this report was compiled largely in 2022 when many COVID-19 restrictions were easing, the full mental health impact of the COVID-19 pandemic remains to be seen – and is likely to endure for many years to come. The trauma and stress of this time will impact all of us for years and even decades. The public recognizes that more must be done to help people struggling with mental health symptoms. An October 2022 public opinion poll from NAMI, conducted by Ipsos, showed that more than 8 in 10 people agree that elected officials need to do more to improve mental health care and treatment.

NAMI National and NAMI State Organizations will be closely watching to see if states rise to meet the many challenges of our national mental health crisis. You can help advocate for change in your state by connecting with your NAMI State Organization. Also, help NAMI advocate for change on Capitol Hill by signing up to join our Advocacy Network here.