



**STATE LEGISLATION REPORT**

# Trends in State Mental Health Policy



2019

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**

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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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State Mental  
Health Policy

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## **Introduction**

NAMI State Organizations bring the voice of people with lived experience of mental illness and their family members to the policymaking process to create positive and systemic change.

### **Overview**

In 2019, an extensive number of mental health-related bills were introduced and passed in state legislatures across the country, indicating that policymakers may be reaching a turning point in their awareness of mental illness, which affects one in five adults and one in six adolescents each year.

Yet, awareness alone does not equal access to mental health services and supports that individuals and families affected by mental health conditions need to thrive. The mental health community still faces many challenges. In fact, **well over half of the people who need mental health treatment do not receive it in any given year.**

Formed in 1979 by a small group of families of adult children with serious mental illness, NAMI has grown into a nationwide grassroots network. With more than 600 state and local affiliates, NAMI is dedicated to improving the lives of individuals and families affected by mental health conditions. A pillar of NAMI's mission is advocating for public policies that ensure individuals and families can get help early, get the best possible care, and be diverted from criminal justice system involvement.

Many mental health policy decisions are made at the state level. Historically, care for people with mental illness was considered the responsibility of the state government, and even now states have tremendous control over the design and funding level of their state mental health systems. NAMI State Organizations bring the voice of people with lived experience of mental illness and their family members to the policymaking process to create positive and systemic change.

This report is a showcase of significant state mental health legislation that was enacted (or nearly enacted) in calendar year 2019. The report explains key trends in mental health policy and offers lessons from NAMI State Organization leaders who played an important role in shaping some of these policies.

The report is intended to offer policy options for state policymakers, NAMI State Organizations, and other mental health advocates to pursue in order to improve the lives of individuals living with mental health conditions and their families.

### **Structure of Report**

The report is divided into three main sections based on the 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 12 areas of focus in total. These areas of focus are not exhaustive; instead, they represent issues of critical importance to NAMI’s mission that also saw significant legislative action in 2019. In each area of focus, key trends and standout bills are identified and briefly analyzed.

Bills are organized into mini-tables within each trend area and are also listed in [this bill reference resource](#) for further review. Bills that fit more than one section or area of focus are listed in all to which they apply. Bills that were vetoed are noted with an asterisk “\*” after the bill number.

Other special components of the report include “Understanding the Issue” features that provide a deeper dive on complex mental health policy issues and “Advocacy Spotlights,” which showcase a NAMI State Organization’s involvement with a key piece of legislation and illustrate how other advocates may replicate their success.

### **Methodology**

This report is focused on standalone mental health legislation that was enacted or nearly enacted in calendar year 2019. The research for this report was conducted primarily using legislative tracking software (Quorum). Only bills that had reached the minimum status of “Passed Second Chamber” in 2019 were considered for analysis. A secondary source of research were NAMI State Organizations’ 2019 state legislative summaries (when available). Review was limited to legislation from the 50 states and Washington, DC.

Bills that did not meet the threshold of having “Passed Second Chamber” (*i.e.*, those that did not advance far into the legislative process) were not included in this report, except where otherwise noted. 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 of all possible issue areas and related legislation.

Even within these limits, over 600 state mental health bills were collected for consideration in this report. Upon further refinement, nearly 100 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.



**Tap a number to navigate to the beginning of each report section.**

**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.



**Tap a bill button to review the entire bill online.**

# 1

## ***People Get Help Early***

Growing evidence shows that when people get help early, it can reduce the long-term symptoms of their conditions. “Getting help early” means providing connections to care, identifying symptoms of a mental health condition early, and intervening with evidence-based and effective treatments as soon as possible to help an individual get well and stay well.

When people get help early, it can change their life’s trajectory. Strategies to ensure people get help early include offering mental health education in schools to build awareness and acceptance of mental health conditions and symptoms. It also includes providing school-based or school-linked mental health care to make sure every school-age child can get needed mental health services and supports. But getting help early is not limited to youth and young adults. NAMI believes that all individuals — from youth through adulthood — should have access to care at the earliest signs or symptoms of a mental health condition, including reducing risk factors for suicide.

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

- 1. Early Intervention***
- 2. Mental Health Education***
- 3. Suicide Prevention***

The legislation covered in this section is aimed at increasing the early identification, support, and treatment of mental health conditions for children and adults.

## Early Intervention

Typically, a person experiencing early episodes of a mental health condition faces long delays before getting treatment that helps. However, recent research shows that early intervention and treatment dramatically impacts the course of mental illness. With effective and timely treatment, early intervention can prevent symptoms from becoming worse, helping an individual continue to stay engaged socially and in school or work. While half of mental health conditions develop by age 14, and 75% by age 24, early intervention is important at all ages — regardless of when symptoms first arise in a person’s life.

### **What does early intervention look like?**

Early invention is most often understood to mean early detection and treatment of mental health symptoms before symptoms become unmanageable. While this is true, early intervention can also include other individual and community-level strategies, such as:

- Mental health awareness promotion, education and prevention programs;
- Creating safe and supportive communities where people have options to seek help and support; and
- Reducing mental health risk factors, such as poverty, homelessness, unemployment, suicidal thoughts and access to illicit substances.

## ● ● ● ● **Trends in 2019 Early Intervention Legislation**

### **Early Childhood Development**

States are increasingly investing in children’s early social and emotional development. These programs are focused on young children, recognizing the opportunity to identify children at risk for serious emotional disturbance (SED) and intervening early to achieve the best outcomes.

Iowa’s enacted HF 690, which required the creation of a children’s behavioral health system with its own unique core services and created a state board for oversight, is a highlight in early intervention policy from 2019 (read more about this effort in the Advocacy Spotlight on [page 10](#)).



## Examples of 2019 Legislation Addressing Early Childhood Development

STATE   BILL NUMBER	DESCRIPTION
<p><b>CO</b>   <b>HB 19-1120</b></p>	<p>An act that requires the Department of Education to create a mental health education resource bank and adopt education standards for mental health and suicide prevention, and allows for children 12 years and older to receive psychotherapy services without parental consent. Includes appropriations.</p>
<p><b>IA</b>   <b>HF 690</b></p>	<p>An act that establishes a children’s behavioral health system and a children’s behavioral health system state board, and requires certain children’s behavioral health core services be available.</p>
<p><b>ME</b>   <b>LD 997</b></p>	<p>An act that requires the establishment and implementation of an early childhood consultation program to enable providers to reduce behavioral health issues in children using low-cost strategies.</p>
<p><b>NH</b>   <b>HB 111</b></p>	<p>An act that creates a state committee to study the effect of the opioid crisis, substance abuse disorders, and mental health and behavioral problems in New Hampshire children and students.</p>
<p><b>ND</b>   <b>SB 2313</b></p>	<p>An act that calls for the development of a system to provide behavioral health services, including early intervention and recovery services, to children; the provision of mental health awareness resources to schools; and the creation of a Children’s cabinet to coordinate care across state government, including tribal nations.</p>
<p><b>OH</b>   <b>HB 12</b></p>	<p>An act that creates a comprehensive learning network to support young children and their families in facilitating behavioral development and to seek to reduce behavioral health disparities among young children.</p>



# Advocacy Spotlight

## IOWA

### Creating a Children’s Mental Health System in Iowa

In Iowa, caring for people with mental health conditions had traditionally been the responsibility of counties, rather than the state. This approach led to huge disparities in what services families could access based on where they lived. Many hurdles contributed to Iowa’s challenges, especially workforce shortages, as there are only 55 child psychiatrists in Iowa. NAMI Iowa Executive Director Peggy Huppert explained that this has meant families face three to four months-long waiting lists for services and traveling several hours to see a provider.

In 2019, NAMI Iowa and other advocates made the first step to address their lack of a coordinated children’s mental health system by passing a state law (HF 690) guaranteeing the development of a statewide children’s mental health system to support all Iowan families. Iowa HF 690 established a children’s behavioral health system, a related board and required specific services to be available statewide.

Momentum for this change first came in 2018 when Governor Kim Reynolds (R) signed an executive order to create the Children’s Mental Health Board, comprised of patient/family advocates (including NAMI Iowa), elected officials, providers, health plans and other stakeholders. Charged with creating a plan for a viable children’s behavioral health system to help families no matter where they lived in the state, the Board had a plan to take to the state legislature by December.

Ultimately, that plan became HF 690, which laid out a vision for a comprehensive children’s mental health system. Most significantly, the bill mandated a specific set of services for children that must be made available in every region of the state by set dates. The bill also mandated crisis services, which were virtually non-existent for children with behavioral health concerns, said Huppert.

HF 690 was passed with overwhelming support in both chambers. “We had the right group of people at the right time with the right amount of pressure to get it done,” said Huppert.



NAMI Iowa Executive Director Peggy Huppert (center) pictured with Iowa Governor Kim Reynolds (left) and Lieutenant Governor Adam Gregg (right).



## Advocacy Spotlight IOWA

“It is now the law in Iowa that we have a system of care for children.”

While the bill had widespread support, NAMI Iowa and their partners did encounter some opposition, including concerns on a provision to require universal behavioral health screening for children. “The stigma surrounding mental health is so strong for some communities that we had parents tell us, ‘I don’t want my kid getting any diagnosis because it will mark them for life,’” explained Huppert.

Finding funding for the new system is the most critical roadblock to implementation, and the COVID-19 pandemic will certainly have an impact. Another challenge is to hold providers, legislators and government agencies accountable to the timeline, even amid the pandemic. Huppert believes that is NAMI’s role. “We, as NAMI, have to bring up the issues that no one else will,” she said.

Despite ongoing challenges, NAMI Iowa knows that the state has taken a huge step toward ensuring children and families can access life-changing care. “It is now the law in Iowa that we have a system of care for children,” said Huppert. “By certain dates, services are to become available. They are not suggestions; they are mandates. I know that people like me and organizations like NAMI are going to continue to put pressure on regions and providers to make sure that those promises are fulfilled.”

### **NAMI Iowa’s Keys to Success**

Looking back at the passage of HF 690, NAMI Iowa shared the following advice for other mental health advocates:

#### **Go Big and Plan for the Long Haul**

Be willing to negotiate, but only when it proves absolutely necessary and not simply to make your bill’s passage more likely.

#### **Build Relationships with Legislators**

Look at your state representatives to see who has the power and influence to help you meet your goals.

#### **Recruit Powerful Allies**

Find support in your community and activate broad coalitions to help tackle issues that affect mental health.

#### **Hold Systems Accountable**

Bring the power of lived experience to the negotiating table and add oversight mechanisms into the bill language to hold key stakeholders accountable.

**Early Psychosis**

Early or first-episode psychosis (FEP) refers to when a person first shows signs of losing contact with reality, such as hallucinations or delusions. This episode of time is critical to connecting a person with potentially life-changing treatment. Sadly, this opportunity is often missed because the type of treatment most effective for FEP, known as coordinated specialty care (CSC), is not widely available. However, in 2019, Illinois and Washington sought to expand access to CSC with new laws aimed at addressing funding barriers for CSC.

**Examples of 2019 Legislation Addressing Early Psychosis**

STATE   BILL NUMBER	DESCRIPTION
<p>IL   HB 2154</p>	<p>An act that requires state regulated health insurance plans to provide coverage of coordinated specialty care for first episode psychosis treatment.</p>
<p>WA   SB 5903</p>	<p>An act that requires the state Medicaid authority to collaborate with the University of Washington and the Washington Council on Behavioral Health to develop a statewide plan to implement and finance coordinated specialty care programs in licensed or certified community behavioral health agencies.</p>

# Understanding the Issue

## Coordinated Specialty Care for First Episode Psychosis

Coordinated specialty care (CSC) for First Episode Psychosis (FEP) is a highly effective, evidence-based intervention which helps young people experiencing early psychosis reach their recovery goals. Every year, roughly 100,000 youth and young adults experience a first episode of psychosis, which can involve loss of contact with reality, such as hallucinations — seeing or hearing things that others do not — or delusions — beliefs that are not based in reality. Psychosis is often associated with schizophrenia and related mental health conditions.

Inadequate and delayed treatment can take a heavy toll on individuals and families. [Schizophrenia costs the U.S. economy an estimated \\$155.7 billion a year](#) in direct health care costs, unemployment and lost productivity for caregivers. Historically, treatment for psychosis has started only after crises — frequently long after the first episode of psychosis. At that stage, treatment is often limited to managing symptoms rather than promoting wellness.

The Recovery After Initial Schizophrenia Episode (RAISE) study by the National Institute of Mental Health (NIMH) showed that FEP programs delivering the CSC model help young people with psychosis get significantly better. This team-based model promotes early intervention and includes recovery-oriented psychotherapy, case management, medication management, family support and education, supported education and employment, and peer support services.

FEP programs delivering CSC are setting a new standard of care and are changing the trajectory of mental illness, including reducing the severity of symptoms, resulting in fewer hospitalizations, and helping young people stay in school longer, get back to work and stay socially connected.

Despite the strong research base, funding remains a challenge for FEP programs. In part due to NAMI's advocacy, the federal Community Mental Health Services Block Grant provides a base level of money for FEP programs in states. Unfortunately, that funding is not adequate to make programs readily available to all who need it. Medicaid plans and commercial health insurance typically do not cover the full cost of FEP programs, especially the critical component of supported education and employment, as well as outreach to the community. Because of this, additional funding is needed to sustain effective, evidenced-based FEP programs.

NAMI believes that every young person experiencing psychosis deserves to realize the promise of hope and recovery. States should consider dedicating general funds to expanding FEP programs, making CSC available to everyone who needs it. Additionally, states should explore innovative ways to ensure program sustainability by developing alternative payment models within state Medicaid programs and regulating coverage for CSC within commercial insurance plans (see [IL HB 2154](#)).

**For additional resources on Coordinated Specialty Care, see:**

NAMI's [First Episode Psychosis Programs: A Guide to State Expansion](#)  
NIMH's research on [Recovery After an Initial Schizophrenia Episode \(RAISE\)](#)

## Mental Health Education

Education is an essential strategy for removing the stigma associated with mental health conditions. The general lack of visibility and discussion around mental health in our society has contributed to children growing up with little or no understanding of what mental health is, how to identify symptoms, how to support their peers and, most importantly, how to manage their own thoughts and emotions.

Health education is a common component of many students' education experience. With [depression and anxiety on the rise in youth](#), incorporating mental health into health education programs, or adding stand-alone mental health curricula, is critical to support youth mental health. This is why NAMI has given priority to growing mental health education in schools as a key objective in NAMI's 2020–2025 Strategic Plan.

### **What does mental health education look like?**

Connecting youth to the right services and supports starts with teaching them how to recognize mental health challenges in themselves and others. Mental health education can teach students from an early age how to talk about mental health, how to recognize signs and symptoms of mental health challenges in themselves as well as friends and family, and where they can go for help.

Beyond mental health curricula, schools can further support students by adopting policies and training programs for staff geared toward supporting youth with mental health challenges and connecting them to services. Examples can include training school personnel on how to recognize the signs and symptoms of mental health conditions and intervene, introducing wellness programs into schools, and developing school processes for regularly notifying students and parents of available mental health resources.

## ● ● ● ● Trends in 2019 Mental Health Education Legislation

### **Mental Health Curricula**

Building up mental health education in primary and secondary schools can significantly reduce the stigma around mental illness, as well as help youth identify symptoms personally and among peers and know how to seek help. In 2019, several states required schools to incorporate mental health into their health curricula or expanded their existing mental health education requirements.

Texas's enacted SB 11 was a highlight in mental health education policy in 2019. The bill requires public school districts to add mental health and suicide prevention education to their curricula, increase school personnel's capacity to support students' mental health, and increase community-based mental health treatment for children. The law was enacted in a challenging environment that many mental

health advocates face in the wake of incidents of mass violence. Read more about this effort in the Advocacy Spotlight on [page 16](#).

### Examples of 2019 Legislation Addressing Mental Health Curricula

STATE   BILL NUMBER	DESCRIPTION
CO   HB 19-1120	An act that requires the Department of Education, upon request, to provide technical assistance to a school district in designing mental health curricula.
MN   HF 1	An act that encourages school districts and charter schools to provide mental health instruction for grades 4-12 and requires that the Commissioner of Education provide districts and charter schools with resources gathered by Minnesota mental health advocates every other year.
NV   SB 204	An act that requires health education courses include instruction on mental health.
NH   HB 131	An act that establishes a commission on mental health education and behavioral health and wellness programs in K-12 schools; the commission is responsible for expanding community and non-profit mental health services, developing threat assessment task forces, promoting evidence-based best practice suicide prevention information and more.
NH   SB 282	An act that requires school districts and chartered public schools to develop suicide prevention policies, provide training for school faculty on suicide prevention, establish a point of contact if a student is believed to be high risk, and educate students on the importance of healthy choices and warning signs of mental health issues.
NJ   S 2861	An act that ensures that students K-12 receive mental health education in conjunction with physical health education and that the curriculum also includes age-appropriate information on substance abuse.
TX   SB 11	An act that requires mental health and suicide prevention as part of the school health curriculum, among other changes.



# Advocacy Spotlight

## TEXAS

Changing School Climate with Mental Health Education

SB 11 requires that mental health be a part of students' education.

On May 18, 2018, a school shooting in Santa Fe, TX, resulted in the death of eight students and two teachers, making it the third-deadliest high school shooting in the U.S. to date. In the aftermath of such tragedies, lawmakers often turn to mental health reform, despite recent studies indicating that mental illness does not drive mass violence. Yet even in this challenging environment, NAMI Texas found success advancing student mental health while fighting stereotypes and misinformation about mental illness with Senate Bill 11 (SB 11).

During the legislative session, NAMI Texas made investing in student mental health and wellbeing a top priority. According to NAMI Texas Executive Director Greg Hansch, it was clear that “all too often, children fall through the cracks and their mental health conditions aren’t addressed until it is a crisis situation.” Research backs up this claim, showing that the delay from the onset of mental health symptoms to treatment is an average of 11 years.

SB 11 requires that mental health be a part of students’ education and school personnel be trained in how to respond to youth experiencing mental health challenges, and it also boosts the children’s mental health workforce. However, the original bill was not a “mental health” bill, it was focused on school safety, violent threats and emergencies. That changed when NAMI Texas and allied organizations succeeded in attaching several amendments to SB 11, adapted from priority bills that had died earlier in the session.

To build support for SB 11 and the need for mental health resources in schools, NAMI Texas worked with the Texas Coalition for Healthy Minds, a diverse coalition of groups dedicated to improving mental health and substance use care in Texas. NAMI Texas identified a unique role they could play in the SB 11

campaign by bringing attention to the role of parents in student mental health. NAMI Texas succeeded in getting language added to the bill that encourages schools to provide parents with mental health information and resources. To make this possible, Alissa Sughrue, Policy



Mental health advocates gather at the NAMI Texas 2019 Mental Health Capitol Day Rally.





### Advocacy Spotlight TEXAS

“This provision will help them better understand what their classmates are going through and how they can help their classmates, friends or peers access care.”

Coordinator at NAMI Texas, explained, “We had to be aggressive about it. Not because anyone was opposed, but because groups consistently forgot about the parents in this issue.”

The biggest challenge NAMI Texas had was repeatedly needing to educate legislators and their staff that mental illness does not cause violence. Attitudes started to change after a hearing on SB 11 when NAMI Texas decided to shift their messaging strategy. “Rather than talking about what does not cause violence, we decided to start talking about what is connected to violence, and that made a big difference,” Sughrue explained.

Ultimately, NAMI Texas and their partners’ advocacy transformed SB 11 from a bill that largely addressed the physical security of school buildings to a broader effort aimed at creating the best possible climate for students to learn and thrive. NAMI Texas is especially excited about the long-term impact of bringing mental health education into the schools. “[This policy change will] facilitate more understanding among public school students,” said Hansch. “They often don’t have any foundation of knowledge about mental health because it’s not something they have been educated on before. So, when they see their fellow students having a hard time, they mistake it for something else and may stigmatize and bully when their classmate/peer is struggling. This provision will help them better understand what their classmates are going through and how they can help their classmates, friends or peers access care.”

#### **NAMI Texas’ Keys to Success**

Looking back at the passage of SB 11, NAMI Texas shared the following advice for other mental health advocates:

##### **Fight Myths with Facts**

Do not allow mental illness and violence to be tied together. Relentlessly educate decision makers about mental illness and the complexities of predicting violence.

##### **Scout for Opportunities**

Look for other avenues for legislative successes if your priority bills hit a

roadblock. NAMI Texas became involved with SB 11 later in session, but they were still able to leave their mark on the bill by inserting key priorities.

##### **Reflect Marginalized Communities**

Examine policies and language for blind spots or disproportionate consequences toward marginalized communities.

**School Protocols and Staff Training**

School personnel can be critical to identifying early symptoms in students and connecting them to care. Several bills in 2019 required schools to design and implement new policies and protocols to promote their students’ mental health and wellness, as well as train school personnel on how to recognize and respond to signs of a mental health condition or crisis, including suicidal ideation.

A 2019 highlight in this area of policy was Washington’s SB 5903, which requires widespread mental health supports to be available and requires trainings for staff. Specifically, the bill requires coordination and training on behavioral health for school district staff, requires the state to provide infant and early childhood mental health consultations to parents, and requires a statewide plan to develop school-based supports for students.

**Examples of 2019 Legislation Addressing School Protocols and Staff Training**

STATE   BILL NUMBER	DESCRIPTION
CA   SB 428*	An act that requires school districts and charter schools to bi-annually notify students and parents on how to access student mental health services on campus and in the community; the bill also requires that a specific percentage of school staff receive mental and behavioral health training.
CT   SB 750	An act that creates a task force to study policies and procedures for higher education institutions regarding the availability of mental health services; the task force will also analyze the way that the institution facilitates the return of students who took a leave of absence due to mental illness and evaluate the mental health training provided to faculty and staff.
IL   SB 1731	An act that requires that every two years, school staff and administrators who work with students K-12 to undergo training to better identify warning signs of mental health conditions and at-risk behavior and to appropriately intervene.
IL   HB 2152	An act that requires each public university to implement peer support programs utilizing student peers living with mental health conditions on campus, in addition to increasing access to clinical mental health services and requiring universities to have specific policies in place to raise mental health awareness and engage students who are in need of mental health services.
NV   SB 80	An act that requires the establishment of a Handle with Care Program, which requires law enforcement officers and others to notify trained public school personnel of a child who has been exposed to a traumatic event.

\* Denotes a bill that was vetoed.

**Examples of 2019 Legislation Addressing School Protocols and Staff Training**  
*(Continued)*

STATE   BILL NUMBER	DESCRIPTION
NH   HB 131	An act that establishes a commission on mental health education and behavioral health and wellness programs in K-12 schools; the commission is responsible for expanding community and non-profit mental health services, developing threat assessment task forces, promoting evidence-based best practice suicide prevention information and more.
OR   HB 2191	An act that includes the mental or behavioral health of a student as a valid reason to be excused by a principal or teacher from school.
TX   SB 11	An act that increases teacher training on mental health and trauma-informed practices; creates a funding mechanism for schools to develop student mental health and suicide prevention strategies; requires schools to increase parental awareness and engagement on issues of mental health, suicide and substance abuse; requires the Texas Education Agency to disseminate mental health resource information to education service centers; and creates the Texas Child Mental Health Consortium.
TX   HB 19	An act that requires local mental health authorities to employ a mental health professional who would be housed at the regional education service center and serve as a resource for school districts in their region.
WA   SB 5903	An act that implements policies relating to children’s mental health including, the creation of a children’s mental health work group, behavioral health training for school district staff, a provision of mental health literacy and healthy relationship curriculum by the superintendent of the school district.

## Suicide Prevention

As the 10th leading cause of death in the United States, suicide is a national public health crisis. In 2018, 10.7 million adults seriously contemplated suicide, including 3.3 million who made suicide plans and 1.4 million who made a nonfatal suicide attempt. Although suicide is rarely caused by any single factor, experiencing a mental health or substance use condition elevates a person’s risk for suicide.

According to the CDC, rates of suicide have increased in nearly every state since 1999. Some demographic groups have seen sharper increases, with dramatic spikes in suicide rates for Black youth and in rural and frontier communities.

Many factors contribute to suicide among those with and without diagnosed mental health conditions. Regardless of an individual’s history, suicidal ideation represents a mental health crisis that requires an early and immediate mental health response with supports like crisis counseling.

### **What do suicide prevention strategies look like?**

Because there is no single cause of suicidal ideation, there are several policy strategies that have been effective in preventing suicide or reducing suicide attempts. First, state legislation may focus on reducing factors that increase risk of suicide, including creating suicide prevention programs that promote outreach and reduce isolation for at-risk students. Additionally, states have pursued strategies that promote resilience and coping strategies at all levels of society (individual, family and community). For example, recent legislation in Louisiana (HB 53) requires school staff to educate students on coping strategies and warning signs of mental health conditions and requires schools to identify a person in the school who can serve as a point of contact for at-risk students. Other bills have encouraged special training to help school personnel communicate with family members about these issues and direct families to appropriate resources.

## ●●●● Trends in 2019 Suicide Prevention Legislation

### **State Bodies to Study and Develop Suicide Prevention Strategies**

In reaction to state-level crises, states will often pursue legislation to create a cross-functional body to study the impact of the issue and explore solutions that will work within that state given its unique make-up. Responding to the growing rates of suicide, in 2019 state policymakers pursued establishing commissions and other bodies to study the issue and develop systemic suicide prevention strategies (MI SB 228 and OR SB 707). In one case, a state sought to specifically examine the issue of suicide in Black youth (NY A6740B).

## Examples of 2019 Legislation Addressing State Bodies to Study and Develop Suicide Prevention Strategies

STATE   BILL NUMBER	DESCRIPTION
MI   SB 228	An act that creates a suicide prevention commission within the Michigan Department of Health and Human Services and describes its duties.
NY   A6740B*	An act that establishes a suicide prevention task force to study current mental health practices and prevention models for Black youth, recommend practices to increase effectiveness, determine potential reasons for the high number of Black youth suicides, and provide a report to the governor of its findings.
OR   SB 707	An act that creates a Youth Suicide Intervention and Prevention Advisory Committee to advise the Oregon Health Authority on the development and administration of strategies to address suicide intervention and prevention for children and youth 10–24 years of age.

\* Denotes a bill that was vetoed.

### **Suicide Prevention Training**

Suicide rates for young adults are particularly high, with suicide being the second-leading cause of death for people aged 10–34 years old. As a result, state policymakers worked in 2019 to implement trainings on how to recognize and respond to the warning signs of suicide for students and school personnel in primary and secondary schools and higher education settings (HI SB 383; LA HB 53; NV AB 114; NV SB 204; NH SB 282; OR SB 52; and TN HB 1354). Lawmakers also focused on suicide prevention programs for first responders (NJ A 1028 and NV SB 483). An outlier and notable highlight in suicide prevention legislative activity was Maryland’s HB 77, which decriminalized attempted suicide.

Nevada’s enacted legislation, SB 204, was a high point in suicide prevention policymaking in 2019. The legislation required a multi-faceted policy for suicide prevention to be adopted by each public and private school that will include prevention procedures, outreach and training. Implementation will be supported by a provision requiring the development of a model policy for schools to follow. More broadly, the law also adds mental health into schools’ health education courses.

## Examples of 2019 Legislation Addressing Suicide Prevention Training

STATE   BILL NUMBER	DESCRIPTION
HI   SB 383	An act that requires the development of mandatory youth suicide awareness and prevention programs for public and charter schools' teachers and school staff.
LA   HB 53	An act that requires suicide prevention training for school employees, including awareness of risk factors, communication skills with parents, and dissemination of information on mental health resources to students and families.
MD   HB 77	An act that decriminalizes attempted suicide.
NV   AB 114	An act that requires schools to report whether or not they provide mental health or suicide prevention courses, suicide prevention training for teachers and administrators and the number of incidents of suicide or attempted suicide by students.
NV   SB 204	An act that requires suicide prevention plans to be adopted by all schools, requires plans to reach out to students who are at high risk of suicide, requires health classes to include instruction on mental health, and authorizes the denial of a license to operate a private school for failure to adhere to this legislation.
NV   SB 483	An act that extends an existing State Program for Suicide Prevention to include family members of veterans, members of the military and other persons at risk of suicide in the list of persons to whom such training must be provided. Previously, the training was limited to law enforcement, health care providers and school employees.
NH   SB 282	An act that requires school districts and chartered public schools to develop suicide prevention policies, provide training for school faculty on suicide prevention, establish a point of contact if a student is believed to be high risk, educate students on the importance of healthy choices and warning signs of mental health issues and identify a person who can serve as a point of contact for at-risk students.
NJ   A 1028	An act that requires the state to create a training curriculum to prevent suicide by law enforcement officers and requires law enforcement agencies to report incidents of suicide by a law enforcement officer to the Attorney General.

**Examples of 2019 Legislation Addressing Suicide Prevention Training**  
*(Continued)*

STATE   BILL NUMBER	DESCRIPTION
OR   SB 52	<p>An act that requires that each school district adopt a policy regarding student suicide prevention for students K-12; the plan must require interventions and activities that reduce risk and promote healing, including identification of school officials who will handle reports of suicide risk, a procedure by which a person may request a school district review action of a school regarding suicide risk, and methods to address the needs of high-risk groups.</p>
TN   HB 1354	<p>An act that requires each state higher institution develop and implement a suicide prevention plan for students and faculty and provide the plan once a semester; each state higher institution may also seek help from appropriate organizations regarding the development of suicide prevention programs.</p>



## OTHER AREAS OF FOCUS

# People Get Help Early

### **Mental Health Professionals in Schools**

To bolster students' access to mental health care in educational settings (primary, secondary and higher education), some states have set minimum student-to-mental health professional ratios (KY [SB 1](#); IL [HB 2152](#); and WA [HB 1355](#)) and encouraged partnerships with local mental health treatment providers (CA [SB 75](#)).

### **Foster Care System Reform**

In 2019, states prepared for foster care system changes to implement both mandatory and optional components of the federal Family First Prevention Services Act (FFPSA), which was passed in 2018 with implementation ongoing. These changes focused on compliance with mandatory federal congregate care requirements and development of optional prevention services programs for children “at-risk” of entering foster care (CO [HB 19-1308](#); MT [HB 604](#); NH [SB 14](#); OR [SB 221](#); TX [SB 355](#); TX [SB 781](#); VT [H 532](#); WA [HB 1900](#); WV [HB 2010](#)).

### **Multi-System Youth**

Another theme of 2019 state policymaking was to study the unique needs of multi-system youth (ND [SB 2313](#)) and several efforts to support youth in the juvenile justice system specifically. This included state legislation clarifying the civil rights of justice-involved youth (IL [HB 2649](#)); defining acceptable standards for holding, incarcerating and discharging juveniles (MS [SB 2840](#)); and establishing requirements for justice-involved juveniles' access to mental health treatment and other programming (IL [HB 3704](#) and NH [SB 14](#)). Other notable bills increased resources for homeless youth (CA [AB 1235](#)) and youth that had been sex-trafficked (MS [HB 571](#)).

**NOTE:** Any bills listed in the section are not included in the Bill Reference Resource. Use links for more information.



# 2

## People Get the Best Possible Care

One in five adults in the U.S. experiences a mental health condition, but less than half receive treatment. NAMI's priority that every person “get the best possible care” means that comprehensive mental health care should be the standard for everyone in our country, with access to quality treatment when and where people need it.

When people get the best possible care, they have health insurance that includes parity coverage of mental health and substance use care. They are also able to access a full continuum of culturally competent mental health services and treatment options. To do that, NAMI supports policies that expand the mental health workforce and inclusion of peers and families in decisions that impact them.

In this section, we focus on legislation in six areas of focus:

- 1. *Medicaid and State-Regulated Health Insurance Coverage***
- 2. *Mental Health and Substance Use Parity***
- 3. *Medication Access***
- 4. *Continuum of Mental Health Services***
- 5. *Mental Health Workforce***
- 6. *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.

## Medicaid and State-Regulated Health Insurance Coverage

NAMI believes that all people with mental health conditions deserve accessible, affordable and comprehensive health care. This is critical for individuals with mental health conditions to access care for both their mental and physical health needs. There are a variety of types of insurance coverage, governed by both federal and state governments. States play a significant role in Medicaid plans, as well as fully insured health benefit plans and state employee health benefit plans (collectively referred to as “state-regulated coverage” in this report).

Medicaid is the public health insurance program for individuals with low income and is the single largest payer of mental health services in the U.S. In fact, Medicaid covers more than one in four non-elderly adults with serious mental illness. While Medicaid benefits vary from state to state, Medicaid plans usually offer more comprehensive mental health benefits than private insurers. And more people have been able to get Medicaid coverage in recent years due to the Affordable Care Act (ACA), which made Medicaid expansion possible.

State-regulated plans represent a significant portion of the private health insurance market. The most common examples of state-regulated plans include individual and small group plans, such as those available on the federal health insurance exchange (Healthcare.gov) and state-based exchanges.

### **What should health insurance coverage for mental health care look like?**

Every health plan should include mental health benefits that are comprehensive, accessible and affordable — and covered at parity with other types of health care benefits. Mental health benefits should cover a range of mental health services spanning from outpatient to acute care, and an extensive variety of mental health professionals should be covered. Coverage should be barrier-free, meaning individuals should not have to jump through any administrative hurdles, such as work requirements, to sign up or maintain their coverage.

## ● ● ● ● Trends in 2019 Medicaid and State-Regulated Health Insurance Coverage Legislation

### **Medicaid Coverage**

To date, 39 states (including Washington, DC) have expanded Medicaid as allowed in the ACA. Medicaid expansion has proven to be a critical source of coverage and care for persons with mental health conditions.

Sadly, most of the legislative action in 2019 on Medicaid expansion involved state legislatures pursuing only limited expansions, including some that rolled back voter-approved full Medicaid expansion, while other bills would have restricted access to

services by adding barriers such as work requirements. [NAMI opposes any effort to take Medicaid coverage away from people who do not meet a work requirement.](#) Instead, [NAMI urges all states to expand Medicaid](#), as indicated in the ACA, to ensure more people with mental health conditions have access to essential health care services and supports.

In 2019, Tennessee sought to become the first state to condense their Medicaid funding into a block grant with HB 1280 and a subsequent waiver proposal. NAMI [opposes block grants or per-capita caps in Medicaid](#), which impose financing limits that jeopardize coverage and services for individuals with mental health conditions. Read more about the impact of block grants and NAMI Tennessee’s efforts to protect Medicaid funding in the Advocacy Spotlight on [page 28](#).

One notable exception and positive development in Medicaid legislation in 2019 was North Dakota’s SB 2012. Not only did the bill extend the state’s Medicaid expansion program through July 2021, the bill expanded the number of Medicaid-covered mental health services and mental health professionals to better serve people with serious mental illness.

### Example of 2019 Legislation Addressing Medicaid Coverage

STATE   BILL NUMBER	DESCRIPTION
<div data-bbox="196 1310 457 1354"> <span>ND</span>   <span>SB 2012</span> </div>	<p>An act that extends the existing Medicaid expansion program through July 2021; creates a community behavioral health program to provide comprehensive community-based services; and establishes a peer support specialist certification.</p>



# Advocacy Spotlight

## TENNESSEE

Don't Cap Our Care: Protecting Medicaid as a Mental Health Lifeline

Medicaid is one of the most important pathways for people to receive mental health care. Medicaid is traditionally funded with an open-ended funding formula that allows the program to easily expand to serve those in need. Yet in 2019, Tennessee became the first state in the nation to take a step toward forgoing the traditional Medicaid funding formula and implementing a block grant, putting individuals with mental health conditions and their families at risk of losing coverage and care.

After promises from the Trump Administration to provide states with greater flexibility in running their state Medicaid programs, the Tennessee legislature passed [HB 1280](#), a bill ordering the state's Medicaid agency to seek a waiver to transform their federal Medicaid funding into a single lump-sum block grant, which would cap funds from the federal government and jeopardize care.

The resulting Medicaid waiver proposal concerned health advocates across the state (and country). NAMI Tennessee got involved in the waiver process right away, realizing they brought a unique voice to the conversation by drawing attention to the mental health-specific impact of the Medicaid block grant. "I was surprised at the lack of groups that were stepping up to talk about mental health," explained NAMI Tennessee Director of Public Policy Alisa LaPolt.

NAMI Tennessee's campaign to protect Medicaid involved sending advocates to attend public hearings on the proposed waiver and offering testimony to put a spotlight on how critical Medicaid funding is to the mental health community. NAMI Tennessee leaders were strategic with their public comments, ensuring they would be heard at the first public hearing on the waiver, when there was heavy media attention. Further, to show the broad opposition to the proposal, NAMI Tennessee mobilized NAMI Affiliates to reach their local advocates, educate them on the issue and activate them to contact policymakers.

Advocates united against the block grant have faced a tough political environment, with both the governor and state legislature leaders enthusiastically supporting the block grant proposal on the argument that, if

“We have a responsibility to ensure that all individuals, regardless of income level or employment status, have access to mental health care.”



Advocates gather for NAMI Tennessee's 2019 Day at the Hill at the Tennessee State Capitol in Nashville.



## Advocacy Spotlight TENNESSEE

approved, it would offer flexibility and even generate savings. (At the time of this report, the waiver is still under review by the Centers for Medicare and Medicaid Services). However, nonpartisan analysis has consistently shown that Medicaid block grants equal Medicaid cuts. “The block grant program is capped at a certain dollar amount, and that is an incentive for the state to save money by cutting programs,” said LaPolt.

Despite the unknown outcome, NAMI Tennessee knows that their advocacy has been effective and worthwhile. LaPolt emphasized why this Medicaid fight was so important to NAMI Tennessee: “We have a responsibility to ensure that all individuals, regardless of income level or employment status, have access to mental health care.”

### **NAMI Tennessee’s Keys to Success**

Looking back at their fight to protect Medicaid, NAMI Tennessee shared the following advice for other mental health advocates:

#### **Simpler Is Better**

Simplify the issue down to its core impact so it can better resonate with both your advocates and legislators.

#### **Consider Your Word Choices**

How you talk about benefits or programs matters. Avoid using any language characterizing Medicaid as an “entitlement” or “handout.” Equate Medicaid to other types of health insurance; do not say Medicaid “beneficiary” and instead say Medicaid “enrollee” or “member.”

#### **Understand Political Realities**

Avoid burning bridges if a legislator happens to vote against your policy priorities. You may not have their support for every vote, but if you keep communication lines open and respectful, you can gain their support in the future.

#### **Seek Out Experts**

NAMI Tennessee reached out to NAMI’s national office for technical assistance in analyzing and responding to the TN waiver proposal.

**Patient Protections in State-Regulated Plans**

The ACA made vast improvements in the availability, quality and affordability of health insurance, including the expansion of mental health as an essential health benefit. However, the ACA’s future is uncertain due to a pending federal lawsuit challenging the law’s constitutionality, which is expected to be decided in spring of 2021, as well as ongoing efforts to chip away at the landmark health law. In response, states have stepped in to take preemptive action to protect individuals by incorporating important ACA consumer protections into state law.

Washington’s HB 1870 is particularly noteworthy as one of the more comprehensive state laws that preserves a wide range of ACA consumer protections, including those most vital to people with mental health conditions. Another bill to note is Maryland’s enacted SB 28, which applies mental health and substance use parity protections to short-term limited duration health plans (STLD), a type of “junk” insurance. NAMI opposes the expansion of STLD plans and has joined [a lawsuit](#) to invalidate the federal STLD insurance plan rule. To understand the dangers of STLD plans for individuals with mental health conditions, read [this factsheet](#).

**Examples of 2019 Legislation Addressing Patient Protections in State-Regulated Plans**

STATE   BILL NUMBER	DESCRIPTION
<p>MD   SB 28</p>	<p>An act that requires coverage for behavioral health disorders in short-term limited duration insurance; a health benefit plan must provide benefits of the diagnosis and treatment of mental illness, emotional disorders, drug use disorders and alcohol use disorders.</p>
<p>NV   AB 170</p>	<p>An act that requires an insurer to provide certain information relating to accessing health care services to the Office of Consumer Health Assistance; requires an insurer to offer a health benefit plan regardless of health status.</p>
<p>VT   H 524</p>	<p>An act that requires minimum essential coverage based on the criteria established in federal law; requires that applicable individuals and their dependents are covered at all times.</p>
<p>WA   HB 1870</p>	<p>An act that ensures state law is consistent with federal consumer protection laws and the Affordable Care Act.</p>

# Understanding the Issue

## ACA Consumer Protections

The Patient Protection and Affordable Care Act (ACA) of 2010 included consumer protections to help improve the quality and affordability of health insurance and ended many discriminatory practices. These protections have helped people with mental health conditions gain comprehensive health coverage and receive mental health services.

Before the ACA, state laws had a patchwork of protections that left large gaps in coverage, especially for people who didn't have employer-based insurance. Policies in the individual or small group insurance market covered fewer benefits and were more expensive, with few states requiring health plans to cover mental health services. Health insurers could deny or cancel health insurance because of having a mental health condition, or charge people more for their coverage. This meant that many people with preexisting conditions, such as mental health conditions or substance use disorders, could not afford private health insurance, and if they could, mental health coverage was often inadequate — if covered at all.

### The ACA changed this by:

**Expanding Medicaid coverage** for adults with incomes up to 133% of the federal poverty level.

**Mandating coverage of mental health** as one of 10 Essential Health Benefits in many health plans.

**Applying mental health and substance use parity** protections to all new small group and individual

market plans so that coverage of mental health and substance use disorder services is on par with medical and surgical benefits.

**Ending health insurers' ability to cancel, limit, outright deny, or charge more for coverage** of people with pre-existing health conditions, including mental illness.

**Prohibiting yearly and lifetime spending caps** so that people are not cut off from critical mental health services during periods of great need.

**Extending family coverage up to age 26**, giving young adults more coverage options at a time when many mental health conditions first appear.

**Requiring coverage of a wide range of preventive services** at no out-of-pocket cost.

**Providing tax credits and cost sharing subsidies to make health insurance more affordable** for individuals and families.

These ACA protections opened the door for many people with mental health and substance use disorders to gain health coverage. For example, before the ACA, many young people were kicked off their parents' insurance by early adulthood — often a critical time when symptoms of mental illnesses can first appear. Thanks to the ACA, young adults with mental health conditions are more likely to be insured and receive care, reducing the economic and emotional burden on these young adults and their families.

# Understanding the Issue

## ACA Consumer Protections

NAMI believes that all people with mental health conditions deserve accessible, affordable and comprehensive health care. At the time of this report, the ACA remains the law of the land, but legal and regulatory efforts have weakened the law and attempted to repeal it entirely. This includes efforts to expand other forms of insurance that do not have these same consumer protections, also

called “junk insurance,” which often do not cover mental health and can leave people with few options when they need care. NAMI continues to advocate for comprehensive mental health coverage and consumer protections at the federal level and supports efforts to strengthen state-level insurance requirements, oversight and enforcement.

***For more information on how the ACA impacted health insurance for people with mental health conditions, see:***

NAMI's *What the Affordable Care Act Has Meant for People with Mental Health Conditions — And What Could Be Lost*



## Mental Health and Substance Use Parity

A person's health insurance plan determines what mental health services they can receive, how much those services will cost and which mental health providers they can see. Too often, health insurance covers mental health care differently than other types of medical services, creating barriers to affordable, accessible mental health care and reinforcing a stigma around mental illness and seeking mental health treatment.

Parity is the basic idea that mental health and substance use care are to be covered at the same level as care for other health conditions. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), which required plans that cover mental health and substance use care to provide equitable coverage compared to coverage of medical/surgical treatment. The ACA further expanded the impact of the federal parity law by requiring most health plans to cover mental health and substance use disorder care. To build on this, states have enacted parity legislation to expand protections and/or improve compliance and enforcement of the federal law. These efforts have helped create a more level playing field to treat mental and physical health conditions alike.

### What do state parity efforts look like?

While MHPAEA is federal law, its enforcement has largely been the responsibility of the states, namely state departments of insurance. Active implementation of parity requirements has been challenging for state regulators and insurers alike. [Insurance data shows](#) that the disparity in benefits between what the parity law requires versus what individuals can access is large and is only growing larger.

Fortunately, state policymakers and mental health advocates, including many NAMI State Organizations, have led the call for greater transparency and accountability of parity compliance to stop insurance discrimination against individuals with mental health conditions.

### ●●●● Trends in 2019 Mental Health and Substance Use Parity Legislation

A number of states in 2019 advanced or enacted legislation based on the [Kennedy Forum's model parity bill](#), which is endorsed by NAMI and other mental health and addiction advocacy organizations. The model bill establishes reporting requirements for insurers to demonstrate how they design and apply their managed care tactics and specifies how state insurance departments can implement parity and report on their activities.

An often-overlooked element of insurance coverage related to parity is network adequacy. Ideally, insurers will have robust listings of in-network providers for

individuals to easily find the right provider. However, a recent [Milliman report](#) discovered that mental health and substance use provider networks are often inadequate, forcing people to go out-of-network. Massachusetts' enacted H 4210 helps address this problem by requiring insurers to maintain more accurate information on their networks and is a highlight in parity policy from 2019 (read more about this effort in the Advocacy Spotlight on [page 35](#)).

### Examples of 2019 Legislation Addressing Mental Health and Substance Use Parity

STATE   BILL NUMBER	DESCRIPTION
CO   HB 19-1269	An act that requires full compliance with federal parity requirements in Medicaid and for certain private health plans, updates language on mental health and substance use disorders (SUD) and updates SUD coverage requirements.
DC   B22-0597	An act that requires health insurers comply with the requirements of MHPAEA; imposes annual reporting requirements on health insurers; and bars treatment limitations on the provision of benefits for mental health or substance use disorders unless certain requirements are met. <i>Note that DC B22-0597 passed in 2017 but was enacted in 2019.</i>
ME   LD 1694	An act that requires health plans to report their compliance with MHPAEA to the Bureau of Insurance and specifies how the Superintendent of Insurance can monitor and then enforce parity based on these reports.
MA   H 4210	An act that ensures that accurate information concerning providers is properly listed for each network plan and requires that the provider directory be electronically available, in a searchable format, updated on a monthly basis and accessible to the general public.
NH   SB 272	An act that authorizes the insurance commissioner to enforce MHPAEA and requires the commissioner to examine and evaluate health insurers, health service corporations and health maintenance organizations for compliance.
NJ   A 2031	An act that requires certain insurers provide coverage for medically necessary behavioral health care services; prevents insurers from imposing less favorable benefit limitations on mental health and substance use disorder benefits; and requires the Department of Banking and Insurance to report publicly and to the legislature on parity compliance activities.
WY   HB 211	An act that mandates health insurance coverage parity for mental health and substance use disorders; the commissioner may promulgate reasonable rules which establish exemptions from this application.



# Advocacy Spotlight

## MASSACHUSETTS

### Getting Rid of Ghosts in Massachusetts

“Parents would look up the list of providers to help their kids. They’d call up the 50 names listed and by the end they’d just be in tears.”

Massachusetts has a serious ghost problem, but haunted houses aren’t to blame. For NAMI members, the “ghosts” are found inside their health plan.

If you have sought out mental health care by calling up your health insurance plan’s list of providers, you may have noticed that few, if any, of the providers listed are truly available. These networks — ones that appear robust on paper but, in reality, don’t exist — are called “ghost” or “phantom” networks. To address this, NAMI Massachusetts fought for [H 4210](#), a new state law aimed at eliminating ghost networks for behavioral health.

Ghost networks for mental health care are a common experience for NAMI families. “Parents would look up the list of providers to help their kids. They’d call up the 50 names listed and by the end they’d just be in tears,” explained Monica Luke, Board Member for NAMI Massachusetts. Providers listed by insurers often aren’t taking new patients, are no longer accepting that insurance, have closed or have the wrong contact information — all of which forces people to look outside of their network to receive care and causes families to pay more.

NAMI Massachusetts partnered with several groups, including the [Children’s Mental Health Campaign](#), the [Massachusetts Mental Health Coalition](#) and [Massachusetts Association for Mental Health](#), to work on state legislation to eliminate ghost networks (S 2295, which was later rolled into H 4210). This broad coalition prioritized holding insurance companies accountable for the information they provide — not only which clinicians are in-network but, more importantly, which clinicians are open to new patients.

Being part of a coalition meant sharing responsibility for the legislation’s progress. NAMI Massachusetts’ role was to ensure that the voice of lived experience would be front-and-center during the process. That meant having members from local NAMI Affiliate organizations testify during committee hearings and also building grassroots support for the bill. NAMI Massachusetts relied on digital advocacy campaigns to activate grassroots leaders and credits those campaigns for helping to get the bill over the finish line. “When our community contacts legislators, it’s much different than a provider or any other stakeholder. These services are for us,” explained Luke.



“Ghost-buster” graphic from the Children’s Mental Health Campaign used by coalition partners, including NAMI Massachusetts.



### Advocacy Spotlight MASSACHUSETTS

“When our community contacts legislators, it’s much different than a provider or any other stakeholder. These services are for us.”

Additionally, NAMI Massachusetts found a natural ally with providers’ associations, whose members had consistently struggled to get on insurance panels because they were reported as “full” by insurers. Of course, the experience of individuals and families painted a much different picture.

While the strength of the coalition got the legislation passed, implementation of the law has not been without challenges. Compared to other providers, mental health providers may not take as many patients because mental health care is time-intensive, and patients are seen frequently, often once a week or more. However, NAMI Massachusetts was able to collaborate with other members of the Massachusetts Mental Health Coalition on working with the Massachusetts Division of Insurance to prioritize implementation, as well as helping them determine what data needs to be collected to provide an accurate picture of behavioral health providers’ availability.

Despite these challenges, Luke shared that it was easy and straightforward to educate legislators and grassroots advocates on the issue. Luke said, “Once we gave folks an example of what a ghost network was, they immediately understood, probably because they’d encountered one before in their own personal life.”

#### **NAMI Massachusetts’ Keys to Success**

Looking back at the passage of H 4210, NAMI Massachusetts shared the following advice for other mental health advocates:

##### **Amplify Your Power Through Coalitions**

Partner with coalitions to expand your capacity to get things done. Often, coalition leads will produce template action alerts and other helpful resources for the benefit of all coalition members, and coalitions with diverse organizations can bring unique and powerful perspectives to the table.

##### **Seek Community Input**

Take the time to speak directly with your members to better understand what issues are affecting your specific community and learn what advocacy opportunities you might have to make an impact.

# Understanding the Issue

## The Limits of Parity Law and How to Respond

The 2008 federal parity law was an unprecedented advancement in mental health coverage and a testament to the advocates, including many NAMI leaders, that ensured its passage. Sadly, ensuring access to comprehensive mental health care is more complicated than ensuring the enforcement of this landmark law. There are limits to where parity applies, how well it can strengthen mental health benefits and the types of insurance discrimination it can address. Fortunately, states are finding solutions to these limitations.

Occasionally, the federal parity law is misrepresented as a cure-all for fixing poor insurance coverage of mental health care. That is largely based on the misconceptions that the federal parity law:

- 1) applies to all health plans and
- 2) requires coverage of all possible mental health and substance use services.

In truth, the federal parity law only applies to some health plans. Parity does not apply to Medicare plans, small group self-insured employer-based plans or Medicaid fee-for-service plans.

Additionally, parity only comes into play for plans that have or are required to offer a mental health benefit in the first place. For those plans, the parity law requires mental health coverage that is equitable to medical/surgical health coverage but does not require complete coverage. Understanding these nuances is critical in light of new federal flexibilities that allow for the expanded sale of health plans that have fewer required benefits — including plans that lack mental health benefits altogether. In

other words, as junk insurance plans have become more common, mental health parity is at risk.

Further undermining the vision set forth in the parity law is the improper use of “medical necessity” criteria. In March 2018, a federal court found that a subsidiary of UnitedHealth Group used flawed clinical criteria to deny coverage of mental health and substance use services. The court found that they repeatedly deemed mental health and substance use disorder services not “medically necessary,” despite providers’ recommendations, as a strategy for denying care to enrollees and reducing costs. This type of insurance discrimination cannot be addressed by parity strategies, as care is denied too early in the insurance review process for a parity analysis to even be done.

States can help protect consumers from these harmful practices and strengthen the reach and impact of parity laws. States can prohibit, limit or aggressively regulate the sale of junk insurance plans (for example, [MD SB 28](#) that extends parity protections to short term, limited duration plans). States can also ensure that their statutes extend parity protections to all health insurance plans within their jurisdiction (Medicaid and state-regulated plans). Finally, new strategies are emerging for addressing mental health and substance use disorder insurance discrimination based on medical necessity criteria. California’s [SB 855](#), enacted in 2020, is one such trailblazing measure that specifies medical necessity criteria must be based on generally accepted standards of care and that all medically necessary mental health services must be covered by insurance.

## Medication Access

Although it may not always be a part of an individual's mental health treatment, medication can be a valuable tool in a person's recovery. Access to prescription medications is essential for many people to successfully manage their mental health condition. For individuals who take medications, one size does not fit all. Mental health medications affect people in different ways, and individuals need to be able to use a medication that works best for them.

Research has found that medication access issues for individuals with mental health conditions result in the worsening of symptoms and increased psychiatric hospitalizations and emergency department visits.

Unfortunately, many barriers often make it harder for individuals to get their prescriptions. Common barriers include step therapy (or "fail first") protocols, prior authorization requirements and preferred drug lists or formulary restrictions. These obstacles can block or delay needed treatment, as well as increase the administrative burden on providers.

### **What does protecting medication access look like?**

Protecting medication access is about ensuring the fewest possible barriers come between individuals and the medications that they need. If barriers are in place, such as step therapy or prior authorization, states should require that it is clear how and why those processes are applied, how prescribers and patients can request an exemption from the process if needed, and that psychiatric medications be exempted from these processes as much as possible. For psychiatric medications, it's also important, regardless of what type of health plan, that formularies be as open as possible and psychiatric medications be categorically excluded from preferred drug lists, which limit patients to certain drugs within the same class.

### ●●●● **Trends in 2019 Medication Access Legislation**

Step therapy reform was the biggest legislative trend in improving access to medications for mental health conditions at the state level in 2019. Step therapy policies are especially harmful to people with mental health conditions. (Read our "Understanding the Issue" on [page 40](#) to better understand the impact of step therapy on the mental health community and state spending.)

Reform efforts in 2019 focused on limiting the use of step therapy, establishing a clear and timely process for patients to request a step therapy exemption from their insurer, and ensuring that patients who are successfully using a specific medication are not forced to switch.

Oklahoma’s 2019 bipartisan step therapy law (OK SB 509) was particularly effective. The legislation requires health plans to establish step therapy guidelines based on clinical practice standards, and it also requires processes for exemptions to be created for any drug subjected to step therapy protocols.

Other trends that improved medication access included establishing clear exemptions from and timelines for prior authorization processes (MD HB 751) and limiting out-of-pocket drug costs for patients with chronic conditions, including mental health conditions (NJ A 2431).

### Examples of 2019 Legislation Addressing Medication Access

Note some of the bills in this table did not meet “Passed Second Chamber” threshold.

STATE   BILL NUMBER	DESCRIPTION
<div style="border: 1px solid #00968f; border-radius: 15px; padding: 5px; display: inline-block;"> <span style="margin-right: 10px;">DE</span> <span>HB 105</span> </div>	<p>An act that allows patients and prescribing practitioners to have a clear, readily accessible and convenient process to request a step therapy exception determination.</p>
<div style="border: 1px solid #00968f; border-radius: 15px; padding: 5px; display: inline-block;"> <span style="margin-right: 10px;">KS</span> <span>SB 93</span> </div>	<p>An act that requires health insurance plans to consider available and recognized evidence-based and peer-reviewed clinical practice guidelines when establishing step therapy protocols; requires health insurance plans to provide any clinical review criteria applicable to a specific prescription drug covered by the plan; and requires access for patients and prescribers to a clear and readily accessible process to request an exception.</p>
<div style="border: 1px solid #00968f; border-radius: 15px; padding: 5px; display: inline-block;"> <span style="margin-right: 10px;">MD</span> <span>HB 751</span> </div>	<p>An act that requires a certain entity to allow a health care provider to indicate whether a drug is to be used to treat a certain condition; prohibits an entity from requesting a reauthorization for a repeat prescription during a specific time period; and requires a detailed explanation for denial of coverage.</p>
<div style="border: 1px solid #00968f; border-radius: 15px; padding: 5px; display: inline-block;"> <span style="margin-right: 10px;">NJ</span> <span>A 2431</span> </div>	<p>An act that requires health insurers, under certain policies or contracts that provide coverage for prescription drugs, to place limitations on covered persons’ cost sharing for prescription drugs.</p>
<div style="border: 1px solid #00968f; border-radius: 15px; padding: 5px; display: inline-block;"> <span style="margin-right: 10px;">OK</span> <span>SB 509</span> </div>	<p>An act that requires insurers use clinical practice guidelines for developing step therapy protocols; requires insurers to provide a process to request a step therapy exception; and requires the step therapy exception process be posted online.</p>
<div style="border: 1px solid #00968f; border-radius: 15px; padding: 5px; display: inline-block;"> <span style="margin-right: 10px;">WA</span> <span>HB 1879</span> </div>	<p>An act that requires a prescription drug utilization management protocol be evidence-based and updated regularly; and requires that the patient and prescribing practitioner have access to a clear, readily accessible and convenient process to request an exception.</p>

# Understanding the Issue

## Step Therapy

Step therapy (also known as “fail first”) refers to an insurance practice that requires individuals to take a lower-cost drug before permitting them to take another, more expensive drug — regardless of what their physician or prescriber recommends. Used to cut costs, step therapy policies are applied when someone is seeking treatment for the first time, but they can also be applied when someone is already taking a pricier medication and doing well on it but switches their health insurance plan.

Step therapy policies are particularly harmful to people with mental health conditions for two reasons:

**Mental health conditions are complex.** Psychiatric illnesses arise from both biological and experiential factors. For example, different people with the same clinical diagnosis of “depression” may have widely different symptoms and root causes of their condition. As a result, there are no “one-size-fits-all” treatments for any mental health condition.

**Psychiatric medications are not interchangeable, even within the same drug class.** While psychiatric medications may have similar effectiveness as other drugs in the same drug class, they are unique in how they affect each person and their symptoms. The side effects also impact individuals differently.

NAMI members know all too well how common it is for people to spend weeks, months or even years trying to find the right antidepressant, antipsychotic or other psychiatric medication that helps to manage their symptoms without any intolerable side effects.

The costs of medication failure for people with mental health conditions are substantial. When individuals with mental illness are forced to try and fail on a certain medication simply because it’s cheaper, that process can have disastrous results, including an increased chance of emergency department visits, hospitalization, homelessness, incarceration or suicide.

NAMI believes that individuals deserve access to the full array of treatment options, including access to the right medication at the right time. Due to the unique harms that step therapy poses for individuals with mental health and other complex health conditions, some states have implemented reform to limit the use of step therapy. Notably, in the over 20 states that have enacted step therapy reform legislation, none have shown any actual added costs to the state as a result of that legislation (source: State Access to Innovative Medicines Coalition Step Therapy Fiscal Impact June 2020 Fact Sheet).



## Continuum of Mental Health Services

The lack of accessible services is a huge reason why 60% of people in need of mental health care never receive it. As the primary administrators of public mental health systems, state governments must figure out how to best allocate and coordinate available resources to close this treatment gap.

Fortunately, studies show that public investment in mental health services is not only effective, but a wise financial decision. For every dollar spent on community mental health services, the return on investment is many times over.

In order to meet their specific needs, individuals and families deserve choices in services, settings and providers. Yet, traditional state mental health systems and funding streams are piecemeal and fragmented, leaving huge gaps in what services are available.

### **What does a mental health continuum-of-care look like?**

An effective mental health system for individuals and families affected by mental health conditions requires a full continuum-of-care, a term which refers to the complete range of services and supports that aid in treatment. There is no single course of mental health treatment that is appropriate for all individuals; rather there are many pathways to the successful management of mental health conditions. Read more about the distinct elements in a continuum-of-care in our “Understanding the Issue” on page 43.

### **Trends in 2019 Continuum of Mental Health Services Legislation**

While mental health systems often have many gaps, crisis services and intensive services are especially hard to access. In 2019, lawmakers sought to fill common mental health service gaps — such as emergency services and intermediate/intensive care for mental health — by improving health coverage for those services and by defining new types of mental health facilities and services in state law.

Of particular note is Washington’s HB 1394, which contains significant system changes to support individuals with intensive needs. The law creates a new provider type, Intensive Behavioral Health Facility (IBHF), a community-based residential treatment facility for individuals with behavioral health conditions who require care that cannot be met in other settings. This bill further creates Mental Health Drop-In Centers to provide individuals with voluntary, short-term non-crisis services. Finally, the bill aims to increase psychiatric treatment capacity in hospitals for individuals receiving treatment on an involuntary basis.

An additional effort in Texas required local mental health authorities to assess their capacity for providing a wide range of mental health services (TX SB 633).

### Examples of 2019 Legislation Addressing Continuum of Mental Health Services

Note some of the bills in this table did not meet “Passed Second Chamber” threshold.

STATE   BILL NUMBER	DESCRIPTION
CA   AB 451	An act that requires a psychiatric unit within a general acute care hospital to provide emergency services regardless of whether the facility operates as an emergency department.
MA   H 907	An act that requires insurers to allow any individual who is engaged in a continuing course of treatment with a licensed mental health provider eligible for coverage to continue treatment with said provider through an out-of-network option and restricts additional charges that can be placed on individuals for such care.
MA   H 909	An act that provides health care coverage for emergency psychiatric services to individuals who are insured under group insurance commission benefits on a non-discriminatory basis for medically necessary programs.
NH   SB 11	An act that authorizes the Department of Health and Human Services to use general surplus funds for designated receiving facilities and voluntary inpatient psychiatric admissions; requires insurers to reimburse certain facilities for emergency room boarding.
TX   SB 633	An act that increases the capacity of local mental health authorities to provide access to services in specific counties; the Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money for this specific purpose.
WA   HB 1394	An act that ensures continuum of care for behavioral health patients; authorizes the Department of Health to certify/credential Intensive Behavioral Health Treatment Facilities and Mental Health Peer Respite Centers; and establishes a pilot Mental Health Drop-In Center program.

# Understanding the Issue

## Using NAMI’s Mental Health Ecosystem to Identify Service Gaps

Mental health care does not always begin and end in the mental health system. Due to the high rate of justice system involvement for people with mental health conditions, advocates, mental health professionals and law enforcement must partner to divert people with mental illness from the criminal justice system. While many of these efforts have improved responses to people experiencing a mental health crisis, many frontline personnel continue to ask: “Divert to what?”

NAMI developed *Divert to What? Community Services that Enhance Diversion*, a Mental Health Ecosystem framework that can be used to identify the gaps in services and opportunities that can support these efforts. The Ecosystem can be used as an advocacy tool for speaking with policymakers, but it can also be effective for collaborative groups involving law enforcement, mental health professionals, advocates, and other stakeholders committed to reducing their community’s dependence on the criminal justice system to respond to mental health issues. It identifies supports and services that are often necessary to help people with mental illness maintain their wellness, but it also acknowledges that every community’s ecosystem will look different based on needs, the resources available to meet those needs, and the existing system available to build upon.

**Services and supports in the Ecosystem are broken into four categories (peer and family supports should be available across all categories):**

**Outpatient Care** is a set of services to support people experiencing symptoms of mental health conditions in getting help early, staying in the

community and reducing their need for more intensive — and costly — services later. These services include screenings and assessments for mental health conditions, medications and medication management, cognitive and behavioral therapies, primary health care and treatment for co-occurring disorders.

**Social Support** refers to services that assist in recovery and wellness beyond just medication and cognitive therapy. Access to a safe place to live, income and a supportive community are key pillars to overall wellness. Services include transportation, income supports, housing, supported employment and education, [NAMI programs](#), case management and intensive multidisciplinary programs.

**Crisis Services** include a variety of supports that provide a safe and humane response to someone experiencing a mental health crisis. With a goal to reduce the role of law enforcement and increase connections to community-based care, crisis care should include crisis respite centers, hotlines, mobile crisis units, non-law enforcement crisis transportation and mobile outreach.

**Inpatient Care** refers to mental health care provided in a hospital or residential setting, which can reduce the stress of daily responsibilities for a period for those who require more intensive care. In addition to providing psychiatric services, services should include programming that focuses on life skills that prepare someone to return to their community. Inpatient care includes short-term inpatient care, long-term inpatient care and competency restoration services.



**For more information, visit:**  
[nami.org/divert-to-what](https://nami.org/divert-to-what)

## Mental Health Workforce

Many types of professionals deliver the evidence-based cognitive, behavioral and medication therapies that are key to mental health treatment. Those professionals include (but are not limited to): psychiatrists, psychologists, nurses, physician assistants, counselors, marriage and family therapists, social workers and peer support workers.

Unfortunately, there is a severe mental health workforce shortage in the U.S. A 2016 report from the Health Resources & Services Administration (HRSA) shows that certain areas of the country have few or no mental health or substance use disorder treatment providers at all. Workforce shortages are further intensified by problems such as high turnover and job vacancy rates, a lack of specialized providers (e.g., for children or older adults), aging workers, and low salaries and service reimbursement rates in the mental health field.

### **What does addressing the workforce shortage look like?**

To meet the increased demand for services, especially during national crises, states must invest in and support strategies to grow the workforce, train talented professionals and retain their skills within the mental health system. This can include addressing licensure rules, offering financial incentives and expanding the workforce through peer support specialists.

## ●●●● Trends in 2019 Mental Health Workforce Legislation

### **Licensure and Practice Rules**

To address workforce shortages, states have bolstered their mental health workforce with changes to mental health professionals' licensure and practice rules. These changes include: making out-of-state providers available with licensure reciprocity agreements (GA HB 26; KY SB 22; ND SB 2012; and WA SB 5054); creating new licensures for mental health-related professionals (NJ A 4608 and NJ A 1604); expanding/clarifying the scope of practice of specific health professionals (NH SB 225); and enabling providers to fulfill certain staffing requirements via telehealth (MD HB 570).

### Examples of 2019 Legislation Addressing Licensure and Practice Rules

STATE   BILL NUMBER	DESCRIPTION
GA   HB 26	An act that revises provisions relating to exceptions in licensure; requires criminal background checks for licensure; establishes and provides telepsychology; and enters an interstate compact known as the Psychology Interjurisdictional Compact.
KY   SB 22	An act that develops a streamlined process that allows physicians to become licensed in multiple states to enhance the portability of a medical license.
MD   HB 570	An act that requires regulations be adopted by authorizing outpatient behavioral health programs to satisfy any regulatory requirement that a medical director be onsite through the use of telehealth instead.
NH   SB 225	An act that expands the state's mental health workforce to include physician assistants, including providing reimbursement for their services and authorizing them to carry out involuntary emergency admissions examinations.
NJ   A 1604	An act that provides for the licensure of recreational therapists; upon payment to the board, a license may be granted to any person who is licensed in another state if the requirements are equivalent.
NJ   A 4608	An act that provides for the licensure of behavior analysts and establishes the State Board of Behavior Analyst Examiner.
ND   SB 2012	An act that requires behavioral health divisions to enter reciprocity agreements with others states to certify non-resident applicants as peer support specialists.
WA   SB 5054	An act that increases the behavioral health workforce by establishing a reciprocity program; allows providers with credentials in another state to practice without examination if standards in states are equivalent.

**Financial Incentives for Workforce Recruitment**

Providers report that recruiting and retaining well-trained staff is a major challenge due to low payment rates from insurers that limit the salaries they can offer potential employees. To incentivize individuals to pursue careers in mental health care and target that care to underserved populations, states have created programs that offer financial incentives, including student loan forgiveness for mental health professionals.

California’s AB 565 should be noted for adding county mental health programs as an eligible “practice setting” for an existing state loan forgiveness program. Often, mental health providers are inadvertently excluded from workforce incentive programs because the settings in which they provide care are not explicitly named as eligible sites in the original program.

**Examples of 2019 Legislation Addressing Financial Incentives for Workforce Recruitment**

*Note some of the bills in this table did not meet “Passed Second Chamber” threshold.*

STATE   BILL NUMBER	DESCRIPTION
<p>CA   AB 565</p>	<p>An act that establishes a program that provides financial incentives, including repayment of educational loans to a physician or surgeon who practices in medically underserved areas; establishes an appropriated account to provide funding for this program; and expands groups of persons eligible for financial incentives.</p>
<p>IA   HF 532</p>	<p>An act that requires the University of Iowa hospitals and clinics to give priority in awarding federal residency positions to residents of Iowa or individuals who earned degrees from Iowa and requires University of Iowa Carver College of Medicine to conduct a study related to workforce challenges regarding recruitment.</p>
<p>WA   HB 1668</p>	<p>An act that creates the Washington Health Corps, providing loan repayment and conditional scholarships, to support healthcare professionals who provide services in underserved communities. The Washington Health Corps includes a new Behavioral Health Loan Repayment Program (BHLRP). The BHLRP provides loan repayment for credentialed health care professionals who serve in underserved behavioral health areas.</p>

**Peer Support Training and Certification**

Using peer support workers to expand the mental health workforce and improve access to care has gained attention as a promising strategy across the country. Peer support workers draw upon their personal knowledge and lived experience to provide clients with education and support, make connections to other services, and promote recovery and resiliency. Depending upon their training and certification, they may provide either mental health and/or substance use support services.

In 2019, states worked to grow peer support services by establishing training and certification programs for mental health peer specialists.

**Examples of 2019 Legislation Addressing Peer Support Training and Certification**

STATE   BILL NUMBER	DESCRIPTION
CA   SB 10*	An act that requires the State Department of Health Care Services to establish by July 2020 a statewide peer support specialist certification program; requires an amendment of the Medicaid state plan to include certified peer support specialists as a provider type for Medi-Cal program.
ND   SB 2012	An act that establishes peer support specialist certification.

\* Denotes a bill that was vetoed.

## Inclusive and Culturally Competent Care

Lived experience, culture, beliefs, sexual orientation, gender identity, values, race and language all affect how individuals experience mental health conditions. In fact, cultural differences can influence what treatments, coping mechanisms and supports work for a person with a mental health condition. Moreover, no one should be subject to practices that can cause or worsen mental health symptoms. The care and treatment a person receives should not only be evidence-based, but it should also reflect a person’s culture and identity.

People with mental health conditions have always faced stigma and discrimination. More than half of individuals with a mental health condition don’t receive treatment, and members of some communities, including Black, Indigenous and People of Color (BIPOC) and LGBTQI+, face even more barriers to accessing care and effective treatments. But when a person is able to access care, and that treatment incorporates cultural needs and differences, it can significantly improve outcomes.

### **What does providing inclusive and culturally competent care look like?**

To provide effective care relevant to individuals’ experiences, states should include peers and families in any efforts to reform or change mental health systems. Inclusion of peers and families is not only important at the individual treatment level, but the voices of lived experience are also crucial to inform changes to mental health systems and can help ensure that the needs of those affected by mental illness are met. States should also work to prioritize policies that tailor mental health care to the needs of unique communities and ban discredited practices that can cause further trauma.

## Trends in Inclusive and Culturally Competent Care Legislation **Lived Experience Requirements for Advisory Bodies**

In 2019, several states commissioned formal advisory bodies to improve the state’s mental health system (such as Iowa’s efforts on children’s mental health, as noted on [page 10](#) in the Early Intervention area of focus). Many of these advisory bodies specifically require the inclusion of peers and family members with lived experience of mental health conditions. These measures showcase the community-level impact of state mental health policies and provide for greater transparency and opportunity for community input on state mental health systems.

Bringing the voice of lived experience to the policymaking table is always a best practice, no matter how broad or specific the issue. Maine’s LD 40 required family members to be part of a Commission tasked with revamping the entire system serving children with behavioral health conditions and developmental disabilities. Meanwhile, Oregon’s SB 138 required a “consumer of mental health services” or a



“family member of a consumer” to be a part of the Mental Health Clinical Advisory Group, which advises the state on medication algorithms of psychiatric medications.

Ideally, the bodies will have multiple representatives from statewide mental health advocacy organizations that include openings for both individuals with direct lived experience and the lived experience of family members/caregivers to provide the broadest possible perspective of the mental health system from the peer and family communities.

**Examples of 2019 Legislation Addressing Lived Experience Requirements for Advisory Bodies**

STATE   BILL NUMBER	DESCRIPTION
CA   AB 1352	An act that establishes a mental health board to serve in an advisory role and requires the board to review local public mental health systems and advise governing bodies; encourages governing bodies to provide mental health board budget.
IA   HF 690	An act that establishes a children’s behavioral health system and a children’s behavioral health system state board to oversee implementation of the new system.
ME   LD 40	An act that establishes the Commission to Study Children’s Mental Health to study children’s mental health and state and federal laws regarding mental health; commission’s report must be submitted in time for the following legislative session.
MI   SB 228	An act that creates a suicide prevention commission within the legislative council; designates responsibilities to certain state officers and entities; and allows the commission to research policy recommendations from relevant sources from other states in order to make recommendations to the governor on health policy.
OR   SB 138	An act that creates the Mental Health Clinical Advisory group which shall develop evidence-based mental health treatments and drugs; requires advisory group to report to interim committees on its program in developing algorithms for mental health drugs.

**Culturally Relevant Responses**

Mental health care is also more effective when it is tailored to be relevant to the culture of the people it is serving. Increasingly, there has been a state legislative focus on studying and responding to mental health concerns, particularly suicide, within the context of specific populations, including military service members and veterans (AZ HB 2488 and NV SB 483), first responders (IL HB 2766 and NJ A 1028) and African Americans (NY A 6740B\*).

**Examples of 2019 Legislation Addressing Culturally Relevant Responses**

STATE   BILL NUMBER	DESCRIPTION
AZ   HB 2488	An act that requires the Department of Health Services to compile an annual report on veteran suicides; report must not contain any personal identifiers; Department of Veterans' Services shall submit all data, including protected health information, if deemed necessary.
IL   HB 2766	An act that creates the First Responders Suicide Task Force to help reduce risk and rates of suicide; requires Task Force to issue final report by Dec 2020 and be dissolved by end of 2021.
NV   SB 483	An act that requires the Statewide Program for Suicide Prevention to include provision of suicide prevention training for family members of veterans, at-risk military members, law enforcement and other groups; and creates public awareness for issues relating to suicide prevention.
NJ   A 1028	An act that establishes a training curriculum designed to prevent suicide by law enforcement officers; training shall be made available to each state, county and municipal law enforcement department and each campus police department; training shall be administered once every five years.
NY   A 6740B*	An act that creates a Black youth suicide prevention task force that will examine and evaluate how to improve mental health and suicide prevention for Black youth.

\* Denotes a bill that was vetoed.

**Banning of Discredited Practices**

Members of the LGBTQI+ community have been subjected to a “treatment” known as conversation therapy, a discredited practice that attempts to alter a person’s gender identity and/or sexual orientation. Research shows that conversion therapy is harmful, especially for LGBTQI+ youth, and can trigger depression, anxiety or self-destructive behavior. [NAMI opposes the practice of conversation therapy](#) and applauds the states that took action in 2019 to ban it.

**Examples of 2019 Legislation Addressing Discredited Practices**

STATE   BILL NUMBER	DESCRIPTION
<p>CO   HB 19-1129</p>	<p>An act that prohibits a licensed psychiatric physician from engaging in conversion therapy with a patient under the age of 18; a licensee who engages in these practices is subject to disciplinary action.</p>
<p>HI   HB 664</p>	<p>An act that clarifies that the existing ban on sexual orientation change efforts applies to conversion therapy practices or treatments that seek to change an individual’s sexual orientation or gender identity.</p>
<p>MA   H 140</p>	<p>An act that establishes that a health care provider shall not advertise or engage in sexual orientation or gender identity change efforts with patients less than 18 years old; health care providers who violate this act shall be subject to discipline by licensing board.</p>
<p>NY   A 576</p>	<p>An act that prohibits mental health professionals from engaging in sexual orientation change efforts with patients less than 18 years old; expands definition of professional misconduct with respect to mental health professionals.</p>



## OTHER AREAS OF FOCUS

# People Get the Best Possible Care

### **Integration of Care**

In order to improve the quality of mental health care that individuals and families receive, some states focused on increasing integration between primary and mental health care (IL [SB 2085](#); WA [SB 5432](#); and WA [HB 1593](#)), including through the use of behavioral health homes (OR [SB 22](#)). Integrated health care brings specialty mental health care together with primary care to better treat the whole person and improve health outcomes.

### **Involuntary Treatment**

Regarding inpatient involuntary treatment (also known as inpatient commitment), the state of Hawaii enacted legislation to create a task force to examine existing laws and make recommendations to the legislature to reduce unnecessary emergency department admissions and improve access to the most appropriate level of care (HI [HB 1013](#)). States continue to develop policies on the use of involuntary outpatient treatment, also known as Assisted Outpatient Treatment (AOT). Building off trends from recent years, a few states expanded their commitment statutes and lowered outpatient commitment criteria (MD [SB 0403](#); UT [SB 39](#); and WA [HB 1907](#)).

**NOTE:** Any bills listed in the section are not included in the Bill Reference Resource. Use links for more information.



# 3

## **People Get Diverted from Justice System Involvement**

When people are in a mental health crisis, they frequently encounter police rather than get medical attention. As a result, people with mental illness are over-represented in the criminal justice system. On any given day, approximately 44% of people incarcerated in jails and 37% of people in state and federal prisons have a history of mental illness. Jails and prisons have become America’s de facto mental health providers but are often unable to provide adequate care as part of a system that is not built to provide health services. That’s why NAMI prioritizes diverting people with mental health conditions from justice system involvement.

Diverting people from justice system involvement ensures that mental health crises get a mental health response. Every community should have robust crisis services for people experiencing a psychiatric emergency — allowing them to receive the help they need. Communities should also prioritize diverting people with mental health conditions to treatment and services at every opportunity — before arrest, after arrest and at all points within the justice system. For those who are already justice-involved, states should prioritize efforts to connect individuals with mental health conditions to care 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 providing appropriate care to people in a mental health crisis and keeping individuals connected to care by diverting them to treatment and supports rather than incarceration.

## Crisis Response

Any mental health crisis requires a safe and humane response. When people in crises don't receive the care they need, they can instead end up in hospital emergency rooms, living on the streets, involved in the criminal justice system or losing their lives.

A mental health crisis should have a mental health response, ideally from a robust crisis care system. Sadly, people in a mental health crisis are often more likely to encounter police than to be connected to appropriate care, with tragic consequences. Receiving timely and appropriate crisis services can be the difference between life and death for individuals with serious mental illness, as nearly one in four people shot and killed by police officers since 2015 has had a mental health condition. Crisis care offers effective alternatives to a law enforcement-only response, including (but not limited to):

- Mobile crisis units
- Crisis hotlines
- Crisis centers
- Non-law enforcement crisis transportation

### **What does providing robust mental health crisis care look like?**

Mental health crisis response services should be a vital part of states' broader mental health systems. While crisis services are highly localized, state policymakers can facilitate community-level changes by requiring training and collaboration for key stakeholders and by offering funding mechanisms for desperately needed crisis services.

## ●●●● Trends in 2019 Crisis Response Legislation

### **De-Escalation Training for First Responders**

One strategy to help ensure that people in a mental health crisis do not end up in jail or prison is to provide training to first responders, primarily law enforcement, about the signs of mental health conditions and how to successfully de-escalate mental health crisis situations, often in the form of Crisis Intervention Team (CIT)-related training. In 2019, many states passed legislation to bolster their current mental health training requirements.

Note that beyond training, CIT and similar programs aim to not only train officers, but also forge ongoing partnerships between law enforcement, mental health treatment providers and the advocacy community (read more about this in our "Understanding the Issue" section on [page 58](#)).

### Examples of 2019 Legislation Addressing De-Escalation Training Efforts for First Responders

STATE   BILL NUMBER	DESCRIPTION
NV   AB 478	An act that requires that peace officers annually complete at least 12 hours of continuing education on racial profiling, mental health and officer wellbeing.
WA   HB 1064	An act that adopts annual de-escalation training and curriculum for law enforcement officers and makes de-escalation and less lethal options required as a part of law enforcement decision making.

#### **Crisis Services**

During a mental health crisis, and often after an initial law enforcement encounter, people with mental illness are too often taken to jail simply because “there’s nowhere else to go.” Unfortunately, the lack of robust crisis care means there is nowhere to divert people in a mental health crisis. To address this problem, states have passed legislation to invest in building out crisis service systems that include 24/7 crisis treatment centers, crisis lines and mobile crisis outreach teams.

By setting aside funding for mental health crisis service centers and a mobile crisis unit, New Hampshire’s enacted SB 11 was a 2019 highlight in mental health crisis services legislation. The law was enacted to help address significant psychiatric boarding. Read more about NAMI New Hampshire’s effort to draw attention to this issue in the Advocacy Spotlight on [page 56](#)).

### Examples of 2019 Legislation Addressing Crisis Services

STATE   BILL NUMBER	DESCRIPTION
MT   HB 660	An act that establishes a mobile crisis unit program; the department shall award competitive grants to local communities for establishing mobile crisis units.
NH   SB 11	An act that establishes that the Department of Health and Human Services commissioner shall solicit requests for proposals for either a fourth mobile crisis team or a second behavioral health crisis treatment center.
WI   AB 56	An act that establishes funding for mobile crisis outreach teams, regional crisis centers and crisis intervention programs.



# Advocacy Spotlight

## NEW HAMPSHIRE

Numbers Don't Lie: Addressing Psychiatric Boarding in New Hampshire

“ [Psychiatric boarding is] medically, legally, morally, ethically, and economically wrong.”

In New Hampshire, if someone goes to the emergency room because they are having a mental health crisis, they consistently find that the hospital has no inpatient capacity to treat them. While the hospital would normally transfer the patient to another hospital or center that specializes in mental health, there aren't enough beds statewide to accommodate the number of people in need. Patients are stuck waiting, with minimal care, in emergency rooms until a bed opens somewhere, a problem known as “psychiatric boarding.”

NAMI New Hampshire has been a longtime, vocal advocate against psychiatric boarding. NAMI New Hampshire Executive Director Ken Norton has described the issue as “medically, legally, morally, ethically, and economically wrong.” Through their advocacy, NAMI New Hampshire has made the issue a priority for state policymakers and successfully pressed the state to track and release data on how many people were being boarded each day.

NAMI New Hampshire and other organizations helped shape legislation, Senate Bill 11 (SB 11), to address psychiatric boarding by increasing resources for the mental health service delivery system. The legislation not only set aside funding for crisis service centers and a mobile crisis unit, but it also ensured that people who are involuntarily hospitalized receive a timely hearing. Additionally, SB 11 provided a mechanism for hospitals to be reimbursed for people who are held in emergency rooms, which NAMI New Hampshire hopes will lead to better conditions for those waiting on a bed.

NAMI New Hampshire first drew attention to this issue with a large press conference in 2013. Once the state began releasing data on how many people were being boarded, NAMI New Hampshire started posting those numbers on social media twice per week. These posts drew a lot of attention and comments, and were widely shared, which in turn garnered a lot of media attention. Norton also took this data directly to Governor Chris Sununu (R) when he took office in 2017.

SB 11 emerged in part from a 10-Year Mental Health Plan, developed by the state to increase mental health resources and quality of care. That plan came from legislation



New Hampshire Governor Chris Sununu signs SB 11 into law at NAMI New Hampshire office.





**Advocacy Spotlight  
NEW HAMPSHIRE**

The enactment of SB 11 takes an important step forward in realizing the vision of the 10-year Mental Health Plan.

NAMI New Hampshire helped craft in 2017 ([House Bill 400](#), which required creation of a new mental health plan). A delay in completion of the 10-year plan resulted in numerous mental health bills being introduced, which created confusion and conflict among advocates who had been hoping that the 10-year plan would prompt the state legislature to produce a more comprehensive reform bill.

Advocates argued whether psychiatric boarding should take top priority or if, instead, they should focus on other elements of the 10-year plan. Eventually, NAMI New Hampshire and others were able to coalesce support around SB 11 by reaffirming the commitment that they would continue to fight for all elements of the 10-year plan, including and beyond SB 11.

The enactment of SB 11 takes an important step forward in realizing the vision of the 10-Year Mental Health Plan. Although the fight for adequate crisis resources is not over, SB 11 will help “divert people from the hospital, law enforcement and incarceration,” explained Norton. He added that SB 11 was made possible by “incredible compromise, ongoing discussions and political maneuvering” by the mental health advocacy community together with legislators from both parties determined to move mental health reform forward. NAMI New Hampshire was thrilled when Governor Sununu asked if he could sign the bill at their office, and there was a big turnout of legislators, advocates, families, and people who had experienced psychiatric boarding, and media on hand as the bill was signed into law.

**NAMI New Hampshire’s Keys to Success**

Looking back at the passage of SB 11, NAMI New Hampshire shared the following advice for other mental health advocates:

**Stay on Message**

Stay united with other organizations whenever possible and emphasize commitment to common goals.

**Leverage the Power of Data**

To increase awareness and attract media attention, use clear and convincing data to illustrate the issue at hand.

# Understanding the Issue

## Involving Community Stakeholders and Building Partnerships for Crisis Response

People with mental illness are overrepresented in our nation's criminal justice system. A main contributor to this issue is the absence of comprehensive crisis systems and a reliance on law enforcement to address the needs of people experiencing a mental health crisis. But a mental health crisis deserves a mental health response, which is why many communities are developing crisis response systems to effectively divert people with mental illness away from the justice system and into mental health care.

Effective crisis response must work across systems to meet the needs of people experiencing a mental health crisis, so community partnerships involving a variety of stakeholders are essential when building a local crisis response system. Strong partnerships with key stakeholders involved can help gain buy-in for developing and sustaining a new system, help inform aspects of the new crisis system, and support the work of implementation and ongoing sustainability.

### Some key partners might include:

#### Law Enforcement

Despite the importance of reducing the role of law enforcement in mental health crisis, they are currently the primary responders to mental health crises in most communities. Their knowledge of current crisis response can be essential to identifying gaps and opportunities. There also may be instances where law enforcement will need to be part of a crisis response, so getting their buy-in early is helpful.

#### Mental Health Providers and Local Agencies

Mental health providers can provide insights into crisis response, particularly current barriers to developing and sustaining crisis services. It is also important to have leaders from local mental or behavioral health departments involved in any efforts. New services will be part of developing a crisis response system and these groups will be important in developing, operating and coordinating those services.

#### Mental Health Advocates

Many advocacy groups, such as NAMI, are already engaged in advocating for alternative crisis responses. Advocates play a key role in engaging policymakers and leaders, ensuring that resources and policies are committed to sustain the crisis response system. Advocates should not only be involved in raising awareness around the problems with the current system, but also ensuring that any response meets the needs of those with mental illness who have had direct interactions with the local crisis care system.

#### Hospitals

People in crisis are often taken to emergency rooms for evaluation and acute care, regardless of whether the hospital offers any kind of psychiatric care or not. Including hospital executives or leaders can support coordination with other health care providers to reduce delays to care for individuals in need.

#### Emergency Services

Emergency medical services (EMS), firefighters and 911 call centers can all play a role in responding to a

# Understanding the Issue

## Involving Community Stakeholders and Building Partnerships for Crisis Response

mental health crisis. Not only can they help identify current gaps and opportunities for developing a crisis response system, but their resources might also be used in a new crisis response.

Other partners to consider include leaders from homelessness services and shelters, workforce development centers or other social services providers. While they might not be involved in an

immediate crisis, the ultimate goal of robust crisis care is to help people stay in the community, and these organizations are part of ongoing care and support. Business leaders and local policymakers (such as mayors, governors, city managers or county commissioners) can also be a key to ensuring the crisis response system you are developing receives the resources it needs.

***For additional resources on partnerships or building crisis response systems, see:***

Chapters 1 and 2 of the CIT International guide, [\*Crisis Intervention Team \(CIT\) Programs: A best practice guide for transforming community responses to mental health crises\*](#)

SAMHSA's [\*National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit\*](#)

## Diversion

When individuals experiencing mental health symptoms come to the attention of law enforcement, communities should have policies and programs to divert them to treatment and other services — before arrest, after arrest and at all points in the justice system.

Two million times a year, people with serious mental illness are booked into America’s jails and prisons. Criminalizing mental health conditions is ineffective and costly for states and harmful to the individuals who are incarcerated, their family members and their community.

### **What does diversion look like?**

Helping people avoid or get out of jail and into community alternatives is a top priority for NAMI. Diversion programs can help ensure that individuals are guided to mental health services and supports as an alternative to incarceration. NAMI supports a variety of approaches to diverting individuals from unnecessary incarceration into appropriate treatment, including pre-booking (police-based) diversion, post-booking (court-based) diversion, alternative sentencing programs and post-adjudication diversion (conditional release).

## ●●●● **Trends in 2019 Diversion Legislation**

### **Mental Health Courts and Diversion Programs**

Ideally, mental health diversion takes place pre-arrest or pre-booking, so individuals avoid incarceration altogether. However, post-arrest or post-booking diversion programs are the more common type of jail diversion. Mental health courts, specialized courts that give individuals suspended sentences in exchange for completion of a court-ordered treatment plan, are an example of a post-arrest diversion program. In 2019, New Hampshire and Texas enacted legislation dedicated to creating and expanding their mental health courts. Notably, Washington increased access to pre-booking diversion with SB 5444, which gives law enforcement the authority they need to divert individuals to treatment instead of arresting them.

### Examples of 2019 Legislation Addressing Mental Health Courts and Diversion Programs

STATE   BILL NUMBER	DESCRIPTION
<p>NH   SB 51</p>	<p>An act that establishes a commission to study the expansion of the mental health court system; the commission shall submit a report of its findings on or before November 2020.</p>
<p>TX   HB 601</p>	<p>An act that clarifies procedures and reporting requirements for individuals in the criminal justice system who may have a mental illness with the aim of diverting more individuals to a mental health court or treatment program.</p>
<p>WA   SB 5444</p>	<p>An act that establishes that when a police officer has reasonable cause to believe an individual who has committed a crime suffers from a mental disorder, the police officer has the authority to and should take the individual to a crisis stabilization unit or triage facility.</p>

## Rehabilitation and Reentry

Once incarcerated, many individuals lose access to needed medications and other treatment services and end up getting worse, not better. In fact, less than half of people (45%) with a history of mental illness receive mental health treatment while held in local jails.

And individuals with a mental illness stay in jail longer than their counterparts without mental illness. They are at risk of victimization and, often, their mental health conditions can get worse.

Most of the individuals who are incarcerated are not violent criminals, and most people in jails have not even gone to trial yet, so they have not been convicted of a crime. Many others are serving short sentences for minor crimes. In addition to having inadequate access to mental health care in jail, this problem continues after individuals are released. After leaving jail, many individuals no longer have health insurance coverage and no connection to community-based health care. A criminal record often makes it hard for individuals to get a job or housing. Many individuals, especially without access to mental health services and supports, have a difficult time successfully re-entering the community and avoiding re-incarceration.

### **What does successful rehabilitation and reentry look like?**

Individuals should experience a timely competency evaluation and restoration process to reduce the amount of time spent in jail. Additionally, when individuals are in jail or prison, they should have access to needed medication and support, be exposed to opportunities to further their education and future employment opportunities, and should not be subjected to harmful practices, such as solitary confinement.

As they approach their release date, individuals should be signed up for health coverage before release, if possible, and should get extensive help planning for their basic needs to ensure they get back on track. This should include, but is not limited to, connections to a community-based mental health treatment provider (including setting up an initial appointment), safe and stable housing, income support, food assistance, and continued support with their education and finding a job.

## ●●●● **Trends in 2019 Rehabilitation and Reentry Legislation** **Competency Restoration**

For any criminal trial to move forward, courts must first determine that the defendant is competent to stand trial. For people with mental illness, they can spend months waiting for a competency evaluation and even longer for competency restoration services, which typically involves psychiatric services. This creates a

backlog of court cases and greatly extends the amount of time people with mental health conditions are forced to stay in jail.

Fortunately, states can take legislative action to create a timelier process for competency evaluations and restorations.

**Examples of 2019 Legislation Addressing Competency Restoration**

STATE   BILL NUMBER	DESCRIPTION
CO   SB 19-223	<p>An act that enables courts to order competency evaluations be conducted on an outpatient basis or at the place the defendant is in custody; if the department conducts in-custody competency evaluations, the evaluation shall begin as soon as practicable; and evaluations shall be completed within 42 days if out-of-custody.</p>
WA   SB 5444	<p>An act that provides timely competency evaluations and restoration services to persons suffering from behavioral health disorders; to be eligible for outpatient competency restoration, a defendant must adhere to medication and abstain from alcohol and unprescribed drugs.</p>

**Solitary Confinement**

Solitary confinement can trigger and worsen mental health symptoms and increases the risk of suicide and self-harm. Solitary confinement is particularly harmful for individuals with mental health conditions, and NAMI urges all federal, state and local corrections officials to use alternatives to solitary confinement for this population.

Recognizing the evidence on the dangers of solitary confinement, some states passed laws restricting its use in 2019.

**Examples of 2019 Legislation Addressing Solitary Confinement**

STATE   BILL NUMBER	DESCRIPTION
NJ   A 314	An act that declares that isolated confinement in state correctional facilities should only be used when necessary and should not be used against vulnerable populations or for time periods that foster trauma.
NM   HB 364	An act that establishes that an inmate who is younger than 18 years old or an inmate who is pregnant shall not be placed in restricted housing; an inmate with a serious mental disability shall not be placed in restricted housing; an inmate with a serious mental disability may be placed in restricted housing for no more than 48 hours if to prevent an imminent threat on the inmate or another inmate and a report must be filed.
VA   HB 1642	An act that requires the Department of Corrections to report to the General Assembly and the Governor on or before October 1 of each year certain population statistics (including mental health codes) of persons incarcerated in state correctional institutions, including certain statistics regarding offenders placed in and released from restrictive housing.
VA   SB 1777	



**Health Services for Justice-Involved Populations**

Strengthening access to health care for people who are incarcerated and re-entering the community helps to both improve their mental health and reduces the likelihood that they will return to jail or prison. In 2019, states took measures to improve the health of justice-involved populations, including by increasing reimbursement rates for health services provided in correctional settings (NC H 106), providing navigator services to those re-entering the community (WA SB 5444), and implementing changes to connect correctional health systems with community-based health care systems (OR SB 973). Additionally, Nevada became the fourth state to ban private prisons, citing concerns that for-profit correctional institutions can jeopardize inmates’ access to health care (NV AB 183).

A notable highlight for promising policy promoting health services for justice-involved individuals is Washington’s SB 5444, which created the position of Forensic Navigator. This new position is designed to help people with mental health conditions connect to services in the community with the aim of stopping the revolving door in and out of our corrections system.

**Examples of 2019 Legislation Addressing Health Services for Justice-Involved Populations**

STATE   BILL NUMBER	DESCRIPTION
NV   AB 183	An act that prohibits private entities from providing certain core correctional services in state prisons; services include housing, custody, medical and mental health treatment.
NC   H 106	An act that improves inmate health care reimbursement and establishes a telemedicine pilot program; requires departments to work together to enable social workers to qualify for and receive federal reimbursement related to Medicaid eligibility for inmates.
OR   SB 973	An act that establishes the Improving People’s Access to Community-based Treatment, Supports and Services Program which will award grants to counties and recognized Indian tribes to establish evidence-based and tribal-based programs to provide support and services within the criminal justice system.
WA   SB 5444	An act that establishes a forensic navigator (FN) position to assist people who are referred for a competency to stand trial evaluation or who are ordered to receive outpatient competency restoration.

## Conclusion

### Help NAMI Advocate for Change on Capitol Hill

Join our advocacy network at [nami.org/TakeAction](http://nami.org/TakeAction)

NAMI State Organizations fight for individuals and families affected by mental illness at your statehouse and are responsible for many of the incredible policy changes described in this report.

Find your NAMI State Organization at [nami.org/Local](http://nami.org/Local)



2019 was a very active year in state policymaking on mental health. Across the states, clear areas of progress and focus emerged. Notably, states are bringing mental health and suicide prevention into their formal education curriculums, which is a critical step forward in helping youth understand how to recognize mental health conditions and how they can find support for themselves or a loved one.

Mental health advocates also repeatedly mobilized against harmful state legislation or administrative efforts that threatened Medicaid funding for mental health services and Medicaid coverage for people with mental health conditions. At the same time, advocates were active in reforming parts of the commercial insurance markets by passing laws that mandate more active and transparent enforcement of the federal parity law.

Finally, reforming mental health crisis response was a clear priority for many states. While NAMI envisions a world in which a robust mental health crisis service system exists to support people in crisis, law enforcement officers remain the de facto response in many areas. Fortunately, states are increasingly passing legislation to create alternatives to law enforcement response, such as mobile crisis teams and crisis treatment centers.

It is worth mentioning that this report was compiled in 2020 as we experienced the outbreak of COVID-19 and a national economic downturn, making 2020 a year like no other. COVID-19 has rocked the nation's mental health with a rapid increase in the number of individuals experiencing symptoms of mental health conditions for the first time, and those with existing conditions seeing their symptoms worsen. As of this writing, the [CDC reports that one-third](#) of people in the U.S. now meet the clinical criteria for depression or anxiety.

Our nation's public health crisis goes beyond COVID-19 as we grapple with the mental health impact of not only the pandemic, but the economic crisis and recent efforts to address racial injustice. States' support of mental health will be more critical in the years to come than ever before.

NAMI's national office and NAMI State Organizations will be closely watching how states support mental health during this time and will fight to ensure that people with mental health conditions and their families have the resources they need to survive and thrive.