2022/ 2023

PUBLIC POLICY AGENDA

Mental Health America of Indiana

MENTAL HEALTH AMERICA OF INDIANA

Working for mental wellness and recovery for all Hoosiers.

A MESSAGE FROM OUR PRESIDENT

Dear Advocate,

Mental Health America of Indiana's advocacy network echoes a powerful voice for change. Thousands of individuals statewide take active roles in protecting Indiana's mental health through legislative advocacy. Because of the support of individuals like you, we won major victories at the state and local levels. We welcome you to join us in advocating for the following policy reform and continue our mission to bring victory over mental illness for all.

Stephen C. McCaffrey, JD
President and CEO, Mental Health America of Indiana

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ISSUE: ACCESS TO MEDICATIONS FOR MENTAL HEALTH AND SUBSTANCE ABUSE

STATEMENT: Access and adherence to medications is critical for people with serious mental illness and addiction. Due to research in the previous decades, new medications have been developed that can have increased adherence and thus better outcomes and fewer side effects for individuals with serious mental illness and addictive disorders. Studies have shown that by cutting reimbursement costs in mental health and substance abuse medications, states have spent more money in the long term on even more costly services, such as crisis care, residential, and hospital services. Most importantly, quality of life for individuals is impaired and the individual may not fully recover to the functioning level that they had achieved, if switching medications is required. Use of medications or procedures as part of a treatment plan to provide treatment in lieu of incarceration in the criminal justice system is most critical, while also being cognizant of preventing the diversion of inappropriate medications.

Mental Health America of Indiana will work to ensure that persons with mental illness and addictive disorders have access and coverage for the most appropriate medications, whether they are provided by Medicaid, DMHA, DOC, local jails, private insurance, or by any other payer source or in any other treatment setting. MHAI will support efforts to promote appropriate medication adherence, while at the same time work to reduce the inappropriate diversion and misuse of behavioral health medications.

PRIORITY LEVEL: I

ISSUE: FORENSIC ISSUES

STATEMENT: Individuals with mental health and addictive disorders, as well as individuals with co- occurring developmental disabilities, often fall through the cracks in our criminal justice system. Our correction facilities are often not appropriate for persons with a mental illness or addictive disorders. Diversion, when appropriate, may avoid the criminalization of mental illness and addiction and the resulting labeling that often creates barriers to housing, employment, and the ability to be a productive member of society. MHAI will advocate for a comprehensive change in our system, to provide for a continuum of mental health and addiction treatment for patients, prior to arrest or after charged, with a misdemeanor or felony, for both juveniles and adults. MHAI supports the creation of pathways for reductions in the length of probation and parole time due to the provision of behavioral supports.

The continuum should follow the sequential intercept model and must include: crisis intervention, a statewide pre- and post-diversion program with treatment for individuals, problem-solving courts, including mental health and drug courts, a statewide community corrections program with a mental health and addiction treatment component; re-entry programs, including treatment, employment, and sealing criminal records from the public when appropriate; as well as a forensic facility designed to treat forensic patients that includes access to appropriate mental health and addiction medications.

Police and correction officers must receive significant mental health and addiction education and programming, including but not limited to CIT training. Access to funding through Medicaid and other sources when permitted must be made available to ensure access to treatment through DMHA certified community-based care providers. MHAI will support a Medicaid waiver to provide behavioral health treatment reimbursement for individuals incarcerated in DOC.

ARREST AND CONVICTION ADMISSIONS

An overcrowding and an ever-expanding Department of Corrections budget is due in large part to offenders who recycle back through the system or recidivate. One of the main predictors of whether or not an ex offender will return to prison is his or her ability to get a job. Non-violent alcohol and other drug offenders often face life long barriers to securing employment due to their criminal histories. MHAI will work to improve legislation that will eliminate the barriers associated with criminal histories that prevent ex-offenders from securing employment.

AUTISM, DEVELOPMENTAL DISABILITY AND INTELLECTUAL DISABILITY

Individuals with Autism Spectrum Disorder, a Developmental Disability, or an intellectual disability, like those with mental illness or substance abuse, should be permitted to participate in a forensic diversion program. Further, a criminal court should be permitted to appoint a court appointed special advocate to assist a person with Autism or an intellectual disability who is charged with a criminal offense. MHAI will support alternatives to incarceration for persons with disabilities.

PRIORITY LEVEL: I

ISSUE: OPIOID TREATMENT

STATEMENT: Indiana and the rest of the nation, is experiencing a public health crisis. Prescription drug misuse has been declared an epidemic by the CDC and heroin use and overdoses are increasing at unacceptable levels. Individuals with opioid addiction are often unable to obtain the full continuum of services appropriate to their treatment. Those who complete detoxification tend to have longer times to relapse than those who dropout, yet most are denied coverage for inpatient detoxification services due to medical necessity provisions requiring a life-threatening situation, which opioid addiction rarely is. Inpatient methadone substitution and taper is an option not currently available for detox, but should be available in an ASAM 4.0 or 3.7 operationalized facility, as it can usually be accomplished in 5 to 7 days and has a retention rate of 80%. Outpatient detoxification takes longer to minimize withdrawal symptoms and to decrease dropout and relapse, and only about 20% complete it. Further, outpatient detox is not always an appropriate option for all patients, as inpatient might be required for a successful outcome with Medication Assisted Treatment, severe co- morbidities and/or mental illnesses, or multiple failed attempts at out- of-home detox and/or homelessness.

The opioid epidemic has criminal justice implications as well. The National Center on Addiction and Substance Abuse found that of the 2.3 million U.S. inmates, 1.5 million suffer from substance abuse addiction and another 458,000 inmates either had histories of substance abuse, were under the influence of alcohol or other drugs at the time of committing their crimes; committed their offenses to get money to buy drugs; or were incarcerated for an alcohol or drug violation. Combined, the two groups make up 85 percent of the U.S. prison population, according to the report, “Behind Bars II, Substance Abuse and America’s Prison Population.”

The report also found that alcohol and other drugs are significant factors in all crimes, including 78 percent of violent crimes, 83 percent of property crimes and 77 percent of public order, immigration, or weapons offenses as well as probation and parole violations. Many individuals released from prison are prime candidates for Medication Assisted Treatment (MAT).

MHAI supports federal Comprehensive Opioid Recovery Centers and state Comprehensive Addiction Recovery Centers to provide access to comprehensive opioid addiction treatment programs which include access to counseling, detoxification, and all FDA approved medication assisted treatment (MAT) agents including long-acting injectable medications to provide comprehensive opioid addiction treatment plans for successful recovery outcomes. This treatment must be accessible in inpatient, residential, community-based treatment, child welfare, DOC, jails as well as probation and diversion, and in all ASAM levels of care.

Opioid Treatment Centers must be integrated into the healthcare delivery system, including use of assessments, treatment plans with periodic review, therapy, all available MATs based on clinical need and informed consent. OTPs and OBOTs must be required to accept third party payors for the cost of providing medication, including written billing, credit, Medicaid/HIP,Medicare and insurance for services provided.

MHAI will also support access to abuse deterrent formulations of opioid medications to mitigate the initial opioid abuse.
Funding to the state and localities from opioid pharma settlements should be targeted to addiction and co-occurring mental illness, prevention, education, and treatment, including Opioid Use Disorder and Alcohol Use Disorder, as well as cooccurring mental health prevention, education, and treatment.

PRIORITY LEVEL: I

ISSUE: MENTAL HEALTH AND ADDICTION FUNDING

STATEMENT: By all accounts, there are many more persons in need of public services funded by the Division of Mental Health and Addiction, than are receiving services.

SED children and individuals with addictive disorders have the greatest deficits. It is imperative that the budget for the Division of Mental Health and Addiction be increased for community services. The gap that currently exists between the need and the services provided has left the system in need.

Funding should be prioritized and made available for prevention, and suicide prevention in particular. A fee charged to carriers to pay for 988 services will be critical.

Mental Health America of Indiana will work to ensure that mental health and addiction services are appropriately funded through the DMHA budget and any other funding opportunity.

PRIORITY LEVEL: I

ISSUE: SMOKE FREE AIR AND CIGARETTE TAX

STATEMENT: The incidence of smoking among those with mental illness and addictive disorders far exceeds the rates of the overall population. Secondhand smoke is a serious health hazard that causes premature death and disease. According to studies, smoke free policies decrease absenteeism among non-smoking employees, reduce maintenance costs, and lower insurance rates.

MHAI will support comprehensive legislation calling for smoke free air throughout Indiana that includes the provision of therapeutic and pharmacological interventions for persons with mental illness or addictive disorders. MHAI will also support efforts to increase the price of tobacco and e-liquid products through taxes or other means like raising the age of use of tobacco and e-liquids products to 21 in an effort to decrease utilization of all tobacco products.

PRIORITY LEVEL: I

ISSUE: UNDERAGE DRINKING

More than a quarter of the American population who are too young to drink are doing so anyway according to a new report issued today by the Substance Abuse and Mental Health Services Administration (SAMHSA). Although there has been progress in reducing the extent of underage drinking in recent years, particularly among those aged 17 and younger, therates of underage drinking are still unacceptably high. In 2016, 47% of young adults aged 18-25 were current alcohol users. Almost 63% of people ages 12-20 reported binge drinking (NSDUH, 2016).

ALCOHOL TAX
Reallocating or raising the alcohol tax is a new way to provide funding for mental health and addiction treatment. Additionally, research shows that an increase in alcohol taxes or the cost of alcoholic beverages causes a decrease in underage consumption and adult high-risk drinking. Increased taxes also lead to a decrease in alcohol-related traffic crashes, violent crimes and cases of liver cirrhosis.

Alcohol taxes have not been raised in Indiana since 1981. Adjusting for inflation, the average Indiana beer tax in 2000 was one-third of the beer tax in 1968. The more the price is increased, the greater the impact on underage drinking. Indiana is losing millions of dollars in revenue each year that the tax remains the same, resulting in inadequate funding for the enforcement of alcohol laws and the prevention and treatment of alcohol abuse.

PRIORITY LEVEL: I

ISSUE: ACCESS TO HEALTHCARE

STATEMENT: Mental Health America believes that all individuals and families should have access to a broad scope of medically appropriate, evidence-based interventions in the continuum of behavioral health services and supports, irrespective of the community, residential or inpatient setting.

Indiana--and the country as a whole--has expanded health care coverage in a way that includes Parity for mental health and addictive disorders. MHAI will support state legislative and regulatory efforts to assure the implementation of the federal parity legislation.

MHAI supports groundbreaking steps toward improving access and reimbursement for mental health and substance use disorder treatment services. Significantly, mental health and substance use disorder services are components of the essential benefits package that must be offered under the ACA. The legislation strives to have a health care system that provides a comprehensive, culturally and linguistically appropriate, behavioral health system of services and supports.

Additionally, MHA will be engaged with employers, insurers, and providers to provide for meaningful access to behavioral health coverage and services. It is critical that administrative process barriers such as prior authorization, medical necessity, limitations on medications in inpatient and residential stays are not used to inappropriately prevent access to needed behavioral health services. Access to behavioral healthcare is not a theoretical concept and must exist in reality. Individuals must not be limited due to income, disability, or geography.

Tele-behavioral health must be made available on a permanent and widespread basis and include professionals who are both licensed and certified by state agencies. This should include all forms of appropriate technological communication, including audio and video. Services should be comprehensive and connect therapy, medication and support services. To make this possible, MHAI support efforts to expand and upgrade Broadband capability statewide.

PRIORITY LEVEL: I

ISSUE: SUICIDE PREVENTION

STATEMENT: Each year in the U.S., thousands of Americans die by suicide. Suicide is the third leading cause of death for 15-to-24-year- olds, and the sixth leading cause of death for 5-to-14-year-olds.

According to the CDC, LGBTQ youth are almost five times as likely to have attempted suicide compared to heterosexual youth. From 2002 to 2006, suicide was the 3rd leading cause of death for young Hoosiers ages 15-19. According to the 2007 Youth Risk Behavioral Survey, of Indiana's 9th through 12th graders, 19.1% of girls and 12.4% of boys had seriously considered attempting suicide in the last year. However, suicide is clearly not reserved for the young, as the rate of growth of suicide for older adults and veterans is increasing at alarming rates. The lethal means affects the outcome, as men are more likely to use guns and the rates of successful attempts are greater as a result.

Mental Health America believes that many suicides are preventable and that the individual needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. Adolescents, veterans, elder Hoosiers must all be educated and trained on suicide prevention and treatment must be available when needed. MHAI supports
evidence-based suicide prevention programs to help people identify mental health problems, connect individuals with care, and de-escalate crisis situations.

PRIORITY LEVEL: I

ISSUE: DIVERSITY, EQUITY AND INCLUSION (DEI)

STATEMENT: Studies have shown that stigmatization and marginalization that is fostered by legal and social barriers to equality can have mental health consequences. These consequences can include a mental and emotional cycle of doubt, shame, self-loathing, and fear. The result is a six-fold increase in anxiety and depressive disorders and a five-fold increase in suicide attempts by gay teens.

MHAI supports a diverse, inclusive, and equitable state where all citizens, whatever their gender, race, ethnicity, national origin, age, sexual orientation or identity, education, or disability, feel valued and respected.

MHAI is committed to a nondiscriminatory approach to provide equal opportunity in every setting. We respect and value diverse life experiences and heritages and will work to ensure that all voices are valued and heard.

MHAI is committed to modeling diversity and inclusion and to maintaining an inclusive environment with equitable treatment for all.

PRIORITY LEVEL: III

ISSUE: PERINATAL SUBSTANCE ABUSE

STATEMENT: While recognizing the potential harmful effects of perinatal exposure to alcohol, opioids, and other drugs including nicotine on the health and well-being of the mother and the fetus, a multifaceted approach to the problem is required. Addiction is a brain disorder leading to compulsive use of substances, and many others may create this exposure due to a lack of awareness of what constitutes at-risk use during pregnancy.

MHAI recommends an approach that increases public education and awareness of the risk of use to the mother and fetus during pregnancy, improved screening for perinatal exposure, improved care and access to appropriate care for pregnant women who abuse substances, and appropriate medication assisted treatment for the mother and needed supports upon delivery.

MHAI would oppose punitive approaches to address this problem, as such may increase the risk to the fetus and the mother by creating a disincentive to get care and increasing the risk to both during pregnancy.

PRIORITY LEVEL: II

ISSUE: ACCESS TO MENTAL HEALTH AND ADDICTION SERVICES FOR VETERANS

STATEMENT: Indiana has the fourth largest number of National Guard members in the country. A large number of these individuals, reservists, and other members of the armed forces have served or are serving in Iraq (OIF), Afghanistan (OEF), and other war zones. Veterans frequently return home with significant mental health and substance abuse disorders including problems in readjusting to family and civilian life. Post-traumatic stress disorder (PTSD), traumatic brain injury, and suicide are major concerns.

Many are unable to access services for themselves or their families through the Veterans Health Administration (VA) and may also not qualify for Medicaid or public mental health system services. This problem is exacerbated by the overall shortage of qualified mental health and addiction professionals throughout the State and specifically professionals trained to work with veterans.

MHAI will work to ensure access to quality mental health and addiction services for all veterans through VA administered services or services provided and reimbursed outside the VA system of care.

PRIORITY LEVEL: III

ISSUE: CHILDREN'S MENTAL HEALTH AND SAFETY

STATEMENT: The statistics describing the health, mental health, and safety issues affecting today's children, toddlers, and youth under 18 years are concerning, yet represent a minute image of the overall of our priorities as a state. Parents and families still maintain the primary responsibility for ensuring healthy and safe environments that are crucial to child and youth development. However, many parents and families lack adequate support systems and financial and emotional resources to carry out this task. In a rapidly changing and demanding society where children are increasingly influenced by peers, media, technology, and negative public images, it is unrealistic to expect that even the average American family is capable of creating a thriving environment without any reliance on external formal and informal support systems in place. The state must require minimum standards to ensure prevention, mental wellness and safety in environments including schools, childcare, child welfare and any arena that the state has authority.

INFANTS AND TODDLERS

Indiana is home to 251,296 infants and toddlers, representing 3.8 percent of the state's population. As many as 47 percent live in households with incomes less than twice the federal poverty line (in 2017, about $50,000 a year for a family of four), placing them at economic disadvantage. America's youngest children are diverse and are raised in a variety of family contexts. A broad array of policies and services are required to ensure that all of them have an equitable start in life. Infants and toddlers learn through play, active exploration of their environment, and, most importantly, through interactions with the significant adults in their lives. The quality of babies' early learning experiences at home and in other care settings has a lasting impact on their preparedness for life-long learning and success. Parents who require childcare while they work or attend school need access to affordable, high-quality care options that promote positive development.

InIndiana has relatively more burdensome infant care costs, as a percentage of single parents' and married parents' incomes, in comparison to other states. Indiana does not offer a childcare subsidy for low-income parents. Mental Health America of Indiana supports a broad array of policies and services that are required to ensure that all of them have an equitable start in life.

ABUSED AND NEGLECTED CHILDREN

Abused and neglected children are the state's most vulnerable, and overwhelmingly impacted by the Indiana Department of Child Services. MHAI supports services that provide for mental health treatment services and safety.

CHILDREN'S EMOTIONAL AND BEHAVIORAL HEALTH

The prevalence of mental illness, addiction and serious emotional disorders in children and youth under age 18 is oftentimes not adequately or appropriately diagnosed. At the same time, the efficacy of early treatment services for mental illness, addiction and serious emotional disorders is proven and the benefits have been demonstrated.

Mental Health America of Indiana supports and will work to guide and create, opportunities for systematic, standardized and regular screening of children for mental illness, addiction and serious emotional disorders and youth in any and all appropriate settings including but not limited to public and private schools; child welfare; juvenile courts; and primary care settings. Any screening program must:

- Ensure that only qualified personnel conduct the screening and assessment, and develop the service program;
- Ensure that records of the screening, assessment and services are kept confidential in accordance with current privacy standards for these types of records
- Prohibit discrimination based on the screening, assessment and services.
- Require active parental consent.
- Not be used as an assessment

MHAI supports all efforts to avoid stigmatization as well as the parent's right to opt out. Once an illness is identified, treatment must also be made available.

MENTAL HEALTH AND SCHOOLS

School safety must prioritize prevention, early intervention, and treatment services as they relate to behavioral health. We know that students who are stressed or depressed may not feel safe or connected at school and may have difficulty managing their emotions—thereby affecting their ability to learn and interact as other students do. These students are also at higher risk for behavioral and disciplinary issues, bullying, substance use and dropping out of school.

According to NAMI (National Alliance on Mental Illness), 1 out of 5 children ages 13-18 have a serious mental illness. The IYI (Indiana Youth Institute) Kids Count Data from 2018 indicates that 5% of all children in Indiana have been diagnosed with depression and almost 10% have been diagnosed with an anxiety disorder. 1 out of 5 high school students in Indiana have thought about killing themselves and suicide is the second leading cause of death for students ages 14-24.

We know that adverse childhood experiences, which are stressful and traumatic incidents such as abuse or neglect, contribute to increased mental health and substance use. With many students spending more awake time at school than in their own home, the school system does and should play an integral role in ensuring that these students are receiving the mental health services they need to be successful - academically, emotionally, and socially." Secure schools" should be more than buildings with drug or firearms sniffing dogs, security systems or metal detectors. While those measures can be a crucial part of protecting our students and staff, we need to effectively address student mental health ad identify those students at higher risk —or we are not comprehensively examining school safety and potentially impacting some of the violence that has unfortunately become a part of our students' lives.

By providing the opportunity for schools to offer behavioral health programing with funding to increase capacity, schools can develop and maintain partnerships with community mental health service providers and create a safety net for those students and their families who may otherwise not receive the services they need. Most importantly, services in schools provide the opportunity for early intervention and prevention.

SECLUSION AND RESTRAINT

Each year in the Indiana, public school personnel are regularly using restraint and seclusion to control student behavior. In a survey of approximately 1351 (67%) of Indiana's public schools by the U.S. Department of Education, Indiana schools reported using mechanical restraints, seclusion or physical restraints 1650 times during the for the 2009-10 school year. Thus, in Indiana in every school day on average at least nine children were being subjected to the use of mechanical restraints, seclusion or physical restraints.

As a result of the widely recognized risks of restraint and seclusion use, Indiana passed a statewide statute and is developing regulations and policies governing the use of mechanical restraints, seclusion or physical restraint in the public-school setting. MHAI supported the legislation and is a member of the Seclusion and Restraint Commission that is developing regulations, policies and guidelines that are uniform and statewide

BULLYING

Children or adults who are bullied can experience negative physical, school, and mental health issues. Children who are bullied are more likely to experience depression and anxiety, increased feelings of sadness and loneliness, changes in sleep and eating patterns, and loss of interest in activities they used to enjoy. These issues may persist into adulthood.

Bullying can also lead to health complaints and decreased academic achievement—GPA and standardized test scores—and school participation. They are more likely to miss, skip, or drop out of school. A very small number of bullied children might retaliate through extremely violent measures.

Mental Health America continues to support legislative action and implementation to reduce bullying among children and adults.

TRAUMA-INFORMED CARE

Trauma is a near universal experience of individuals with behavioral health disorders. According to the U.S. Department of Health and Human Services Office on Women's Health, 55%--99% of women in substance use treatment and 85%--95% of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood. An individual's experience of trauma impacts every area of human functioning—physical, mental, behavioral, social, and spiritual. The economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at $161 billion in 2000. The human costs are incalculable. Mental Health America recognizes that trauma is treatable and supports efforts to expand the use of evidence-based models of care.

PRIORITY LEVEL: I

ISSUE: MENTAL HEALTH AND ADDICTION WORKFORCE DEVELOPMENT

STATEMENT: The mental health and addiction workforce has long been plagued by shortages, high turnover, and a lack of diversity. There is certainly a need to train other health care providers as well as individuals in recovery to address behavioral health needs. Indiana must strengthen recruitment, retention, and training of specialist behavioral health providers and improve the financial and technical assistance infrastructure to better support and sustain the workforce. The pressing challenge is to scale up strategies to have a meaningful impact on the size and effectiveness of the workforce in light of the implementation of the Affordable Care Act.

The aging and increasing diversity of the US population, combined with the expanded access to services that will be created by health reform, make it imperative to take immediate action. Specific emphasis should include the geriatric behavioral health workforce.

MHAI will advocate for additional university programs, creating more opportunities for career s for individuals who wish to enter the field. MHAI supports state and provider matching funds for behavioral health development programs, certificate and training of other healthcare professionals, loan forgiveness, and any other meansto address the immediate workforce shortage. Loan forgiveness must be funded, which could include licensing fees from the healthcare workforce generally—not just behavioral health. Parity in reimbursement for Addiction Counselors and Recovery Coaches as well as tele-mental health for behavioral health counselors is also a critical response to the workforce shortage

PRIORITY LEVEL: I

ISSUE: PSYCHIATRIC HOSPITALS

STATEMENT: Indiana's commitment to the provision of mental health care is stated in the Constitution. This commitment has historically taken the form of serving large numbers in state hospitals to now serving individuals in the least restrictive setting, with only a small proportion served in state institutions.

However, Indiana must ensure that consumers of mental health and addiction services have access to the full continuum of care, including inpatient psychiatric services. The state must also ensure the quality of these services and whenever appropriate, ensure that they are evidence-based.

MHAI will advocate to ensure access to appropriate and quality services. Specifically, MHAI will work to ensure that an appropriate, evidenced-based, continuum of mental health services, including addiction services, are provided by appropriately credentialed personnel for current patients and individuals for whom long term services are appropriate. Mental Health America of Indiana will advocate for the provision of services in the least restrictive setting and the appropriate use of inpatient beds. This includes competency restoration services that can be provided in the hospital setting or the community setting, whenever appropriate.

Adequate funding must be made available and all dollars generated from potential efficiencies must be reinvested in the mental health system. Evaluation measures must be put into place with appropriate metrics tied to performance and payment.

PRIORITY LEVEL: III

ISSUE: DEATH PENALTY AND PEOPLE WITH MENTAL ILLNESS

STATEMENT: The process of determining guilt and imposing sentence is necessarily more complex for individuals with mental illness. A high standard of care is essential with regard to legal representation as is a psychological/psychiatric evaluation for individuals with mental illness involved in death penalty cases. As it is the policy of our state is to treat those with mental illness, clearly mental illness should always be taken into account during all phases of a potential death penalty case. At a minimum, the death penalty should not be an option for those with severe mental illness.

MHAI will support legislation that prohibits the use of the death penalty for those with severe mental illness.

PRIORITY LEVEL: III

ISSUE: HARM REDUCTION

STATEMENT:
Harm reduction is a set of practical strategies aimed at reducing the negative consequences associated with behavioral misuse. Harm reduction incorporates a spectrum of strategies from safer use, to managed use, to abstinence to work to minimize the harmful effects of drug use, suicide, etc. Harm reduction is a fundamental strategy for many healthcare conditions and should be applied to mental illness, drug use/substance use disorders. Drug use itself is a complex, multifaceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence and some ways of using drugs are clearly safer than others. MHAI supports the non-judgmental provision of services and best practices to people who misuse drugs in order to assist them in reducing attendant harm. Suicide andOverdose deaths have reached record numbers each of last two years, it is critical that harm reduction strategies are more broadly adopted and viewed as critical a part of the continuum of care. Death due to suicide and drug use is at all time high and harm reduction strategies are proven to save lives: the most basic tenant of harm reduction. Harm Reduction needs to be mentioned/listed with prevention, education, treatment, and recovery as a key part of our systems response to behavioral health disorders, suicide and the overdose crisis.

Specifically, MHAI supports access to naloxone by individuals, family members, first responders and community organizations to reduce overdose deaths from drug abuse. MHAI will also supportsyringe service programs (SSP) when such are designed to reduce the incidence of HEP C and HIV and connect to treatment, as SSP participants are also 5x more likely to enter treatment.

MHAI recognizes that Harm Reduction is an important first step that may includes the decriminalization of some controlled substances and paraphernalia, but must be followed with comprehensive treatment and recovery as opposed to languishing in the criminal justice system. Specifically, possession of small amounts of cannabis should not be a felony offense and similarly there is concern that the felony criminalization of paraphernalia may prevent the widespread adoption of many harm reduction strategies, as they may put law enforcement and prosecutors in a position of trying to support local approved healthcare programs (SSPs) while following law.

Harm Reduction is a key part of the White House, Health and Human Services (HHS), and the Substance Abuse Mental Health Services Administration (SAMHSA) national drug strategy. Within Indiana, the Indiana Department of Health (IDOH) and Division of Mental Health and Addiction (DMHA) are embracing and implementing harm reduction strategies. Widespread community knowledge is often behind.Strategic and specific education on harm reduction is needed to health care systems, behavioral healthtreatment providers, and public safety officials.Treatment providers should have connection to harm reduction providers to help provide a safety net for patients who are not yet ready for treatment and falling through the gaps of our traditional healthcare settings/services.

PRIORITY LEVEL: II

ISSUE: RECOVERY RESIDENCES

STATEMENT: As a disease, addiction has biological, psychological, behavioral and social components. Treatment of the disease is critical, but ongoing recovery support is equally important. Recovery housing plays a vital role in the social and behavioral aspects of this disease. Maintaining abstinence for individuals in recovery from substance use is a challenging task. Post-treatment relapse rates vary across studies and definitions of relapse but often exceed 50% within 12 months of treatment. For example, one study found approximately 65% of individuals exiting substance abuse treatment did not remain abstinent two years following the end of substance abuse treatment. Among a sample of over 2,200 participants, another study found a 69% relapse rate at a one-year follow-up. A study conducted by the NIDA determined that 30-day treatment centers were approximately 30-35% more successful in treating addictions. The same study found that if clients transitioned from residential care into some form of aftercare for 6 months or more that the success rates increased to 65-70%. Recovery housing, an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Housing and Urban Development (HUD) must meet standards of quality in order to be effective. The National Alliance of Recovery Residences (NARR) has developed quality standards for recovery housing that includes comprehensive nomenclature, national standards to promote quality, and a certification program. It has 20 state affiliates, INARR (Indiana Alliance of Recovery Residences) being one through Registration as well as Certification for quality assurance and the provision of evidence based practices.

MHAI supports increased access to Recovery Residences and certification for quality assurance.

PRIORITY LEVEL: I

ISSUE: PRESCRIPTION DRUG MISUSE

STATEMENT: Nationally, deaths involving opioids have more than quadrupled since 1999. The sharp rise in opioid overdose deaths closely parallels an equally sharp increase in the prescribing of these drugs. Opioid pain reliever sales in the United States quadrupled from 1999 to 2010. Similarly, the substance use treatment admission rate for opioid abuse in 2010 was seven times higher than in 1999. Significantly, Indiana's overdose death rate for 2010 (14.4 per 100,000 population) is above the national rate (12.4 per 100,000 population). Every effort must be made to prevent the inappropriate prescribing which leads to Opioid Use Disorder. These efforts should include:

- Requiring prescribers to take continuing education courses on proper prescribing practices of opioids and the risk of dependency and addiction. Indiana is one of a handful of states which does not require continuing education as part of its medical licensing requirements;
- Requiring prescribers to discuss with their patients the addictive
- potential of opioids before prescribing. Sometimes called 'Right
- to Know,' practitioners would note in the medical record that the patient has discussed with the practitioner the risks of controlled
- substances and available alternative treatments;
- Requiring all persons with a Controlled Substance Registration (CSR) to register with INSPECT prior to their CSR renewal. Currently only about 40% of all SCR holders are registered with INSPECT.
- Require prescribers to query INSPECT every time they prescribe a controlled substance. In at least one other
- state, mandatory checks have resulted in a reduction of opioids prescribed (12-36%), a reduction in overdose hospitalizations (26%), and a reduction in prescription opioid deaths (25%).
- Require prescribers to be notified of patient overdoses.

- Create a peer review committee within INSPECT to review prescribing and dispensing data to identify prescribers who are working outside established professional standards for referral to the IPLA.
- Requiring Indiana licensing of Office Based Opiate Treatment facilities to ensure appropriate prescribing and evidence-based treatment practice protocols.

MHAI will work to ensure appropriate evidence-based prescribing of prescription opioid medications.

Priority Level: I

ISSUE: ADDICTION TREATMENT TEAMS AND ASSERTIVE COMMUNITY TREATMENT TEAMS

STATEMENT: MHAI was the leader in creating the Addiction Treatment Team model through legislation which would incentivize comprehensive treatment through professional teams, including a licensed prescriber, counselor, and certified recovery coach. These teams can operate as a mobile unit, but the funding source is limited to Recovery Works and should be expanded to Medicaid/HIP. As consumers in rural areas are relatively spread out, it becomes financially unviable to send mobile units to these Mental Health Care Professional Shortage Areas based on current reimbursement models. Expanding the funding sources for Addiction Treatment Teams and Assertive Community Treatment teams allows for greater utilization and penetration into rural and underserved areas, through an approved and existing federal program allowing service expansion to our most vulnerable Hoosiers.

MHAI will support expanding funding for Addiction Treatment Teams and Assertive Community Treatment Teams.

PRIORITY LEVEL: I

ISSUE: CANNABIS USE DISORDER

STATEMENT: Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data, in the past year, 4.2 million people ages 12 and up met criteria for a substance use disorder based on marijuana use. Marijuana's immediate effects include distorted perception, difficulty with thinking and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Chronic use can also lead to compulsive vomiting, requiring medical visits and hospitalization for Cannabinoid Hyperemesis Syndrome. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Studies show that marijuana use has been tied to psychotic behavior and may increase the likelihood of Opioid Use Disorder. Symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use. Cannabis use can be particularly damaging to young people. Still scientific studies of cannabis may yield formulations and protocols that increase its utility and decrease the potential for physical damage to the lungs and airways as well as addiction. MHAI supports scientific research to determine the potential medical benefits of cannabis available by prescription as permitted by the FDA. This does not include the illegal use of marijuana for recreational or "medical purposes".

Criminalization of drug use can be a major barrier to getting people to initiate and accept treatment. It may also affect future employment, even when the charge is on a minor.

While many American cities and states have legalized or decriminalized cannabis use and minimal possession, while retaining prohibitions of public use, only Indiana and Oregon have proposed to reduce penalties across the board for other drugs. Drug courts and other specialized treatment courts have provided an alternative to criminal sanctions, and some help for co-occurring mental health conditions. MHAI supports treatment for drug use generally (including cannabis use) in lieu of incarceration, whenever such does not pose a public safety risk.

MHAI supports the decriminalization of cannabis use such that treatment is made available in lieu of incarceration but does not support the legalization of cannabis for recreational or "medical purposes" except as approved by the FDA.

PRIORITY LEVEL: III

ISSUE: TREATMENT IN THE WORKPLACE

STATEMENT: The economic burden of substance abuse is alarming. The National Institute of Drug Abuse (2016) estimates that the total cost of substance abuse in our nation exceeds $740 billion annually. The opioid epidemic is impacting the available labor force in Indiana and thus the Gross State Product (GSP). According to national data, approximately 25% of job applicants nationwide test positive on drug tests and most are dismissed as a result.

According to an analysis by Ryan Brewer, Ph.D., MBA, Associate Professor of Finance at Indiana University-Purdue University Columbus, the direct loss to the Indiana economy arising from opiate misuse is estimated at $1.5 Billion per year. At the same time, one of the sustaining components of a successful recovery is gainful employment. Work offers the individual in recovery the opportunity to continue to make progress toward the realization of goals, improvement of familial and social relationships, rebuilding financial stability, and restoration of self-confidence, among many other benefits.

Effective recovery may very well include an individual having gainful employment, finding and keeping a job, and making a contribution to society through his or her efforts. Many workplaces sponsor Employee Assistance Programs (EAPs) that offer short-term counseling and/or assistance in linking employees with drug or alcohol problems to local treatment resources, including peer support/recovery groups.

In addition, therapeutic work environments can be helpful to provide employment for individuals in recovery improve job skills, punctuality, and other behaviors necessary for active employment throughout life. In the 2018 legislative session, the Indiana General Assembly took steps to encourage employment and recovery.

With the support of Mental Health America of Indiana, the Indiana Manufactures Association, the Indiana Chamber of Commerce, and others, language passed that would create a voluntary program for employers who wish to assist new hires and tenured employees with treatment as a condition of continued employment.

Under the bill, the Division of Mental Health and Addiction (DMHA) will provide guidelines for employer treatment programs to insure comprehensive and evidenced based treatment. DMHA will also develop and provide resources and training for employers. Further, data will be collected to monitor the effectiveness of the program.

MHAI will work to build a public private partnership with employers and employees to provide treatment and enhance recovery through clinical assessment and evaluation, education, appropriate treatment, and monitoring.

Clearly this type of program can only succeed if employers are able to consider applicants with a criminal history. MHAI will support efforts to eliminate the barriers created by a criminal history for those appropriate individuals in recovery from mental illness and substance use disorder.

PRIORITY LEVEL: I

ISSUE: ISSUE: INDIANA BEHAVIORAL HEALTH COMMISSION

STATEMENT: Mental Health America of Indiana supports the important work of the Indiana Behavioral Health Commission to improve the system of care. Areas of focus include: Assessment and Inventory; Youth and Families; Funding and Data; and System Design and Access.

Specifically, FSSA/DMHA should prioritize:

• Housing

Pay for housing supports and other Social Determinants of Health through the Medicaid program.

• Mental Health Literacy

Implement culturally competent and responsive Mental Health Literacy curriculums, trainings, and monitoring practices throughout relevant systems. Create community-level marketing campaigns, including messaging focused on those with lived experience and/or currently in recovery.

• Treatment Extenders

Develop training programming, certification and/or licensure for nonlicensed staff, and tie such certification/licensure with reimbursement rates that are sustainable for services. Maximize use of Telehealth services by adding certified individuals to the approved list of providers of mental health and addictions care via tele-health.

• Parity

Support recommendations of the Parity Committee of the Commission on Improving the Status of Children to empower parity enforcement in Indiana, looking to issues related to medical necessity, centralized credentialing, and standardization of the prior approval processes.

• Continuum

Fully endorse and certify Certified Community Behavioral Health Centers
(CCBHC) in Indiana with supported Medicaid rate/fee structure adjustment that supports cost-based reimbursement.

• Criminal Justice

Expand Crisis Intervention Training, Expand Mental Health Courts, Expand Competency Restoration and Seek Medicaid Expansion for services while incarcerated, including access to behavioral health medications, including MAT with medication adherence planning. Conduct Recidivism Studies for use with legislators and other policy makers. Expand re-entry services, including forensic peer supports. MHAI supports the creation of pathways for reductions in the length of probation and parole time due to the provision of behavioral supports.

• Children and Families

Expand access to behavioral health services for all children and families and expand prevention services and strategies.

• Workforce

Support legislation that requires the State to develop a plan for the continuation and expansion of the CCBHC grantee program, while developing infrastructure and implementation of Prospective Payment System rate methodology along with transition of all current CMHCs to the CCBHC model over a period of 3 years. CCBHC service requirements shall be considered an emerging best practice for comprehensive behavioral health service providers accredited by the Division of Mental Health & Addictions. Transition to CCBHC model implementation shall consider needed support to Medicaid Rehabilitation Option during this transition and determining where it fits within this new payor structure. Support legislation that expands military spousal licensure recognition language to behavioral health licenses issues under the State Psychology board and Behavioral health & Human Service board while simultaneously supporting the implementation of physician and psychology compacts as well as other future compacts advocated for by other IPLA recognized behavioral health professions. Support the modernization and increasing digitization of the IPLA licensing process. This approach was taken with the Indiana Bureau of Motor Vehicles with solid success.

Use Covid stimulus funds to fund tuition assistance & scholarships and loan repayment program options for behavioral health and recovery professionals including "certified" providers. Consider long-term funding through licensing fees that may increase should expanded licensure recognition. There should be an associated commitment to serve and prioritize funding based on regional needs and equity issues. Enhance recent Telehealth legislation to be inclusive of all providers recognized by the State for the purposes of certification or reimbursement. Support public-private partnership to develop awareness campaign of behavioral health workforce options starting with middle school students through State RFP process. Undertake study regarding the barrier of criminal record barriers to employment in behavioral health including certified peer recovery positions and other behavioral health professionals.

• Crisis/Suicide

Adopt Crisis Now model for Indiana's 988 system, i.e., "Someone to call; Someone to Respond; Somewhere to go. Impose a surcharge on cell carrier service

PRIORITY LEVEL: I

ISSUE: TREATMENT IN EMERGENCY SETTINGS

STATEMENT: MHAI will work to support efforts at the executive/administrative level, or the legislative level if required, to ensure that emergency departments. Recent research has shown (and presented to Governor Holcomb's Commission to Combat Drug Abuse) that nearly 65% of individuals who die from drug overdose have been in an emergency department within the year leading up to their death. Unlike most healthcare issues that have a standard of care in this setting, a standard of care for opioid use disorder and substance use disorder in emergency settings is rare. Unfortunately, research shows that less than 50% of emergency room providers feel prepared providing care for substance use disorder. This is including but not limited to evidence-based practices, recommending levels of care, or connecting to proper services.

Emergency departments are society's safety net for public health and serve as a critical access point to prevent alcohol and drug related deaths. Overdose is the number one cause of death for adults in Indianapolis, surpassing people who died from heart disease, car wrecks, or shootings. With our country experiencing an overdose epidemic that killed over 107,000 people 2021, it's hard to imaging that our emergency settings do not have a standard of care that require the use of the most effective interventions. The use of medications for opioid use disorder (MOUD) is by far the most effective intervention for reducing overdose death yet is rarely prescribed in the emergency setting. This is even more troubling now knowing the majority of those who die from overdose have been in the emergency room within the prior year. Knowing the high risk of death for this population, it is critical that emergency departments establish a standard of care that including evidence-based practices and the interventions that are associated with the greatest reduction in mortality. While MOUD is the evidence-based intervention with highest reduction in mortality, the adoption of peer support, follow up care, connection to appropriate levels of care should all be critical parts of a standard of care.

MHAI will work to support efforts at a legislative and/or administrative level to ensure that emergency departments, our societal safety net for public health and critical access point for those with SUD/AUD/OUD, develop standards of care for those with opioid use disorder and other substance use disorders. MHAI will support efforts to promote proper education for emergency department providers on levels of care, evidence-based practices, follow up services and proper connections to care. The majority of people who die of an overdose are coming to our emergency departments and MHAI will work diligently to make sure there is a standard of care in place that uses the most effective evidence-based practices.

PRIORITY LEVEL: II