2019/2020

PUBLIC POLICY AGENDA

Mental Health America of Indiana

MENTAL HEALTH AMERICA OF INDIANA

Working for mental wellness and recovery for all Hoosiers.

Mental Health America of Indiana

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 to medications is critical for people with serious mental illness and addiction. Due to research in the last decade, new medications have been developed that can have better outcomes and fewer side effects for individuals with serious mental illness and addictive disorders. Studies have shown that by cutting costs in the area of mental health and substance abuse medications, states have spent more money in the long term on even more costly services such as crisis care 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 before switching medications. Use of medications or procedures to reduce the risk of addiction or diversion for illicit activity from treatment is also critical.

Mental Health America of Indiana will work to ensure that persons with mental illness and addictive disorders have access to 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 also work to reduce the diversion and misuse of addiction medications.

PRIORITY LEVEL: I

ISSUE: FORENSIC ISSUES

STATEMENT: Individuals with mental health, addictions, 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 addictions 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 so as to provide for a continuum of mental health and addictions treatment for patients, prior to arrest or after charged, with a misdemeanor or felony, for both juveniles and adults.

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 throughMedicaid and other sources when permitted must be made available to ensure access to treatment through DMHA certified community-based care providers.

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, along with the rest of the nation, is experiencing a public health crisis. Prescription drug abuse 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 detoxification services appropriate to their treatment plan. Some are denied coverage for inpatient detoxification services due to a medical necessity provision requiring a life-threatening situation, which opioid addiction rarely is. 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.

In the years since the National Center on Addiction and Substance Abuse released its first report on substance abuse among the nation's prison population, little progress has been made in reducing the number of inmates with substance abuse problems—thus crowding the nation's prisons and jails. In fact, 65 percent of the nation's inmates met certain medical criteria for substance abuse and addiction, but only 11 percent received treatment for their addictions (The Nation's Health Online Publication). Indiana DOC estimates that over 80 percent of inmates come with a substance abuse issue.

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 access to comprehensive opioid addiction treatment programs which include access to counseling, detoxification, and medication assisted treatment (MAT) agents to provide comprehensive opioid addiction treatment plans for successful recovery outcomes.This treatment must be accessible in 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 focused on abstinence if appropriate with periodic review, therapy, all available MATs based on clinical need and informed consent and required acceptance of Medicaid/HIP and insurance for services provided. MHAI will also support access to abuse deterrent formulations of opioid medications as a means to mitigate the initial abuse.

Funding to the state from pharma settlements should be targeted to addiction treatment, including Opioid Use Disorder and Alcohol Use Disorder.

PRIORITY LEVEL: I

ISSUE: MENTAL HEALTH AND ADDICTION FUNDING

STATEMENT: By all accounts, there are many more
persons in need of services from the Division of Mental Health and Addiction up to 200% of poverty level, 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 providedhas left the system in need. Funding should be prioritized and made available for prevention, suicide prevention in particular.

Still, the total budget for State Operated facilities as compared the community mental health is well above the national average. MHAI supports redirecting funding to community-based services when community services are most appropriate.

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 t h e 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.

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 legislative and regulatory efforts to assure the implementation of the federal parity legislation.

We have taken groundbreaking steps toward improving access to mental health and substance use disorder treatment services. Significantly, we have included mental health and substance use disorder services as well as rehabilitative services as components of the essential benefits package that must be offered. We have created a health care system that provides a comprehensive, culturally and linguistically appropriate, behavioral health system of services and supports.

MHAI supports the State of Indiana's program in an effort to provide mental health and addiction services. In particular, MHAI supports the inclusion of individuals with Serious Mental Illness or chronic Substance Use Disorders access to the Medicaid Rehabilitation Option. In addition, MHAI supports CMHCs ability to make presumptive eligibility determinations under the Medicaid Program to ensure timely access of services.

Finally, MHAI supports health care service integration including the establishment of Medicaid behavioral Health Homes as well as the ability of CMHCs to bill for primary health services when ancillary to behavioral health services. Similarly, MHAI supports all forms of integrated care models on the part of private practitioners in the private insurance market.

Mental Health America of Indiana will work to educate the public through public relations and other means of advocacy regarding the need to access mental health and addiction services at parity. MHA will also work with local, state, and federal decision makers to ensure adequate representation of behavioral health interests in the implementation of any healthcare legislation.

Additionally, MHA will be engaged with employers, insurers, and providers to ensure that the implementation provides for meaningful access to behavioral health coverage and services. It is critical that administrative process barriers such as prior authorization, medical necessity, limitations on inpatient and residential length of stays, as well as work requirements 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. This should include all forms of appropriate technological communication, including audio and video. Barriers should be eliminated and permanently reflect the Executive Order during the COVID pandemic. 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 suicide is 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: NONDISCRIMINATION

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. Successful suicide amounts to a three-fold increase over their heterosexual counterparts. LGBTQ individuals exhibit a higher prevalence of excessive drug, alcohol, and tobacco use and are also over represented among the homeless population. LGBTQ individuals have a 58% incidence of sexual assault, while 66% report being verbally abused and ridiculed and 44% are physically abused at school.

According to the Family Acceptance Project, LGBTQ youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as their peers who reported no or low levels of family rejection. Constitutional bans on same-sex marriage and other laws or regulations have the effect of institutionalizing stigma and discrimination, thereby increasing the incidence of depression, anxiety and abuse. Mental Health America of Indiana would oppose a constitutional amendment and other laws that discriminate against same-sex marriage and will support legislation providing equal rights and cultural competency to promote a positive image and reduce discrimination for LGBTQ individuals as a protected class.

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

MMHAI 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. This would include the ability of master's level therapists to diagnose and develop treatment plans within their scope of practice according to their training. 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.

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 drug use. Harm reduction incorporates a spectrum of strategies from safer use, to managed use, to abstinence to work to minimize the harmful effects of drug abuse. Drug use is a complex, multi-faceted 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 use drugs and the communities in which they live in order to assist them in reducing attendant harm.

MHAI supports access to naloxone by individuals, family members, first responders and community organizations to reduce overdose deaths from drug abuse. MHAI will also support needle exchange programs when such are designed to reduce the incidence of HEP C and HIV. MHAI recognizes that Harm Reduction is an important first step that may include the decriminalization of some controlled substances and paraphernalia 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.

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.

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

PRIORITY LEVEL: I

ISSUE: PRESCRIPTION DRUG ABUSE

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 abuse 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.

PRIORITY LEVEL: I