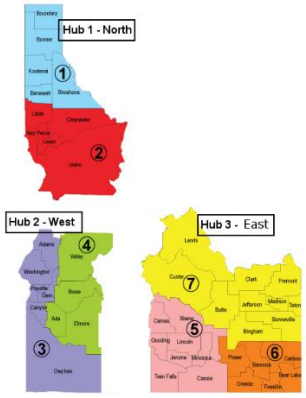
Congratulations on being elected to office. NAMI Idaho thanks you for your service to your constituents and the citizens of Idaho. This briefing is to serve as a backgrounder for you, as well as recommendations for you to use as you navigate the waters of the current state of affairs in mental illness challenges the great state of Idaho is faced with this upcoming session(s).

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. What started as a small group of families gathered around a kitchen table in 1979 has blossomed into the nation's leading voice on mental health. Today, we are an association of hundreds of local affiliates, state organizations and volunteers who work in your community to raise awareness and provide support and education that was not previously available to those in need.

NAMI Idaho was founded and incorporated in 1991 and has six affiliates in the seven regions: Far North (Hub 1, Region 1), Coeur d'Alene (Hub 1, Region 1), Treasure Valley (Hub 2, Region 4), Wood River Valley (Hub 3, Region 5), Idaho Falls (Hub 3, Region 7). Our mission is to improve the quality of life for all those affected by mental illness through support, education, advocacy and research. NAMI ID is a 501(c)(3) organization presently funded by member dues and by private donations and grants.



Our current focus follows:

1) NAMI strongly supports the voter approved ballot measure to expand Medicaid in Idaho without any burdensome requirements. Medicaid expansion will allow people with mental illness that fall in the Gap population to have access to preventive care, to have access to needed medications and treatment and therapies allowing them to better care for themselves and their families, engage with their communities and be more self-sufficient.
2) NAMI Idaho fully support adequate funding for suicide prevention. Members of NAMI have been actively participants in the Idaho Suicide Prevention Planning Team that was convened at the direction of JFAC with the intent language found in the 2019 Division of Public Health Budget. NAMI Idaho supports the Idaho Suicide Prevention Plan put forward by this Team and supports the Division of Public Health Budget request supported by Governor Brad Little to begin to implement this plan. NAMI Idaho plans to continue to participate in the implementation of the plan.

3) NAMI Idaho encourages the Division of Behavior Health to continue to expand their early intervention for First Episode Psychosis treatment to all Regions of the State.

Important Facts on Mental Illness

Mental illnesses are neither character flaws nor bad behavior, but neurobiological diseases, brain disorders, which affect an individual's behavior, functionality and human relationships. Proof of this is the fact that certain drugs help the person to function better. At the present time, mental illnesses are neither preventable nor curable. However, they are treatable and manageable with combinations of medication, supportive counseling, and community support services. The causes of mental illness are complex and currently not fully understood but there is clearly a genetic component to some serious mental illnesses. Although stress or drug and alcohol abuse can precipitate or aggravate mental illness episodes, they are not the primary causes of mental illness.

Mental Health Services in Idaho

1) Idaho citizens and their families do not have adequate access to quality, coordinated and efficient mental health and substance use disorder services. NAMI believes all children and adults living with mental illness in our state should be able to receive the right care at the right time and in the right place to maximize their potential for lives of resiliency, recovery and inclusion.

2) The state of Idaho has continued to underfund behavioral health services. Our state always ranks nationally near the bottom in per capita funding. This was worsened by the budget cuts of 2010 and other years. Although Idaho has made significant recovery from the recession, only a few service cuts have been restored. Due to lack of funding the Regional Behavioral Health Centers can often only provide services to those who are in acute crisis or ordered by the Court to receive services. This strategy limits programs and services to those persons living with mental illness to sooner achieve stability and recovery.

3) NAMI Idaho supported SB 1224A passed by the Legislature in 2014 which integrates the substance abuse and mental health system into a Behavioral Health system with Regional Behavioral Health boards. This transformation and the Regional Boards should emphasize prevention, early diagnosis and intervention, and recovery services in the community settings.

4) It is NAMI Idaho's position that:

   a) Public and private health plans should provide an essential set of effective services and supports for children, youth and adults living with mental illness and co-occurring disorders.
   b) Public and private health plans should have an adequate network of primary care and specialty
   c) Providers who are well-trained in effective and culturally competent services and supports for those living with mental illness and co-occurring disorders.
   d) Care for mental health, addictions and other medical conditions should be integrated in all public and private health care settings.

5. NAMI Idaho supports transparency and accountability in the collection and publication of meaningful performance, process and outcome measures related to Idaho's mental health system. Such data would make for better informed policy decisions and promote quality improvement. NAMI Idaho advocates for standardized statewide data collection and public reporting of process and outcomes data.

NAMI Idaho 2019 Legislative Positions

*Medicaid Expansion

The recent expansion of Medicaid to cover persons in the insurance gap, those below 100% as well as 133% of the federal poverty level, is expected to provide health care for as many as 19,000 people with mental illness who often require expensive medications, therapy, and supports in order to work. As with others in the present coverage gap, they will also be able to access care before medical conditions become an expensive crisis. The program should be implemented without burdensome reporting conditions. For instance, compliance with work requirements would require continuous monitoring for a population, many of whom have jobs which come and go, and would provide many opportunities for missed deadlines to submit proof. The administrative paperwork would also be a burden for the state. A similar problem may also exist with asset tests, which can vary with time.

*Suicide Prevention

1. Suicide is a serious, preventable public health problem that negatively affects communities, families, and individual community members.
2. Idaho suicide rate has consistently been among the highest in the Nation. It is the second leading cause of death for ages 15-34 in Idaho, Idaho was 5th highest in the nation per capita, and we lost 393 individuals to suicide in 2917.
3. The tragedy of these deaths is that lives lost to suicide may have been saved through increased awareness, education, prevention, and intervention strategies.
4. Not everyone who attempts or completes suicide has a mental illness. Although not all people with mental illnesses become suicidal, severe mental illnesses - schizophrenia, bipolar illness, and severe depression – are major risk factors for suicide.
5. "While 95 percent of individuals with a mental illness and/or substance use disorder will never complete suicide, several decades of evidence consistently suggests that as many as 90 percent of individuals who do complete suicide experience a mental or substance use disorder, or both" [1].
6. It is NAMI Idaho's position that:
   a. Suicide prevention is the responsibility of the entire community and requires vision, will, and a commitment from the state, communities and individuals of Idaho.
   b. Suicide prevention should be a part of an adequately funded and supported public and behavioral health system that addresses education, awareness, treatment and community engagement. It should include programs for communities and families with special attention paid to protect those known to be at high risk.
   c. Individuals who seek help for mental health concerns, including suicide should be encouraged and supported.
   d. Idaho should continue to support and maintain the Office of Suicide Prevention. NAMI Idaho fully supports adequate funding for suicide prevention. Members of NAMI have been actively participants in the Idaho Suicide Prevention Planning Team that was convened at the direction of JFAC with the intent language found in the 2019 Division of Public Health Budget. NAMI Idaho supports the Idaho Suicide Prevention Plan put

forward by this Team and supports the Division of Public Health Budget request supported by Governor Brad Little to begin to implement this plan. NAMI Idaho plans to continue to participate in the implementation of the plan.

e. Idaho should continue to support and maintain the Idaho Suicide Prevention Crisis Hotline.

*Early Intervention for First Episode Psychosis

In 2009, the National Institute on Mental Illness (NIMH) found evidence that early intensive and ongoing intervention programs, such as Recovery After an Initial Schizophrenia Episode (RAISE), can foster recovery and prevent the adverse outcomes and cost frequently associated with untreated psychosis.

1. Most individuals with serious mental illness, such as schizophrenia, bipolar disorder and major depression, experience the first signs of illness during adolescence or early adulthood. There are often long delays between symptoms onset and the receipt of evidence-based interventions.
2. Approximately 100,000 adolescents and young adults in the United States experience First Episode Psychosis (FEP) each year (McGrath et al., 2008), with a peak onset occurring between 15-25 years of age. Psychotic disorders such as schizophrenia can derail a young person's social, academic, and vocational development and initiate a trajectory of accumulating disability. Youth who are experiencing First episode psychosis (FEP) are often frightened and confused, and struggle to understand what is happening to them. They also present unique challenges to family members and clinical providers, including irrational behavior, aggression against self or others, difficulties in communication and relating, and conflicts with authority figures.
3. Psychiatrists have long believed that the earlier the treatment of mental illness begins, the better the outcome. Much research has been done on methods of early detection before symptoms begin. It is also documented that with repeated psychotic breaks, a person with mental illness may recover to a lower level of function than before the break[2].
4. The Consolidated Appropriations Act of 2014, H.R.3547, provided funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the development of early psychosis treatment programs across the United States. To ensure that programs implemented are evidence-based, the National Institute of Mental Health was directed to collaborate with SAMHSA in developing input for states regarding what are promising first episode psychosis (FEP) treatment models.
5. These extra block grant funds are presently being used to provide early treatment in some of the regions of Idaho. NAMI Idaho urges that funds be provided to provide early treatment in the entire state.

*Pharmaceutical substitutions

When substitutions to prescribed medications must be made for whatever reason, the psychiatrist in charge of the patient should be consulted in order to get the best possible choice of a different drug and its dosage, even when the change is from a brand name drug to its generic equivalent. The choice may not be left solely to the professional judgment of the pharmacist. Exceptions to this requirement would be for changes made by a psychiatric hospital or the psychiatric ward of a general hospital.

In NAMI's view, there is a substantial scientific evidence demonstrating that psychotropic medications (generic and name brand) do not have "a substantially equivalent therapeutic effect" as another drug as no two medications are molecularly identical. Each medication has a unique

therapeutic and side effect profile, causing wide variation in response from one person to another. Research has demonstrated that therapeutic substitution of medications used to treat serious mental illness can create significant downstream impacts and cause an elevated physical burden on the overall health care system[3]. Because therapeutic substitution for psychotropic medications can cause physical and cognitive complications and prevent the individual from receiving effective treatment, individuals living with serious mental illness will require more emergency room visits, experience an increased risk of homelessness, and interact more frequently with the criminal justice system. These higher costs far outweigh any potential savings achieved through therapeutic substitution by anyone other than the most highly qualified person in charge of the patient.

Workforce and Medicaid Reimbursement

1. In order to effectively meet the mental health needs of its residents, Idaho must establish a stable and excellent behavioral health workforce.
2. Idaho is a mental health professional shortage area; low Medicaid reimbursement rates create a disincentive for qualified mental health professionals.
3. Medicaid reimbursement rates for all mental health providers must be adequate to ensure the availability of quality services in all regions.
4. Enact policies that make it beneficial for hospitals to offer psychiatric residencies in Idaho.

Revenue and Budget

1. NAMI Idaho strives to protect Idaho's children and adults from any further deterioration in mental health services resulting from revenue shortfalls and budget cuts. We advocate at the state legislature and at state agencies to increase understanding of the nature and prevalence of mental illness in our state, by illustrating the costs of untreated mental illness, by illustrating consequential cost increases arising from limitation of mental health services to crisis intervention, and by emphasizing the efficacy of early treatment and the possibility of recovery.
2. NAMI Idaho is committed to the support of legislation seeking to increase state revenue specifically directed to increasing the level of treatment services now being provided to those persons living with mental illness.

The New Managed Care Contract

1. The contract should include inpatient and emergency room care as an incentive to good outpatient care. Otherwise the MCO (managed care organization) should apply for the IMD (institutions for mental disease) exclusion to allow Medicaid payment for short term inpatient care.
2. The MCO should maintain a network of adequately trained mental health providers and peer specialists. A special effort should be made for a distribution of providers that can properly serve the rural areas of Idaho. Although telehealth can be helpful, it should not be relied on exclusively.
3. A continuing effort should be made to involve Idaho's minority groups as providers and patients.
4. Treatment for mental illness, substance abuse, and physical illness should be integrated to the maximum extent possible.
5. Providers should be allowed adequate time with patients to gain the trust needed to obtain adherence to treatment. The cuts to CBRS in recent years have been detrimental to achieving this goal.

6. For the most severely ill patients, ACT treatment should be available, with the attendant team approach and frequent home visits.
7. There should be a special effort to promptly treat persons who have recently undergone a first psychotic break.
8. It is important to allow reimbursement for adequate psychiatric time with patients.
9. As part of a recovery-oriented approach, providers should support patient community involvement to the maximum extent of the patient's ability. This could include employment, formal education, volunteer activities, support groups, clubs, etc.
10. Involvement of families and friends with treatment is important, as they are the daily eyes and ears of patients' behaviors and needs. To encourage this, collateral contacts with families should be billable services.
11. To further assist such contacts, providers should be instructed to make continuing efforts to obtain releases of information from patients. Also, providers should be educated about the many contacts which are permitted under HIPAA.
12. The MCO must be forthright and transparent about the criteria used to approve, reduce, or deny mental health services. Complaint procedures must be made well known.
13. The MCO must collect and make available in a timely fashion data on:
    a. System Performance-availability of services, utilization levels and rate of critical incidents.
    b. Clinical Performance-symptom improvement, hospitalization and diversion rates, quality of life improvement (housing, homelessness, employment, relationships, incarceration).
    c. Administrative Performance-consumer satisfaction surveys, service appeals, service reductions or denials and complaints/grievances. The Medical Loss Ratio (MLR, percent of premium used directly for health care) of the MCO should be in the range of 83%-87% resulting in 83-87% of the total payment to the MCO providing direct mental health care services.

Community Crisis Centers

1. NAMI Idaho believes that Community Crisis Centers can be one of many effective components of an overall Behavioral Health System
2. Currently, law enforcement, jails, and hospital emergency departments are often the default provider of crisis intervention for Idahoans experiencing behavioral health crises.
3. The existing community crisis centers are well used and allow individuals in mental health or drug crisis to get prompt treatment and treatment referral.
4. They relieve law enforcement of waiting hours with them in an emergency room or taking them to jail on a made-up charge, such as disturbing the peace. Thus, waste is reduced from the unnecessary utilization of police time, jails, and emergency rooms.
5. Community crisis centers should be expanded and funded in multiple communities to effectively reach the greatest number of persons throughout the state.
6. Adequate financing should be provided to these crisis centers, realizing that they can be only partially sustained locally.

Crisis Intervention Team (CIT) Training

1. NAMI Idaho supports CIT training of law enforcement officers and other emergency responders to protect their personal safety while not escalating crises in appropriately responding to people living with mental illness.

2. NAMI Idaho endorses the Memphis model of CIT training and the efforts of the Idaho CIT Workgroup to establish state-wide standards of law enforcement training pursuant to this model.

Parity in Mental Health and Substance Use Care

Adopted May 1. 2015

NAMI Idaho believes that:

1. Mental illness and substance abuse should be treated with the same urgency as other health care issues. It is essential to overall health.
2. Insurance plans which do not include mental health treatment should not be allowed, not even short-term plans.
3. The federal Mental Health Parity and Addictions Equity Act (MHPAEA) was enacted in 2008 and represented a significant step forward in addressing pervasive discrimination against people living with mental illness or substance use disorders in health insurance.
4. However, despite passage of this landmark law, people with these disorders still face pervasive barriers in accessing needed care. These barriers include:
    a. Denial rates for inpatient and outpatient MH care that are more than twice those for other types of medical care,
    b. Limits in access to needed psychiatric medications, particularly antipsychotic medications,
    c. Serious shortages of psychiatrists, therapists and other Mental Health professionals,
    d. Insurance networks,
    e. High out of pocket costs (co-pays, deductibles, co-insurance), and
    f. Lack of information necessary to make informed decisions about plans.
5. To address these problems, NAMI Idaho is calling for:
    a. Strong federal and state enforcement of MHPAEA including,
    b. Easily accessible mechanisms for filing complaints,
    c. Monitoring and reporting on non-compliance by federal agencies responsible for enforcement (Department of Labor (DOL), Health and Human Services (HHS)),
    d. Publication by insurers of
        i. Accurate, up to date lists of providers participating in their health insurance networks,
        ii. Clinical criteria used to approve or deny Mental Health and Substance Use Disorder care,
        iii. Clear, easily understandable information about plan benefits, including specific Mental Health and Substance Use Disorder services covered.

Marijuana

NAMI Idaho believes that any approval for medical use of marijuana or its derivatives should be subject to the normal procedures for approving other drugs. This includes standard clinical trials resulting in approval by the Federal Drug Administration (FDA). Such trials are to determine appropriate illnesses, effectiveness, side effects, and optimum doses. Medical marijuana laws in most states do not require any of this testing information.

We mention that as a result of two years of tests of a specific brand of cannabidiol CBD oil by Dr. Robert Wechsler of Idaho (and tests elsewhere), this substance has been found helpful (not a cure) for treatment of two types of treatment resistant seizures. The FDA has approved this treatment. There are also synthetic analogs of other marijuana components which have been

approved because of systematic tests. This is how medical marijuana should be approved, not by legislation or popular vote.

Regular use of marijuana by adolescents for "recreational" purposes is widely suspected, as a result of several studies, to significantly increase the risk of development of psychotic illnesses a few years later, because of damage to rapidly maturing brains during adolescence by a substance whose intended purpose is to create a temporary psychosis[4]. In summary--tobacco attacks the lungs, marijuana attacks the brain. Additionally, marijuana tends to be a gateway drug to use of more harmful brain altering drugs, such as methamphetamine[4]

References

1. Center for Behavioral Health Statistics and Quality, Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015, p. 33.
2. Di Forti, M., Morgan, C., Dazzan, P., Pariante, C., Mondelli, V., Marques, T. R., ... & Butt, A. (2009). High-potency cannabis and the risk of psychosis. *The British Journal of Psychiatry, 195*(6), 488-491.
3. Comments presented at the October 2018 Idaho State Board of Pharmacy from the Idaho Psychiatric Association, 10-2018.
4. NIDA. (2018, June 25). Marijuana. Retrieved from https://www.drugabuse.gov/publications/research-reports/marijuana on 2019, January 24

NAMI Idaho's public positions on federal, state or local legislative policy issues are consistent with NAMI National's public policy platform that can be found at http://www.nami.org/TextTemplate.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=105491

For additional information, please contact the affiliate closest to your district, by going to https://idahonami.org/#Contact, or email idahonami@gmail.com.