Healing and Belonging in America:
A Plan to Improve Mental Health Care and Combat Addiction

We are in the midst of a devastating opioid overdose and addiction epidemic that is harming communities across the country.[1] In the past two decades alone, almost 450,000 people have died due to opioid overdose. By the end of this year, almost nine times as many will have died as the total number of U.S. military deaths during the Vietnam War.[2]

This crisis leaves a harrowing impact far beyond rising death rates. For every person that dies from opioid overdose, countless others are living with opioid use disorder, and family members, friends, and neighbors are deeply affected. Families are being gut-wrenchingly torn apart; since 2000, the number of children placed in foster care due to their parent's opioid use has doubled to nearly 100,000.[3] The annual economic cost of the opioid epidemic is almost $80 billion a year.[4]

Yet for all the attention the opioid epidemic has rightly received, Pete understands that it is only one part of a much larger mental health and substance use disorder crisis. Last year, for every five people who died from opioid overdose, three died from overdose due to other drugs,[5] such as methamphetamine or cocaine;[6] five died by suicide;[7] and nine died an alcohol-related death.[8] Combined, these deaths have contributed to the longest sustained decline in American life expectancy since World War I.[9]

Collectively, these deaths due to drugs, alcohol, and suicide are characterized as "deaths of despair," which are often preceded by people and communities being left behind.[10] It is parents being laid off from the job they've had for decades, and a society's inability to provide them with the opportunity to take care of their family, so they turn to alcohol to numb the pain. It is teenagers coping with childhood trauma, or who live in constant fear of hearing gunshots at school, and need a way to manage their anxiety and

[1] "Understanding the Epidemic." Center for Disease Control and Prevention. December 12, 2018. This source notes that almost 400,000 people died from an overdose involving any opioid, including prescription and illicit opioids, and does not include 2018 overdoses due to opioids. According to the CDC, in 2018, there were 47,500 overdoses due to opioids.

[2] "Vietnam War U.S. Military Fatal Casualty Statistics" National Archives. January 2018.

[3] Thompson, Dennis. "Opioid Epidemic Doubled Number of U.S. Kids Sent to Foster Care." HealthDay. July 15, 2019.

[4] Florence, CS et al. "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013." Medical Care. October 2016.

[5] Ahmad FB, Escobedo LA, Rossen LM, Spencer MR, Warner M, Sutton P. "Provisional drug overdose death counts." National Center for Health Statistics. 2019.

[6] Dembosky, April. "Meth Vs. Opioids: America Has Two Drug Epidemics, But Focuses On One." Kaiser Health News. May 7, 2019.

[7] "Suicide." National Institute of Mental Health, National Institutes of Health. April 2019.

[8] "Alcohol Facts and Statistics." National Institute on Alcohol Abuse and Alcoholism. August 2018.

[9] Bernstein, Lenny. "U.S. life expectancy declines again, a dismal trend not seen since World War I." The Washington Post. November 29, 2018.

[10] Case, Anne and Deaton, Angus. "Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century." Proceedings of the National Academy of Sciences of the United States of America. December 8, 2015.

stress.[11] It is older people whose aging friends don't stop by as often, if at all, and a society's inability to take appropriate care of its elders, even as they become lonelier and more isolated.[12]

This crisis of despair is often portrayed as one unique to middle-aged white America. While mental illness and addiction rates have risen significantly for this demographic, this often ignores the reality that mental illness and addiction have historically been and continue to be high, or are also rising, among people of color and other marginalized people and age groups. Native Americans experience post-traumatic stress disorder twice as often as the general population.[13] LGBTQ youth are almost five times more likely than their straight peers to attempt suicide.[14] Among Latinx people, mental health and overall health has deteriorated significantly under the current Administration.[15] Young Americans report being lonelier than any other age group.[16] Overdose deaths are spiking among Black people, on whose backs the current broken system that criminalizes mental illness and addiction was built during the crack epidemic of the 1980s.[17] And 20 veterans and active service members die by suicide each day, the most shameful indicator of just how badly our nation has failed those who have given so much to our country.[18] This crisis of pain and despair is not one unique to whiteness; it is one that is distinctly American.

This crisis is the result of years of neglect by our political leadership. Our health care system is so broken—and our approach to mental health and addiction so fragmented and frequently punitive—that less than one in five people with a substance use disorder and two of every five people with a mental illness receive treatment.[19,20] To meet this urgent national challenge, we need a new approach to providing mental health care. One truly prepared to tackle this as the crisis it is, and one that understands the key driver of change will be based in strengthening our communities.

Pete understands that we must begin to take mental health more seriously as a nation. For hundreds of thousands of us, it is a matter of life and death. For all of us, it is a matter of our happiness and well-being, because we live with these illnesses or may in the future, or because we know someone who does.

Pete's vision for the future of mental health and addiction care is rooted in embracing prevention and ensuring that every person with a mental illness or a substance use disorder has the resources and support

---

[11] Sinha, Rajita. "Chronic stress, drug use, and vulnerability to addiction." *Annals of the New York Academy of Sciences* vol. 1141 (2008): 105-30. doi:10.1196/annals.1441.030

[12] Hosseinbor, Mohsen et al. "Emotional and social loneliness in individuals with and without substance dependence disorder." *International journal of high risk behaviors & addiction* vol. 3,3 e22688. 25 Aug. 2014, doi:10.5812/ijhrba.22688

[13] Bassett, Deborah, Buchwald, Dedra, and Manson, Spero. "Posttraumatic Stress Disorder and Symptoms among American Indians and Alaska Natives: A Review of the Literature." Social Psychiatry and Psychiatric Epidemiology. March 1, 2015.

[14] Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12. U.S. Department of Health and Human Services. 12 Aug. 2016, www.cdc.gov/mmwr/volumes/65/ss/ss6509a1.htm.

[15] Wan, William, Bever, Lindsey. "Trump's presidency may be making Latinos sick." The Washington Post. July 19, 2019.

[16] Ducharme, Jaime. "Young Americans are the loneliest, according to new study." TIME magazine. May 1, 2018.

[17] James, K, Jordan, A. "The opioid crisis in black communities." Journal of Law Med Ethics. 2018 Jun;46(2):404-421.

[18] Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.

[19] "10% of US adults have drug use disorder at some point in their lives." National Institutes of Health. November 18, 2015.

[20] "Mental Health Facts in America" National Alliance on Mental Illness.

they need to begin to **heal**. We will ensure that at least 75% of people who need mental health or addiction services receive the care that they need, an increase of more than 10 million in Pete's first term, and **prevent 1 million deaths of despair by 2028.** And to help those who heal remain well—and to build Americans' resilience to these illnesses—we must ensure that everyone feels that they **belong** in their community and in our country.

To make this vision a reality, Pete will:

- Reduce stigma by changing the narrative around mental health and addiction.
- Ensure that everyone has access to comprehensive coverage for mental illness and addiction care, including by enforcing mental health parity in health care coverage.
- Expand and better distribute the mental health and addiction workforce throughout communities to provide more people with timely and quality mental health care.
- Universalize access to medication-assisted treatment (MAT) and other treatments for addiction**.**
- Empower communities most affected by mental illness and addiction to address the problem in their own way through $10 billion annual grants over a 10-year period that address policies or programs around prevention, care integration, and community.
- Address disparities in mental health and addiction through national and community-based efforts.
- Decriminalize addiction and mental illness and decrease the number of people incarcerated due to mental illness or substance use by 75% in the first term by decriminalizing all drug possession, expanding access to diversionary programs, and implementing crisis intervention teams with mental health professionals for 911 responses.
- Equip schools and students with skills to identify and respond to mental illness and addiction.
- Promote whole-person care by integrating mental health and addiction care with physical health care and in primary care settings.
- Hold drug companies throughout the drug distribution pipeline accountable for their role in exacerbating the opioid epidemic.
- Expand take-home naloxone programs to all 50 states by 2024 and increase access to harm reduction services to reduce the negative impacts of drug use.
- Increase veteran engagement in the Department of Veterans Affairs (VA) and enhance access to mental health and addiction treatment for veterans.
- Raise awareness of the pervasiveness of trauma and how fundamentally it affects health, and expand care that is trauma-informed.
- Combat the epidemic of social isolation and loneliness, which particularly affects young adults and older Americans.

HEAL

Tackling this crisis starts by ensuring that everyone has access to affordable and comprehensive health coverage, and that mental health and addiction care services are integrated into settings such as primary care. It means using technology to make it much easier for someone to find a therapist to talk to, in person or virtually. It means making it easier to get a prescription for medication to treat addiction, such as

buprenorphine to treat opioid use disorder, so unnecessary regulations don't prevent physicians from prescribing live-saving medication that could help thousands of people every day. To ensure that people with a mental illness or substance use disorder can heal, we will decriminalize these conditions. When someone is undergoing a crisis or is caught using a drug, they should be treated by a health professional rather than be punished in a jail cell.

Enforce mental health and addiction parity so that treatment for mental illness and addiction is as accessible as treatment for other chronic conditions, such as diabetes.

"Mental health parity" means that coverage and treatment for mental health and addiction are provided on equal terms as treatment for other physical conditions. If a health plan offers unlimited doctor visits for medical or surgical services, it must do the same for mental health and addiction services.[21] Parity ensures that insurance plans cannot discriminate against people with mental health conditions or a substance use disorder by charging high co-pays or imposing annual upper limits. Although the government requires many plans to maintain mental health parity, true parity remains out of reach for many. This makes it difficult to find affordable mental health treatment in a timely manner.

An office visit with a mental health clinician, for example, is five times more likely to be out-of-network—and therefore more expensive—than an office visit a primary care clinician.[22] A hospital visit for a mental health condition, such as an anxiety disorder, is four times more likely to be out-of-network than one for a physical condition, like heart disease.[23] Further, mental health clinicians and addiction specialists tend to get paid up to 20% less than other health care clinicians.[24]

To address this, we will:

- **Enforce parity for mental health and addiction treatment coverage across all payers by penalizing insurance plans that do not comply with parity.** We will enforce parity in several ways, including requiring health plans to annually report how they manage and meet parity. Health plans who violate this policy will face fines and statutory penalties, and those plans most often out of compliance will be publicly identified.

- **Establish mental health parity in Medicare and Medicaid.** Medicare remains the only major health plan to not cover mental health and addiction equally. We will also remove the 190-day lifetime limit on inpatient psychiatric admissions. While Medicaid requires managed care services to have parity, fee-for-service procedures currently do not. We will encourage states to require Medicaid parity.

[21] "What Is Mental Health Parity?" National Alliance on Mental Illness.

[22] Melek, Stephen P., Perlman, Daniel, and Davenport, Stoddard. "Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates." Milliman. December 2017.

[23] Melek, Stephen P., Perlman, Daniel, and Davenport, Stoddard. "Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates." Milliman. December 2017.

[24] Melek, Stephen P., Perlman, Daniel, and Davenport, Stoddard. "Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates." Milliman. December 2017.

Improve access to affordable and high-quality mental health and addiction treatment.

For millions of patients, finding the appropriate care is incredibly challenging under our current system. High rates of denials of care by insurers, long wait times, complicated referral processes, and high out-of-pocket costs all serve as barriers to care.[25] As a result, four out of every five people with a substance use disorder, and three out of every five people with a mental illness, never receive treatment.[26,27] To address this, we will:

- **Require insurance plans to provide a free annual mental health check-up to anyone who wants one.** Beneficiaries that exhibit symptoms of mental illness or addiction will be directed to proper follow up.

- **Increase reimbursement rates for mental health and addiction care, including care delivered through telehealth.** Mental health and addiction care clinicians are paid a fraction of what other physicians are paid, prohibiting many from entering the field. Building on encouraging results from Virginia's Medicaid reimbursement increase, we will raise reimbursement rates for mental health and addiction care clinicians.[28] We will also provide reimbursement for teletherapy and telepsychiatry for more types of care settings, and allow professionals to get compensated for virtually treating patients who are at home. This will especially benefit people in rural areas and areas with clinician shortages.

- **Increase access to treatment for people with serious mental illness and addiction by repealing the Medicaid rule that prohibits large psychiatric facilities from receiving reimbursement.** Large inpatient psychiatric facilities are currently prohibited from receiving payment for treating adults on Medicaid—which can limit access to care—especially for people with serious mental illness and addiction requiring residential treatment. We will fully repeal this prohibition, while ensuring it does not replace financing or care that should take place in the community.[29]

- **Invest and promote early interventions for mental health and serious mental illness**. For individuals experiencing a first episode psychosis (e.g. schizophrenia, schizoaffective disorder, schizophreniform disorder), early intervention and treatment is key for decreasing psychotic and

[25] "The Doctor Is Out: Continuing Disparities in Access to Mental and Physical Health Care." National Alliance on Mental Illness. November 2017.
[26] "10% of US adults have drug use disorder at some point in their lives." National Institutes of Health. November 18, 2015.
[27] "Mental Health By The Numbers." National Alliance on Mental Illness.
[28] "Addiction and Recovery Treatment Services: Program Update." Virginia Department of Medical Assistance Services." June 2019.
[29] "There Is No "Silver Bullet" For Mental Health: The Problem Of The IMD Exclusion, " Health Affairs Blog, April 2, 2019.

negative symptoms.[30] In addition, research on early interventions for children and adolescents shows how many mental, emotional, and behavioral problems in young people are preventable with early identification and treatment.[31]

Dramatically expand the mental health and addiction workforce to make culturally and clinically competent mental health and addiction services available to everyone.

115 million Americans, in over 5,100 communities across the country, live in areas with a shortage of mental health and addiction professionals. Only four states and territories meet more than 40% of the demand.[32] Beyond severe shortages, which will only worsen as demand for mental health and addiction services increase, professionals themselves are unevenly distributed across the country.[33]

To address these shortages, we will:

- **Create training and education programs to prepare front line clinicians, such as primary care clinicians, to better address and manage mental health and addiction.** We will increase the number of training programs that train culturally competent medical clinicians to care for patients with opioid use disorder or other substance use disorders.[34] This will include improving programs that provide mentorship for those who are new to treating substance use disorders. We will also prepare mental health and addiction professionals to work in settings beyond mental health and addiction treatment facilities, and incentivize them to work in high-need and low-resourced settings such as primary care, correctional facilities, schools, universities, and faith-based organizations.[35]

- **Expand loan repayment programs to encourage mental health and addiction professionals to choose to work in rural or underserved areas.** In order to attract more clinicians to work in the settings they are needed, we will expand the Public Service Loan Forgiveness (PSLF) program beyond government- and not-for-profit-based employment to include employment in rural private hospitals and practice groups. We will also restructure the program so participants will get a portion of their loan debt forgiven annually, instead of at the end of a 10-year period.

- **Invest in the community workforce, including the use of peer support specialists.** We will invest in peer mental and addiction health specialists, which allows front line clinical tasks to be

[30] Fusar-Poli, Paolo et al. "Improving outcomes of first-episode psychosis: an overview." *World psychiatry : official journal of the World Psychiatric Association (WPA)* vol. 16,3 (2017): 251-265. doi:10.1002/wps.20446

[31] The National Academy of Sciences. "Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions" March 12, 2009.

[32] "Mental Health Care Health Professional Shortage Areas (HPSAs)." Kaiser Family Foundation.

[33] "Behavioral Health Workforce Projections, 2016 - 2030." Health Resources and Services Administration.

[34] Smith, Robert C. et al. "Addressing mental health issues in primary care: An initial curriculum for medical residents." Patient Education and Counseling. 2014.

[35] "Training for Integrating Behavioral Health Into Primary Care." Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

shifted to or shared with peers and people with lived experience in the community and expands the current workforce in a timely and cost-effective way.[36] This includes increasing training and distribution of naloxone for opioid overdose among community members, as well as expanding peer recovery support at harm reduction centers, such as syringe services programs and community crisis centers.

- **Encourage medical schools to require medical students to complete free coursework on how to treat substance use disorders.** In addition, we will create accreditation standards for graduate schools and training programs that reinforce the concept of a mental and physical health integration. We will also work with medical schools, nursing schools, social work programs, and psychology programs to address addiction in their training and curriculum just as they do mental health. We must train our future medical workforce to recognize the importance of mental health and addiction, as well as how to work in a team-based environment to take care of patients.

- **Increase the number of residency programs and fellowships for mental health and addiction clinicians.** By increasing the number of slots available for these types of training programs, we can further increase the number of clinicians who are prepared to address mental health and addiction. These programs and fellowships will be evidence-based and focus on enhancing a team-based approach to care.

- **Expand community members' basic knowledge and training to address mental health and addiction.** This includes expanding Mental Health First Aid programs that teach people how to talk about mental health issues and what to do when they encounter a mental health crisis.

- **Create a three-digit suicide hotline.** According to the FCC, a three-digit hotline would be more effective than the long number for the current National Suicide Prevention Lifeline.[37] This hotline would make it easier for those in crisis to receive life-saving help.

Universalize access to life-saving medication to treat opioid use disorder and increase investment in pharmaceutical research to treat other substance use disorders.

Medication-assisted Treatment (MAT) is the gold standard for treating opioid use disorders.[38] MAT saves lives, keeps people in recovery, and helps patients regain their health and get their lives back on track.[39]

[36] Gagne, Cheryl A. "Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions." American Journal of Preventive Medicine. June 2018.
[37] Report on the National Suicide Hotline Improvement Act of 2018. Wireline Competition Bureau Office of Economics and Analytics, Federal Communications Commission. August 14, 2019.
[38] "Facing Addiction in America: The Surgeon General's Spotlight on Opioids." U.S. Department of Health and Human Services Office of the Surgeon General. September 2018.
[39] McAneny, Barbara L. "Landmark deal on medication-assisted treatment for nation." American Medical Association. January 7, 2019.

Despite its effectiveness, only about 10% of people with opioid addiction receive MAT.[40] This is largely due to unnecessary regulatory burdens that make it easier for clinicians to prescribe potentially addictive medication than medication to treat addiction.

To expand access to life-saving MAT and better address addiction we will:

- **Deregulate buprenorphine to make it easier for more Americans to get access to addiction care.** Currently, prescribers can only provide buprenorphine to a limited number of patients, preventing scores of patients from getting timely access to the medication they need. In fact, few physicians even have the license needed to prescribe buprenorphine.[41] Making buprenorphine more widely available, alongside providing proper training and education for clinicians, will help increase access to critical addiction care.

- **Increase the number of clinicians able to prescribe MAT.** We will amend the Controlled Substances Act to allow prescribers with controlled substances licenses to prescribe buprenorphine without requiring any additional training. We will also expand the types of clinicians able to prescribe MAT.

- **Standardize addiction treatment by defining the elements of care provided throughout the continuum of care using national guidelines.** Individuals with addiction, their families, clinicians, health plans, and other stakeholders should be able to know what kind of care is available at any given treatment program. Resources such as federal dollars should only be used to provide evidence-based care for addiction, just as it is for other medical conditions.

- **Require all insurers to cover all three types of MAT to treat opioid addiction.** We will require insurers, including Medicare and state Medicaid agencies, to cover all three types of MAT so every patient can have access to the type of treatment that works best for them.

- **End policies that require patients to wait days or weeks to receive access to MAT by getting rid of prior authorization.** Some health plans must approve MAT as medically necessary for a patient in order for it to be covered. Yet it is counterproductive to make patients wait to get access to a safe treatment that could save their lives. We will prohibit insurers from using prior authorization and other utilization management tactics for MAT.

- **Incentivize states to increase Medicaid reimbursement rates that clinicians receive for providing MAT.** Some states, such as Virginia and Maryland, have successfully expanded access to MAT by increasing reimbursement rates. We will encourage states to do the same through innovation waivers.[42]

[40] Sandoe, Emma, Fry, Carrie E., and Frank, Richard G. “Policy Levers That States Can Use To Improve Opioid Addiction Treatment And Address The Opioid Epidemic.” Health Affairs. October 2, 2018.

[41] “Practitioner and Program Data.” Substance Abuse and Mental Health Services Administration.

[42] "Section 1332: State Innovation Waivers." Centers for Medicare & Medicaid Services.

- **Increase mobile clinics and access to longer-lasting forms of MAT for patients in hard-to-reach rural or medically underserved areas.** Through grant programs, we will support more mobile clinics that can travel to patients in underserved areas. And since some forms of MAT require daily doses that can only be administered by clinicians, we will make it easier for clinicians to access longer-lasting forms of MAT to help patients in rural and medically-underserved areas. To increase access to MAT, we will make it easier for clinicians to use longer-lasting forms of MAT.

- **Prioritize research to develop medication to treat other types of drug dependence disorders.** Today, many drug use disorders, such as methamphetamine use disorder, cannot be treated with medication. As rates of these types of disorders rise, we must invest in identifying medication and other novel treatments.

Promote whole-person care by integrating the mental health and addiction health care system with the physical health care system.

Mental health and addiction care is primarily delivered in a siloed and fragmented system, separate from mainstream health care, which makes it much harder to access care. Bringing mental health and addiction services to places like primary care will help everyone and support a more team-based approach to health, which can improve outcomes and lower costs.[43,44]

To promote whole-person care and better integrate services, we will:

- **Incentivize the integration, co-location, and deployment of mental health and addiction clinicians in primary care settings**. We propose creating incentives for frontline delivery sites like primary care to integrate mental health clinicians within team-based care delivery models, as well as encouraging them to adopt electronic health records to make patient information sharing across clinicians and teams as seamless as possible. We will use alternative payment models and value-based contracting to incentivize the implementation of mental health and primary care integration models.[45]

- **Pursue innovative payment models that reinforce a more integrated approach to mental health and addiction**. Historically, the way mental health and medical services have been paid for has been separate, driving fragmentation at the clinical and delivery levels. This has made it difficult for many integrated practices as well as non-mental health clinicians to receive payment for addressing mental health and addiction issues in a team-based practice environment. In addition, integrated practice teams have had a hard time financially sustaining their work due to

[43] Mental Health America. "Position Statement: Integration of Mental Health and General Health Care." June 13, 2017.

[44] Kwan, Bethany M et al. "An Evidence Roadmap for Implementation of Integrated Behavioral Health under the Affordable Care Act." *AIMS public health* vol. 2,4 691-717. 20 Oct. 2015, doi:10.3934/publichealth.2015.4.691

[45] "Integrated Care." National Institute on Mental Health, National Institutes of Health. February 2017.

lack of adequate compensation or viable payment models.[46] We propose an ongoing move away from fee-for-service, with a specific focus on alternative payment models that better allow for mental health to be integrated into medical settings.[47]

- **Encourage states to end Medicaid carve-outs.** Carving out mental health is a way a health insurer can contract for mental health and addiction services with a separate entity. While overall this practice is in decline, carving out the mental health benefit often makes it more difficult clinically and financially for communities to integrate mental health and addiction services. Ending Medicaid carve-outs and requiring integration of services through Medicaid managed care contracts will better facilitate clinical and financial integration of mental health.[48] However, whether carved in or carved out, health insurers and practices must be held accountable for addressing mental health and addition with any new modeling and contracting for mental health and addiction services.

Expand take-home naloxone programs to all 50 states by 2024 and advance the implementation of harm reduction services to reduce overdose deaths and the spread of infectious diseases related to needle sharing.

Harm reduction programs are a critical part of any effective response to the opioid and injection drug use crisis. They minimize the negative impact of drug use without encouraging it, while reducing other side effects of drug use. In particular, this means access to syringe service programs for people who inject drugs, that link them to treatment, and provides access to sterile syringes. These programs help prevent transmission of HIV, viral hepatitis, and other infectious diseases associated with needle sharing, and reduce overdoses by deploying medication such as naloxone that help reverse the effects of opioids.[49]

To expand harm reduction services, we will:

- **Make naloxone, a drug that can be administered by any individual, broadly available in order to reverse overdoses.** This includes expanding federal support for the purchase of naloxone by state and local health departments, assuring it is widely available in public spaces and workplaces in a similar way (and in conjunction with) first aid kits and Automated External Defibrillators (AEDs), and encouraging co-prescribing of naloxone with opioids, either by individual physicians or direct dispensing by pharmacists.

- **Remove legislative and regulatory restrictions on the use of federal funds for syringe service programs (SSPs).** Under current law, local authorities have to jump through too many hoops to

[46] Kathol, Roger. "Value-Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes." Annals of Family Medicine. March/April 2014. Volume 12, no. 2 172-175.

[47] Miller, BF, et al. "Payment reform in the patient-centered medical home: Enabling and sustaining integrated behavioral health care." American Psychologist. January 2017.

[48] "Integrating Clinical and Mental Health: Challenges and Opportunities." Bipartisan Policy Center. January 2019.

[49] Logan, Diane E, and G Alan Marlatt. "Harm reduction therapy: a practice-friendly review of research." Journal of clinical psychology vol. 66,2 (2010): 201-14.

use federal dollars for operation of SSPs and may not use these funds for the purchase of syringes. These restrictions hamper state and local responses, both because they limit resources and because they convey a negative message about the value of these programs, despite overwhelming scientific evidence that they can prevent transmission of HIV and hepatitis. The Centers for Disease Control and Prevention (CDC) would also work with states to remove any criminal liability for those participating in SSPs.

Increase veteran engagement with the Department of Veterans Affairs (VA) and enhance access to mental health and addiction treatment for veterans.

Our Veterans have made significant sacrifices for our country–we cannot let them down. We must develop communities that can welcome them home with jobs and opportunity, as well as a robust and effective VA system that can take care of their mental health needs.

- **Increase investments in veterans suicide prevention**. Suicide prevention is grounded in community and support for the conditions that improve quality of life and well-being. Along with investing and enhancing the VA's National Strategy for Preventing Veteran Suicide[50], and supporting policies like limiting access to lethal means, from guns to medications, Pete also believes in the importance of focusing on public health and prevention to address suicide. We believe that we should provide community supports to veterans to improve connection and belonging, while simultaneously increasing access to services when needed.

- **Expand the number of mental health and addiction clinicians treating veterans.** We will ensure the VA is equipped to address veteran mental health and addiction by increasing pay and cutting out red tape for hiring new clinicians. We will also train non-VA mental health clinicians on the unique needs of veterans.

- **Increase access to telehealth, including teletherapy and telepsychiatry, for veterans through the Connected Care pilot program.** The Connected Care program helps clinicians deploy telehealth and mobile health to improve access to care for veterans.[51]

BELONG

Belonging begins by changing the way we think and talk about mental health and addiction to drive home the fact that these illnesses are not moral failings, and that asking for help is not a sign of weakness, but of strength and empowerment. It means training every student across the country to identify and know how to respond to signs of mental illness or addiction, and equipping communities with resources so they can

[50] "National Strategy for Preventing Veteran Suicide: 2018 to 2028." Office of Mental Hleaht and Suicide Prevention, U.S. Department of Veterans Affairs. 2018.
[51] Connected Care Portal. U.S. Department of Veterans Affairs

leverage their own ingenuity and experience to help people recover and become resilient to stressors. It also means helping people become part of something greater by strengthening communal bonds through, for example, national service. And it means creating livable communities that foster well-being, with decent wages, good jobs, affordable housing, and a safe and healthy place to live and raise a family.

Empower communities to leverage their own innovation to improve mental health and prevent addiction through a 10-year $100 billion grant program.

Local communities are at the front lines of this crisis, and so much of the success of addressing mental health and addiction will come down to how local communities support each other, provide care, and partner around complex issues that extend beyond health care.

At the same time, no community's problems look the same, just as no two communities' solutions will look exactly the same. That's why we propose strategies that allow communities to lead and prioritize solutions that can make a meaningful difference on overall health and well-being.

- **Through $10 billion annual Healing and Belonging grants, we will encourage communities most affected by this epidemic to leverage their ingenuity and on-the-ground expertise to help improve health and well-being.** These grants will allow for local communities to leverage federal funds to invest in interventions and structures that could most positively impact mental health and addiction. We will hold communities accountable for ensuring that there is an adequate infrastructure, measurable and realistic metrics, and, if necessary, a sustainability plan to continue the work beyond the life of the grant. As stipulated in the grants themselves, communities might choose to invest in a range of innovations, from social programs that drive impact around the social determinants of health to clinical programs that create novel ways for people to gain access to care both within clinical settings as well as community settings.

- **Launch a National Service plan to strengthen communities throughout the country.** Pete's National Service plan will help young people meaningfully connect with their community by focusing on addressing some of the key challenges of our time, including: building resilience and sustainability against climate disruption through the Climate Corps, improving health and combating addiction through the Community Health Corps, and helping provide companionship to older Americans through the Intergenerational Service Corps. The Intergenerational Service Corps will also create opportunities for mentorship, allowing participants to forge meaningful relationships across communities and across generations. Over time, these programs will strengthen communal bonds and build more livable, healthy, and resilient communities.

- **Invest in social determinants of health for people with chronic physical and mental conditions**. We recognize that simply closing the treatment gap for mental health, while a worthwhile goal, will never solve all of the challenges people face. Investing in vital community assets such as housing, transportation, and schools, is foundational to positive mental health and well-being. This includes expanding Medicaid services to support key health-related social needs

such as housing, employment, and non-medical transportation. And, of course, we must fight poverty itself–a key focus of the Douglass Plan and Empowering Workers agenda.

Address stigma surrounding mental illness and addiction by changing how we talk about it.

The culture that has existed around mental health and addiction is one that has discouraged people from talking about their problems. Language we use to describe people who have a mental illness or a substance use disorder—such as "crazy" or "addict"—is often not supportive and can discourage people from opening up about their own mental illness and/or addiction and seeking care. Further, we frequently talk about mental illness and addiction as personal, moral failings indicative of a character flaw that someone could simply correct if they tried harder. This is untrue. This stigmatizing way of thinking about mental illness and addiction has profoundly shaped how we treat these conditions.

To transform the narrative around mental illness and addiction, and begin to undo the damage caused, we will:

- **Assess and address structural stigma within existing policy at the federal level**. We will require all federal agencies to assess and address structural stigma to ensure that individuals with mental illness and/or substance use disorder are not discriminated against through policy. We will also make sure that language across all federal agencies and programs is consistently inclusive and supportive of those with mental health issues and addiction.

- **Use the Presidential platform to change the narrative around mental health and addiction**. We will work to change the narrative around mental health in this country, including by normalizing the reality that everyone can struggle with their mental health, and that it's okay to open up about it and seek help. By changing our language and our discourse around mental health, we can begin to minimize some of the major issues of stigma.

- **Launch a grant program that provides local organizations with resources and training to the end the stigma around mental illness and addiction.** Through this grant program, we will help communities across the country tackle stigma in culturally-, linguistically-, and historically respectful ways.

Promote student mental health, which has deteriorated at alarming rates, by requiring every school across the country to teach Mental Health First Aid courses, among other initiatives.

Young people's mental health in our country has sharply deteriorated. Today, 70% of teenagers report feeling that anxiety and depression are major problems among their peers, and one in three young adults

report feeling lonely—the highest of any age group.[52,53] Most tragically, suicide rates are rising for this demographic: suicide has doubled among middle school students—the first time in history that more die by suicide than from car crashes—and has increased by over 50% among high school students.[54,55]

We must also take better care of our teachers' mental health, as surveys often show high stress levels and poor mental health.[56] We believe that through financial support and training, we can prepare our schools to better identify mental illness and addiction. To achieve this, we will:

- **Require every school across the country to teach Mental Health First Aid courses.** The Mental Health First Aid program is a course that teaches people to identify and respond to mental illness and addiction in themselves and in others. Evidence indicates the course has helped to increase knowledge of signs and symptoms of mental illness and addiction, improve mental wellness, and reduce stigma.[57] We will also help schools implement other prevention strategies, such as programs to help improve social and emotional learning and well-being.

- **Train teachers and school staff to know how to help students when they need it.** Teachers are often the front line of identifying mental health needs in students. Research shows that providing training programs on mental health increases teachers' knowledge, changes their attitude, and gives them more confidence in addressing mental health with their students and colleagues.[58] Programs such as the National Alliance on Mental Illness's Ending the Silence are trainings that require less hours than Mental Health First Aid and can be used as a complement to Mental Health First Aid to increase awareness around mental health and addiction needs.[59]

- **Expand the mental health workforce into schools.** Bringing mental health services into schools is an effective and efficient way to address children's mental health needs. Whether it be integrating mental health clinicians into existing school-based health clinics, or simply embedding a mental health clinician into a school, having onsite availability opens numerous doors for early identification and treatment.[60] To support these programs, we would support legislation, like the Mental Health in Schools Act, to enhance the provision of mental health in schools.[61]

---

[52] Horowtiz, Julia Menasce and Graf, Nikki. "Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers." Pew Research Center. February 20, 2019.

[53] Norton, Amy. "1 in 3 Young Adults Suffers From Loneliness in U.S." U.S. News & World Report. March 11, 2019.

[54] "Suicide Kills More Middle School Students Than Car Crashes." NBC News. November 4, 2016.

[55] Lohmann, Raychelle Cassanda. "What's Driving the Rise in Teen Depression?" U.S. News & World Report. April 22, 2019.

[56] "2017 Educator Quality of Work Life Survey." American Federation of Teachers and Badass Teachers Association.

[57] "Research & Evidence Base." Mental Health First Aid USA.

[58] Jorm, Anthony F. et al. "Mental health first aid training for high school teachers: a cluster randomized trial." BMC Psychiatry. June 24, 2010.

[59] "NAMI Ending the Silence," National Alliance on Mental Illness.

[60] Chamberlin, Jamie. "Schools expand mental health care." Monitor. January 2009.

[61] H.R. 1211 - Mental Health in Schools Act of 2015. 114th Congress. 2015.

Address disparities in mental health and addiction through both national and community-based efforts.

Mental health and substance use disorder are in part determined by social forces that embed structural inequalities by race, gender, class, sexual orientation, and immigration status, among other factors. Systemically marginalized persons have been denied access to an environment that enables quality health outcomes, regardless of genetics, lifestyle, or even access to health care.

To address this, we propose to:

- **Launch a National Health Equity Strategy.** Health equity must become part of the mission of every federal agency, and a health equity lens must be applied to all federal policies, programs, and proposed legislation. Because health equity is not driven by health agencies alone, leadership for health equity must originate from the White House, as a part of a National Health Equity Strategy. This strategy will designate and fund Health Equity Zones to address communities' most pressing health disparities, especially in communities with histories of redlining and economic and social marginalization.

- **Train the mental health and addiction workforce to combat bias when treating patients.** Transform the health workforce, health systems, and the institutions that train future clinicians to ensure they are prepared to engage with communities in culturally-, linguistically-, and historically appropriate ways.

- **Strengthen enforcement to address health inequity.** Revitalize the Office of Civil Rights across all federal agencies to assure that frameworks are in place to address health inequities, promote equal access, and prohibit discrimination.

Decriminalize mental illness and addiction through diversion, treatment, and re-entry programs, decreasing the number of people incarcerated due to mental illness or substance use by 75% in Pete's first term.

Decades of failed mental health and addiction policy, coupled with mass incarceration that criminalized mental illness and drug use, have left us with a mental health and addiction care system so broken that today there are more people with serious mental illness in prisons than in treatment facilities.[62]

To decriminalize mental illness and addiction, we will:

- **On the federal level, eliminate incarceration for drug possession, reduce sentences for other drug offenses and apply these reductions retroactively, and expunge past convictions.**

[62] "The Treatment of Persons with Mental Illness in Prisons and Jails." Treatment Advocacy Center and National Sheriffs' Association. April 8, 2014.

Research shows that incarceration for drug offenses has no effect on drug misuse, drug arrests, or overdose deaths.[63] In fact, some studies show that incarceration actually *increases* the rate of overdose deaths.[64] We cannot incarcerate ourselves out of this public health problem.

- **Invest in the expansion of diversionary programs for people with mental health or substance use histories to be funneled out of the criminal system prior to a conviction.** These programs should not be alternatives to incarceration, but rather ways to intervene and assist people who need help before they are faced with the criminal legal system.

- **Invest in expanding the evidence-based national curricula training programs for drug courts, mental health courts, and other alternatives to incarceration for justice-involved persons.** Mental health and drug courts can offer judges and prosecutors safe alternatives to conviction and incarceration that prioritizes long-term, community-based treatment for mental health and addiction issues, rather than reflexive punishment. We will invest at the federal level in expansion and evaluation of mental health and drug courts, and similarly, provide technical assistance and federal support to state and local municipalities seeking to implement or expand their alternative court models for mental health and addiction, holding them accountable for standards in alignment with the evidence.

- **Train first responders to identify and deal with mental health crises**. First responders are increasingly responsible for responding to individuals with mental health and addiction needs in crisis. We will integrate mental health clinicians into the first responder workforce, and invest in first responder mental health and addiction training to equip them to address the mental health crisis in real time through de-escalation, therapeutic and care approaches as alternatives to arrest, and hospitalization for people who just need mental health care.

- **Eliminate Medicaid's inmate exception.** An estimated two-thirds of incarcerated people suffer from some form of substance use disorder, and after release, formerly incarcerated people overdose at rates up to 130 times the general population. Between 45-75% of incarcerated people at all levels (federal, state, local) have some form of mental illness.[65] Transitions of care from corrections to community health care settings are challenging, often resulting in delays in care and in receiving necessary prescriptions. Quality of care can also be poor, as correctional settings are not required to provide substance use disorder or mental health treatments. To address this, we will eliminate the Medicaid rule that denies people Medicaid coverage upon imprisonment.

Combat the culture of social isolation and loneliness, which can damage mental and physical health, by helping people form fulfilling connections to others and their community.

[63] "More Imprisonment Does not Reduce State Drug Problems." Pew Charitable Trusts, Issue Brief. March 8, 2018.

[64] Nosrati, Elias, et al. "Economic decline, incarceration, and mortality from drug use disorders in the USA between 1983 and 2014: an observational analysis." Volume 4, Issue 7. July 1, 2019.

[65] Varney, Sarah. "By the numbers: Mental illness behind bars." PBS NewsHour. May 15, 2014.

Half of Americans report feeling lonely either sometimes or always.[66] One in four report that no one really knows them.[67] This epidemic is particularly affecting young adults—the loneliest age group. It is also affecting older Americans, one in three of whom report being lonely, and their caregivers.[68,69] As a person's isolation and/or loneliness increases, it can profoundly affect their mental and physical health, and lead to premature death. Some studies indicate that loneliness can be as damaging to someone's health as smoking 15 cigarettes a day.[70] We believe that everyone should have fulfilling connections to others and their communities, if desired.

To address the epidemic of social isolation and loneliness, we will:

- **Launch a national campaign to end social isolation and loneliness.** Through a national campaign, we will support organizations addressing these issues and raise awareness about loneliness and its impact on individuals and communities, while targeting those most at risk of social isolation to ensure they are reached and supported by culturally-resonant resources. We will work with technology companies and researchers to understand how technology impacts meaningful connections, and support local efforts that encourage community bonds and neighborhood action.

- **Help strengthen social and communal bonds between older and younger Americans through Pete's National Service plan.** Pete's National Service plan includes an Intergenerational Corps with a focus on caregiving, mentorship, and other intergenerational service opportunities. Through this program, younger adults will help older adults continue to live independently by helping them cook a meal at home or driving them to the doctor or grocery store, while benefiting from the older adult's mentorship.

- **Help older adults who choose to age at home continue to live fulfilling lives through the CAPABLE program.**[71] The CAPABLE program teams up a nurse practitioner, a therapist, and a handyman and sends them to older adults' homes, where they help older adults stay healthy and achieve personal wellness goals. A program evaluation showed an average of $10,000 in Medicare savings per participant, as well as reduced depression and disability for participants.[72]

Raise awareness of the pervasiveness of trauma and how fundamentally it affects health, and expand trauma-informed care.

---

66 "New Cigna Study Reveals Loneliness At Epidemic Levels in America." Cigna. May 1, 2018.

67 "New Cigna Study Reveals Loneliness At Epidemic Levels in America." Cigna. May 1, 2018.

68 Ducharme, Jaime. "One in Three Older Americans Is Lonely. Here's What Can Help." TIME Magazine. September 24, 2018.

69 Pinquart, M. & Sorensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. Psychology and Aging, 18(2), 250-267.

70 "The Loneliness Epidemic." Health Resources & Services Administration. January 2019.

71 "Community Aging in Place - Advancing Better Living for Elders (CAPABLE)" Johns Hopkins University School of Nursing.

72 Baker, Beth. "Novel Program Helps Older Adults With Aging In Place." Forbes. April 26, 2017.

Nearly 90% of people living in the United States have experienced at least one traumatic event in their lifetime, and a majority have experienced multiple traumatic events.[73] Traumatic events include exposure to combat, physical and psychological abuse, sexual assault, and adverse childhood experiences. The experience of trauma has lifelong repercussions and has been associated with chronic mental and physical health conditions such as substance use, depression, and cardiovascular disease. Trauma also has collective and intergenerational effects, such as the cultural and historical trauma experienced by Native Americans due to injustice and oppression, and Black people due to slavery, Jim Crow, and decades of institutional and overt racism.

Currently, we are seeing the multi-generational impacts of trauma among children who have been inhumanely separated from their parents at the border and immigrant and refugee families who have been targeted by ICE. One recent study found adverse health outcomes among Latinx people associated with the outcome of the 2016 election.[74] Care informed by trauma acknowledges that what a person has been through profoundly impacts their health, and helps create a safe, supportive, and respectful care environment. Trauma-informed care must be utilized in all settings, not just clinical care.

To expand trauma-informed care, we will:

- **Direct the U.S. Surgeon General to study trauma and its effects and ensure that federal programs across agencies work to build resilience and address trauma and its impact.** While there is increased recognition within the health care delivery system of the health impact of trauma, providing all agencies with the policies and tools needed to address trauma is central to a systemic approach. We will also fund research on best practices for trauma-informed care.

- **Ensure that Medicare beneficiaries receive trauma-informed care and incentivize state Medicaid programs to pay for trauma-informed care and services.** This includes supporting physical and mental health services as well as social support that can address trauma and prevent its effect across generations. One promising approach is the Integrated Care for Kids model, which takes a multi-generational approach to addressing the opioid crisis.[75]

- **Expand funding for local efforts to train clinicians to provide trauma-informed care.** This could include funding for Health Equity Zones to help create trauma-informed communities and public institutions.

[73] Kilpatrick, Dean G. et al. "National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using *DSM-IV* and *DSM-5* Criteria." Journal of Traumatic Stress. October 2013.

[74] Gemmill, Alison et al. "Association of Preterm Births Among US Latina Women With the 2016 Presidential Election." JAMA Network Open. July 19, 2019.

[75] "Integrated Care for Kids (InCK) Model." Centers for Medicare & Medicaid Services. June 19, 2019.

- **Increase access to mental health resources for caregivers.** Direct care workers are at risk of negative mental health outcomes.[76,77] Studies indicate a high level of workplace violence targeted at homecare workers, which can result in depression, anxiety, and fear.[78] Caregivers may also experience secondary trauma, and can experience grief, as well as economic insecurity, around the loss of a loved one or client.

Hold the drug manufacturers, distributors, and pharmacies that exacerbated the opioid crisis for profit accountable, and ensure there are systems in place to prevent a repeat of this experience.

The opioid crisis was fueled in part by the willingness of the entire pharmaceutical supply chain system to ignore the rampant overprescribing of opioids in certain communities. There is a shared burden in particular among the pharmaceutical companies, pharmacy benefit managers, and pharmacies (many which are part of large chains) who profited from overprescribing. But the federal government also has some responsibility, including the Department of Justice's Drug Enforcement Administration (DEA), which had information showing that there was overprescribing.

- **Work with state Attorneys General to support state-level lawsuits**. More states and counties are bringing forward litigation against pharmaceutical companies to not only hold them accountable for the crisis, but also cover the cost of the opioid epidemic.[79]

- **Revamp the DEA's role in monitoring prescription of controlled pharmaceuticals.** The DEA must take a public health and law enforcement approach to the use of their data systems, so that health and legal authorities are alerted to any new dangers.

[76] Schulz, Richard, and Paula R Sherwood. "Physical and mental health effects of family caregiving." *The American journal of nursing* vol. 108,9 Suppl (2008): 23-7; quiz 27. doi:10.1097/01.NAJ.0000336406.45248.4c

[77] Margaret J. Penning, Zheng Wu, Caregiver Stress and Mental Health: Impact of Caregiving Relationship and Gender, *The Gerontologist*, Volume 56, Issue 6, 1 December 2016, Pages 1102–1113.

[78] Hanson, Ginger C et al. "Workplace violence against homecare workers and its relationship with workers health outcomes: a cross-sectional study." *BMC public health* vol. 15 11. January 17, 2015.

[79] Mann, Brian. "Cities And States Look To Big Pharma To Cover Costs Of The Opioid Epidemic." NPR. May 27, 2019.