National Coalition for Mental Health Recovery
Formerly known as the National Coalition of Mental Health Consumer/Survivor Organizations
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2010 POLICY PRIORITIES

1. **Increase the funding of peer run networks and services in every state through Mental Health Block grant and increase federal appropriations for consumer-run statewide organizations/coalitions.**

2. **Increase the funding for peer-run alternatives to hospitalization such as crisis respite, warmlines, and in-home supports.**

3. Promote trauma-informed, holistic services and supports.

a. Ensure that training and continuing education in behavioral health is based on holistic, trauma-informed approaches.

b. Advocate that the National Center for Complementary and Alternative Medicine (NCCAM) emphasize the uses of complementary and alternative medicine for mental health issues.

4. Reform Medicaid and Medicare to support recovery and community integration.

A. Ensure full implementation of Medicare parity legislation.

B. Recommendations for state Medicaid reform:

1. Promote supervision of peers by other peers.[1]
2. Reimburse peers working in a variety of roles.[2]
3. Allow peers to use self-determination care accounts to hire other peers.
4. Expand the definition of "medical necessity" to include recovery and community integration.[3]
5. Promote the central involvement of peers in the evaluation of services.
6. Provide clear and accurate information about Medicaid to consumers.
7. Ensure significant participation by mental health peers on Medicaid Advisory Councils.[4]

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[1] The Coalition supports revising the language of the August, 2007 CMS letter to state Medicaid Directors, which specified that "mental health professionals should supervise peer specialists, " to reflect language used by the Pennsylvania Medicaid office: "Peer specialists can be supervised by either a mental health professional or a person with a bachelor's degree and 2 years of direct care as a peer and/or mental health worker or a person with a high school diploma or general equivalency degree and four years of mental health direct care experience, which may include experience in peer support services."

[2] Medicaid should reimburse peers to work in a variety of roles including Personal Care Attendants (PCAs) in mental health, peer bridgers in inpatient settings, members of crisis teams, and wellness coaches in addition to the role of Certified Peer Specialist.

[3] Each state is allowed to develop its own definition of "medical necessity" for operation of the Medicaid program in the state.

[4] Code of Federal Regulations 42, Section 431.12 requires that states form committees to advise Medicaid agencies. Those committees must include recipients of services and they must provide financial arrangements, if necessary, to

5. Create model legislation to carry forward our priority policy recommendations.

6. Enable people to return to work through consumer-driven Social Security reform, using the following strategies:

a. Raise asset limits and income limits
b. Increase work incentives such as Plans for Achieving Self-Support (PASS)[5] and Impairment-Related Work Expenses (IRWEs)[6]
c. Increase employment-related supports (education, training, child care)
d. Re-evaluate benefits based on geography
e. Promote coordination amongst agencies that provide benefits to ensure coordination of benefits.

7. Limit pharmaceutical industry influence on policy and practice by eliminating direct-to-consumer advertising and doctor incentives.

8. Reform the Food and Drug Administration (FDA) to ensure independent research on pharmaceuticals and to block the reclassification of ECT devices to Class II.

9. Promote universal psychosocial coverage – "parity with choice" covering a variety of peer-run alternatives in the community and rural/tribal areas.

10. Ensure peers are adequately prepared to participate in all major policy and planning decisions at all levels.

11. Reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA) including continued funding of consumer-run Technical Assistance Centers.

12. Ensure the human and civil rights of people with psychiatric disabilities, including the right to community-based alternatives to unnecessary institutionalization as articulated in the *Olmstead* decision and the Americans with Disabilities Act (ADA).

13. Increase accessibility and affordability of housing for people with psychiatric disabilities; ensure adequate funding of consumer/survivor run housing.

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make recipient participation possible. Currently, these councils rarely include mental health peers, and rarely have influence on state Medicaid policy decisions. We recommend this regulation be expanded to state that "at least two representatives from each major disability group" be on the Medicaid Advisory Council. These representatives need to represent a significant proportion of the persons with the disability, and themselves have the disability of the group they represent. They need not however, presently be Medicaid recipients. The representatives from the disability groups should be informed of the appropriate federal and state Medicaid regulations by consumer-run Technical Assistance Centers (TACs). The participants' transportation and time should be covered by the State Medicaid Office.

[5] PASS plans allow a person with a disability to set aside otherwise countable income and/or resources for a specific period of time in order to achieve a work goal.

[6] Allowable expenses that can be deducted from a disabled person's gross monthly wages.