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MECHANISMS FOR ADVANCING HEALTH EQUITY

Policy Brief

Six Policies that Advance Mental Health and Well-Being

Introduction

Mental Health Awareness Month aims to rid the stigma around mental health, allowing those who experience mental health conditions to feel secure and supported, while also encouraging those who may not share these experiences to understand the importance of prioritizing mental health and wellbeing. It is important to acknowledge that distinguishing mental health from other types of health conditions is culturally specific and not a universally shared distinction. Although individual needs and ways of understanding mental health may differ, creating the social conditions that support the mental health of all individuals is a necessary element of creating healthy communities. In recognition of Mental Health Awareness Month, Network attorneys and staff have identified six key policies with the potential to significantly improve mental health outcomes across the United States. This policy brief covers a wide range of areas focused on communities and those who work to support communities. It is designed as a practical resource for public health professionals, leaders, and partners, offering strategies to enhance mental health and well-being while reducing disparities in mental health care.

Overview of Policies

Chart Title

POLICY	DESCRIPTION	EVIDENCE IN ACTION (EXAMPLE)
Promote minor consent to mental health treatment for youth covered by Medicaid	States can legislate to ensure that minors have the right to consent to mental health treatment and that youth covered by Medicaid have equal opportunity to consent to services as their peers who have private insurance coverage.	In 2023, California passed legislation to ensure that youth covered by Medicaid can consent to receive outpatient mental health treatment if they are 12 or older and considered mature enough to participate intelligently in their care. Before the passage of this legislation, the consent standard applicable to youth covered by Medicaid was more stringent than the standard applicable to youth covered by private insurance. This legislation eliminates barriers to mental health treatment for youth covered by Medicaid, promoting access to supportive care for all California youth and advancing health equity.
Create green schoolyards	Convert asphalt playgrounds to nature	Increasing access to green schoolyards has long been part of the City of Milwaukee's Green Infrastructure Plan. Access to nature and green space

	playgrounds to benefit children's and youth's mental and physical health.	reduces stress and supports children's learning and well-being. Milwaukee Public Schools have partnered with the Milwaukee Metropolitan Sewerage District, the National League of Cities, and the Children and Nature Network on a strategy for reduced stormwater runoff, enhanced social and emotional learning, and increased children's and youth's mental health. In particular, students tend to experience less anxiety and depression and greater ability to focus, regulate their emotions, and resolve conflicts with their peers when they spend time in more natural environments.
Administer perinatal and postpartum mental health screenings	Requiring early and routine screenings during the pregnancy and postpartum period can help prevent postpartum depression.	In 2023, Arkansas passed two laws requiring providers to screen postpartum individuals for depression within six weeks of giving birth. This screening must be covered by all private insurers without a copay or deductible. Further, the state Medicaid plan is required to reimburse providers for depression screenings during pregnancy. Perinatal and Postpartum Mental health screenings help detect symptoms of depression, mood, and anxiety disorders.
Center culture in 988 call crisis response by providing access to culturally specific crisis counseling	States can enact 988 legislation that supports culturally centered 988 services sought by individuals whose cultural practices are often excluded from crisis counseling and related services.	As part of legislation to support the implementation of the National Suicide & Crisis Lifeline 988, the state of Washington passed legislation containing the mechanisms to support the creation of the state's 988 Native and Strong Lifeline (NSLL). The NSLL centers Indigenous knowledge by staffing the NSLL with trained Indigenous counselors who provide culturally based crisis counseling to Indigenous persons with a Washington area code. NSLL is also the result of a community participatory process and was designed around needs identified by Indigenous people.[1]
Increase mental health support for frontline harm reduction workers	Using creative strategies to provide access to mental health support is critical to ensure frontline harm reduction workers can continue doing life-saving work.	Frontline harm reduction workers are experiencing the direct and vicarious trauma of stigma, dehumanization, and loss. In light of common barriers to accessing mental health support, individual programs have devised creative ways to advocate for their frontline workers. Many insurance companies are required under federal law to provide parity for mental health services, but navigating the insurance processes and finding services that are understanding of harm reduction can be a barrier to seeking assistance.[2] Offering a variety of services on-site or having a dedicated mental health professional for a harm reduction program can be a way of alleviating these barriers.
Provide widespread access to paid leave and a supportive workforce culture	Access to, and a workforce culture that supports use of, paid leave for all workers that is not limited to emergencies and illness or federal or state policymaking supports population health, advances health equity, and allows workers to maintain their health and well-being.	In 2021, the Maine Earned Paid Leave (MEPL) law went into effect, ensuring minimum paid leave for almost all workers in the state.[3] Applying to all industries except for seasonal industries, employers with over 10 employees in Maine must allow employees up to 40 hours of earned paid leave per year. The law applies to all employees, including part-time and temporary workers, offering workers a chance to take time off without financial loss. Maine also guarantees 12 weeks of paid leave per year to nearly all Maine workers for medical, parental, caregiving, and deployment-related leave, as well as safe leave for workers experiencing sexual or domestic violence.[4] Benefits will be available to Maine workers in 2026. Employers must also cultivate a workforce culture that supports employee use of their leave. One practical resource created for the governmental public health workforce, Putting Our People First: A Discussion Guide for Public Health Agencies to Advance Worker Well-Being, provides actionable planning steps and discussion points for agency leadership and staff to address and prioritize worker health.[5]

Promoting Minor Consent to Mental Health Treatment for Youth Covered by Medicaid

State laws that empower youth to independently consent to mental health care services remove barriers to care and protect the confidentiality of potentially sensitive health information.[6] Laws vary greatly with some states providing no minor consent to care policy while others set a minimum age requirement to consent to mental health care, typically ranging from 12 to 16.[7] For some, adolescents' right to consent to care raises ethical and legal questions and concerns about parental rights,[8] but the need for confidential mental health services among youth is evident. In 2021, over 29 percent of high schoolers reported that their mental health was "most of the time or always not good."[9] The same year, 55 percent of high school students reported experiencing emotional abuse by a parent or other adult at home and 11 percent reported experiencing physical abuse.[10] Children and adolescents cite perceived social stigma, concerns about provider confidentiality and trust, and structural barriers including financial costs among the reasons for not seeking mental health care.[11]

Certain communities of youth disproportionately experience poor mental health symptoms. For example, among LGBTQ youth, 41 percent seriously considered attempting suicide in 2022 and 56 percent of those who wanted mental health care were not able to receive it.[12] Fewer than 40 percent of LGBTQ youth found their home to be LGBTQ-affirming.[13] Additionally, young people of color face greater risks of developing adverse mental health conditions, such as anxiety and depression,[14] and, in recent years, Black young people age 10-24 have experienced the greatest increase in suicide rates compared to young people in other racial and ethnic groups.[15] Living in a lower-income household is also associated with an increased prevalence of mental and behavioral health challenges among youth.[16]

Expanding the rights of youth to consent to confidential mental health care is an important step towards supporting youth mental health. But, to mitigate these inequities, state laws and policies governing minor consent to mental health treatment must ensure access for all minors, including those from households with lower incomes. In October 2023, California passed Assembly Bill No. 665 to further this end, expanding access to mental health treatment for California youth covered by Medicaid.[17] AB 665 seeks to eliminate an inequitable discrepancy in California law, which establishes two distinct standards governing minor consent to mental health treatment. While a minor covered by private insurance can consent to outpatient mental health services if they are age 12 or older and considered mature enough to participate intelligently in the treatment, minors covered by Medicaid are subject to a more stringent standard.[18] AB 665, which goes into effect in July 2024, harmonizes the two standards so that all California youth age 12 or older can access mental health treatment if they are considered mature enough to participate in the care.[19]

AB 665 promotes health equity by supporting access to confidential mental health treatment for young people from lower income households, at least 70 percent of whom are youth of color.[20] These youth may be more likely to experience economic-related drivers of adverse mental health symptoms,[21] including lack of access to stable housing[22] and food insecurity.[23] Policies that promote access to mental health treatment for youth covered by Medicaid, as well as youth covered by private insurance, thus support wellbeing and avoid exacerbating inequities.

Written by Emma Kaeser, J.D., Staff Attorney, ekaeser@networkforphl.org, and Susan Fleurant, J.D., M.P.H., Staff Attorney, sfleurant@networkforphl.org, Network for Public Health Law – Mid-States Region.

Green Schoolyards and Access to Green Space

School districts are often one of the largest governmental landowners in a community. Changing aspects of the built and natural environments of schools can affect the health of the wider community, particularly when

schools in neighborhoods historically impacted by racially restrictive housing covenants and loan-making criteria are prioritized.[24] Green schoolyards convert asphalt and grass playgrounds and school environments to include native plants, gardens, trees, rocks, and other natural features. Green schoolyards provide environmental health, physical health, and mental health benefits to children.[25] Environmental health benefits include increased capacity to absorb stormwater, increased shade, reduced contribution to extreme heat and the urban heat island effect, and improved air quality.[26] Physical health benefits may include increased physical activity and fewer injuries compared to asphalt playgrounds.[27] Mental health benefits include reduced stress, enhanced social and emotional learning, and beginning to reverse racial trauma associated with redlining, segregation, and inequitable access to green space.[28]

Along with cities like Chicago and Little Rock, Milwaukee has participated in a learning cohort aimed at supporting the transition to green schoolyards sponsored by the National League of Cities and the Children and Nature Network.[29] For at least five years, the city of Milwaukee has prioritized green schoolyards as a key component of its Green Infrastructure Plan.[30] Milwaukee Public Schools has partnered with the Milwaukee Metropolitan Sewerage District, the Milwaukee Public Schools Foundation, Reflo (a nonprofit organization) and others to open green schoolyards.[31] In October 2023, the Milwaukee Public Schools held a celebration of opening five more green schoolyards, bringing the total number of transformed green schoolyards to 26 since 2019.[32] Students and community members celebrated the enhanced opportunities to learn and have fun, while school officials cited evidence about increased creativity, alertness, and ability to focus.

Under the federal Inflation Reduction Act, the U.S. Forest Service has awarded Urban and Community Forestry Grants, including a $12 million grant that Milwaukee received in 2023 for its Growing Milwaukee's Tree Canopy and Community Resilience initiative.[33] Among other things, the city will use the grant funds to build upon its efforts to green city schoolyards, especially in neighborhoods which currently have less tree cover, through partnerships between Milwaukee Forestry Department, Milwaukee Public Schools, Milwaukee County Parks, and the Metropolitan Milwaukee Sewerage District. For states seeking to bring to scale efforts to expand the tree canopy in individual schools, school districts, and communities, recent guidelines published by the California Department of Forestry and Fire Protection for the federal Urban Community and Forestry Grants it administers within the state may be of interest.[34]

Written by Jill Krueger, J.D., Director, krueger@networkforphl.org, Network for Public Health Law – Climate and Health.

Perinatal and Postpartum Mental Health Screenings

One bright spot in public health is that U.S. maternal mortality rates decreased in 2022. However, a new report released by the Centers for Disease Control and Prevention (CDC) found that rates are still higher than they were in 2018 and 2019.[35] Further, racial disparities persist, with the maternal mortality rates for Black women at a staggering 49.6 deaths per 100,000 live births compared to 19.0 for White women, 16.9 for Hispanic women, and 13.2 for Asian women.[36] A 2022 report from the CDC found that 84 percent of maternal mortality deaths were preventable.[37] While cardiac and coronary conditions were a leading cause of death, the most frequent underlying health conditions causing pregnancy-related deaths were mental health conditions.[38] The CDC report defines mental health conditions to "include deaths of suicide, overdose/poisoning related to substance use disorder, and other deaths determined by the [State Maternal Mortality Review Committee] to be related to a mental health condition, including substance use disorder."[39] Mental health conditions were the leading cause of maternal mortality across all races, for Hispanic women, non-Hispanic White women, and American Indian and Alaskan Native women.[40] The United States is experiencing a maternal mental health

crisis which has been further exacerbated by the recent COVID-19 pandemic and its associated economic, social, and emotional impact.[41]

Mental health screening is an effective tool for detecting symptoms of mood and anxiety disorder among pregnant and postpartum people. The U.S. Preventive Services Task Force recommends that screenings for depression are provided to all pregnant persons in the U.S. and those with increased risk for perinatal depression are referred for counseling.[42] In 2022, nearly all states covered postpartum depression screening and treatment however reimbursement varied (e.g. California reimburses for two screenings per year per pregnant/postpartum enrollee while Kansas reimburses for three prenatal screenings and five postpartum screenings).[43]

In 2023, Arkansas passed two laws aimed at addressing the maternal mental health crisis that seek to increase health equity within the state. Arkansas has one of the worst maternal mortality rates in the country, with 43.5 deaths per 100,000 live births, which as discussed above is linked with mental health.[44] Evidence shows that Black maternal mortality in Arkansas doubled in 20 years and was 89 per 100,000 live births in 2019.[45] Moreover, in a recent study, 20 percent of participants interviewed reported experiencing postpartum depression within four months of giving birth.[46] Twenty-five percent reported depression during their pregnancies.[47] These high rates are unsurprising given that 26 percent of participants reported experiencing depression within the three months before becoming pregnant.[48] Lead sponsor of both bills, state Representative Aaron Pilkington, said, "[i]f we're able to catch this early on within the first six weeks, the hope is that we're able to get mom the care she needs so that she could have a healthy postpartum time."[49] The first bill requires a provider who is present at the birth of a child, or caring for a postpartum individual, to administer a depression screening within the first six weeks postpartum.[50] The bill further requires that private insurance reimburse the provider for this screening without charging the patient a copay or deductible. A companion act requires that the state Medicaid plan reimburse for depression screening during pregnancy.[51] Arkansas Medicaid covers 40 percent of births in the state.[52] Arkansas is taking action to require screenings postpartum, and coverage for them. Further action could include requiring multiple consistent screenings throughout pregnancy and the postpartum period, as well as ensuring a strong provider network for mental health referrals. Additionally, as Arkansas is the only state that has not proposed or implemented the Medicaid postpartum expansion, the state should consider expanding Medicaid to guarantee a strong continuum of care for those in need of ongoing support postpartum.[53]

Written by Joanna Suder, J.D., Senior Attorney, jsuder@networkforphl.org, Network for Public Health Law – Reproductive Health, and Joyce Imafidon, M.P.H., M.A., CDC Public Health Law Fellow 2023 and current doctoral student in Maternal Child Health and Policy, imafidon@uab.edu, University of Alabama – Birmingham.

Using A Community-Based Participatory Approach to Create an Indigenous 988 Lifeline

When it comes to mental health and crisis response what is often missing in the rollout of new laws and policies is an effort to build up these services in a way that adequately meets culturally diverse needs. The provision of culturally inclusive services is too often treated as an issue to be considered after a program has been implemented. Considering that American Indian and Alaska Native people have long experienced a disproportionately high risk of suicide and suicide deaths, it would be a mistake to assume that it is possible to promote mental health either using facially culturally neutral efforts (that reflect dominant cultural norms) or by relying on often intermittent cultural "competency" trainings of an overwhelmingly White workforce. Meeting the mental health needs of American Indian and Alaska Native people requires the ability to address the impacts of racism such as historical trauma, which requires true cultural inclusivity. For Indigenous people in the U.S., as

defined by a leading scholar, historical trauma refers to generational trauma that creates emotional and psychological harm, including unresolved grief from past massive traumas.[54] It is trauma that is produced by a history of genocide, forced relocation, and other racist practices justified through racist legal discourses portraying Tribes as not only culturally different (and therefore inferior) but incompatible with and unable to assimilate with "civilized" (defined as White) culture.[55] The multiple negative health impacts of historical trauma, which include survivors' guilt, depression, and suicide ideation continue to this day.[56] What such examples show is that mental health and crisis response must center culture to promote healing and to bring about a more just way of supporting mental health for everyone.

A state that has led the way in centering culture and community is Washington. As part of the federal government's efforts to strengthen access to mental health support, it required that the National Suicide & Crisis Lifeline be accessible in all states using the dialing code 988.[57] Washington responded by passing comprehensive 988 legislation, including legislation that contained mechanisms that led to the creation of the state's 988 Native and Strong Lifeline (NSLL).[58] The NSLL is staffed with trained Indigenous counselors who can provide crisis counseling to Indigenous persons who have a Washington area code.[59] Counselors answer each call with the affirming act of identifying their Tribal affiliation and are equipped with the knowledge and skills to draw on Indigenous practices in their provision of crisis counseling.[60] Although some states have enacted legislation in anticipation of an increase in the need for institutional support, given the expected rise in call rates, by providing funding and addressing other issues such as lifeline staffing, mobile crisis response, and coordination of services, state legislative response has widely varied.[61] Washington is the only state that has created a 988 lifeline that is staffed by and serves Indigenous people.[62] And in leading the way, it serves as an example of how states can provide institutional support for cultural healing.[63]

While Washington is the first state to successfully enact these policies, the foundational philosophy of this work is rooted in a community-based research approach. We have historically seen policies surrounding Indigenous groups authored by the same culturally dominant groups who formerly oppressed these communities. The result is policies that affect Indigenous experiences without acknowledging or recognizing Indigenous opinions on the issue. NSLL decided to subvert this standard practice and do something different: NSLL utilized aspects of an approach known as "Community Based Participatory Research" (CBPR) to better serve the population the bill intended to support. CBPR addresses the social, structural, and physical environmental inequities a community is facing through active involvement between the respective community members and researchers throughout the research process.[64] When used in the public health sphere, CBPR is an effective tool to not only reduce health disparities within the relevant demographic, but an incredible way to bridge the gap between the academic nature of research/policy making and the communities policymakers aim to serve. In the case of the NSLL, this looked like their operating body, the Volunteers of America Western Washington (VOAWW), going door to door within Indigenous communities surveying the population on their needs, strengths, and challenges they face when they seek crisis care services. This feedback informed the design of NSLL and the curriculum that VOAWW developed to train counselors.[65]

It is important to note that this approach was utilized to not only deliver effective crisis response in Washington, but this practice can serve as a model for other states that are working to expand these services. By replicating the methods used by VOAWW, culturally specific crisis response can become the standard practice for communities that need it, all while promoting community voices that have been long overlooked and underrepresented within the governmental system. CBPR is not limited to crisis-response programs such as the NSLL but can be used by any policy-making group to better embed equity in their work while empowering communities and others who will be affected by the policy.

Written by April Shaw, PhD, JD, Senior Staff Attorney – Health Equity, ashaw@networkforphl.org, and Daniel Wacker, Program Development Associate – National Office, dwacker@networkforphl.org, Network for Public Health Law.

Mental Health Supports for Frontline Harm Reduction Workers

Drug overdoses were responsible for the deaths of nearly 107,000 people in the United States in 2021.[66] Many of these deaths are due to the lack of a safe supply of illicit drugs, lack of access to healthcare for people who use drugs, and lack of access to harm reduction tools that can help reduce overdose and other drug-related harm. Dedicated, compassionate harm reduction staff, including those with lived and living experience using drugs, have given years of their lives to supporting individuals who are disproportionately affected by the criminalization of drugs and are at high risk of drug-related harm. In the process, these professionals experience the vicarious and direct trauma of stigma, dehumanization, and loss.[67] Additionally, they are often experiencing the moral injury of having to say "no" or "we can't help you" because of criminal restrictions, funding restrictions, or understaffing. There is often an inability to process the grief around them because they are too busy filling out paperwork for reporting or jumping through other hoops to keep the program afloat.

There is a lack of mental health treatment for harm reduction workers experiencing consistent loss, grief, and trauma. Often, harm reduction workers are part-time or volunteers who are not eligible for insurance benefits, but even full-time employees with benefits may have difficulty navigating those services and finding providers who understand harm reduction and the work they do, furthering the workers' experience of stigma.[68]

Harm reduction programs facing this lack of institutional support use creativity to support their staff. Some programs have created internal policies to provide self-care services such as yoga and acupuncture. Others provide workers with unlimited paid time off to let them deal with traumatic experiences in their own ways. Still, others may find money in their budgets to allow for on-site group counseling, as workers experiencing collective trauma often find individual therapy to be inadequate to address the nature of their grief. Many of these policies are supported by various research studies.[69]

In order to best support these workers and the people they serve, the broader drug policy regime needs to change. The criminalization of people who use drugs and the denial of access to a safe drug supply increases overdose and other drug-related harm. As we work to make these broader policy changes, providing support for the frontline staff who deal with the fallout of our policy failures daily is a necessary step to protecting workers' mental health.

Written by Amy Lieberman, J.D., Deputy Director, alieberman@networkforphl.org, and Ashleigh Dennis, J.D., Staff Attorney, adennis@networkforphl.org, Network for Public Health Law – Harm Reduction.

Widespread Access to Paid Leave and a Supportive Workforce Culture

The existence of paid leave for workers supports both population health and personal health and well-being, but the U.S. continues to fall behind peer nations when it comes to paid time off from work. Unlike other similarly situated countries, the U.S. does not require paid family and medical leave for private sector employees or guaranteed access to paid sick time and paid time off.[70] The Family and Medical Leave Act provides a federal guarantee of time off for eligible workers for certain medical and parental leave reasons, but it does not require employers to offer paid leave.[71]

Temporary federal measures during the onset of the COVID-19 pandemic showcased the health benefits of paid sick leave: the Families First Coronavirus Act mandated paid sick leave in certain circumstances, which helped to reduce disease transmission.[72] Other research has shown that access to paid family and medical leave is associated with decreased infant mortality, increased financial security for caregivers, and improved physical and mental health for new parents.[73] However, access to paid leave is not equitable. Lower-wage and part-time workers are less likely to access paid sick leave compared to their higher-income counterparts, as is the case for Black and Hispanic workers.[74] State preemption of workers' rights, including paid leave policies, may be one contributing factor.[75]

As of March 15, 2024, at least 15 states and D.C. have statewide paid sick leave laws.[76] Another three states—Maine, Nevada, and Illinois—have statewide paid leave laws that allow time off for *any* reason.[77] Maine was the first state to adopt such a law, the Maine Earned Paid Leave (MEPL) law, with eligibility for employees in public, private, full-time, and part-time work. While the MEPL law preempts localities from enacting their own earned paid leave laws, the laws in Nevada and Illinois do not. Additionally, Maine's more recent law on comprehensive paid family and medical leave provides Maine workers the opportunity to take more time off without financial stress and was supported by the Maine Paid Leave Coalition, whose values and principles include no preemption.[78]

This legal landscape leaves workers across the country relying on their employers to both provide leave over legislative guarantees and cultivate a workforce culture that supports employee use of their leave. More universal access to paid leave and a supportive workforce culture is critical for public, physical, and mental health because people need to be able to elect to stay home while sick or experiencing burnout, high levels of stress, or mental health concerns. The flexibility to take leave without financial or workplace repercussions also allows working people and their families to engage in regular physical and mental health maintenance, including civic engagement activities such as voting or lobbying, which supports their well-being in the long term. Individuals should not be forced to choose between working while sick, caretaking, fulfilling their civic duties, or taking unpaid time off. To that end, workforce infrastructure must also support workers to feel secure enough to make use of their access to paid leave. More than 40 percent of U.S. workers who *do* receive any form of paid time off take less time than their employers give—and over half of government, public administration, or military workers reported taking less paid time off than they were given.[79] In a survey of workers reporting their reasoning for not taking time off, Black workers were more likely than White workers to report that they were concerned that if they used all their time off, they would risk losing their jobs.[80] Another survey of public health workers revealed rising stress and burnout from the COVID-19 pandemic, highlighting the need for a public health workforce paradigm shift to better support total worker health.[81] Measuring utilization of paid time off allows us to understand not only where individuals can take paid leave, but if workplace policy and culture supports them to do so. In other words, implementation matters to fully realize the benefits of paid leave policies.

Written by Arianna Murray, Law Clerk, murray@networkforphl.org and Darlene Huang Briggs, J.D., M.P.H., Deputy Director, dhbriggs@networkforphl.org Network for Public Health Law – Special Projects.

Conclusion

This policy brief explored a selection of policies that can advance mental health and health equity. While not exhaustive, this list represents a starting point for recognizing the crucial role that law and policy play in shaping mental health outcomes as well as access to services. It helps highlight different frameworks for care, ensuring equitable distribution of resources, and protecting those who experience mental health conditions and

others who need better policies to promote their mental health and well-being. We invite you to reach out to the Network contributors with any questions, comments, or ideas to further support your efforts.

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