

Public Policy Priorities

The National Coalition for Mental Health Recovery (NCMHR) is a coalition of advocates and organizations representative of people with mental health diagnoses. The overarching priority of the National Coalition for Mental Health Recovery is to advocate for a recovery-focused mental health system that prevents crisis, protects rights, and promotes social justice, wellness, economic empowerment, and social inclusion.



01. "Nothing About Us Without Us"

Ensure that we, people with mental health diagnoses and/or psychiatric disabilities, are not only included in decision-making at all levels of government and policy pertaining to mental health, but that our voices and opinions are prioritized.



02. Promote Racial and Social Justice

Promote racial and social justice and equity in our movement for recovery-focused mental health services by protecting the rights of and promoting the inclusion of people of color, LGBTQIA+ individuals, and multiply marginalized people with mental health diagnoses.



03. Increase Alternatives to Forced and Coercive Treatment

Increase the availability and accessibility of alternatives to forced and coercive treatment by advocating for the funding and development of peer-run programs; promoting appropriately funded accessible, affordable, and safe housing; and addressing the cycle of poverty.



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Goal 1: "Nothing About Us Without Us"

Ensure that we, people with mental health diagnoses and/or psychiatric disabilities, are not only included in decision-making at all levels of government and policy pertaining to mental health, but that our voices and opinions are prioritized.

Our voices must be centered.

People with mental health conditions and disabilities are rarely involved in governmental, leadership, and policy conversations and decisions concerning services for people with psychiatric disabilities and make up less than 0.1% of senior employees in cabinet-level federal departments.

More specifically, government reports, mental health care quality assessment and improvement strategies, and policy conversations and development do not center the perspectives and priorities of service recipients and other people with mental health diagnoses. For example:

- U.S. Government Accountability Office (GAO) behavioral health reports since 2015 have centered the perspectives of neurotypical mental health professionals without psychiatric disabilities and not the priorities and opinions of people with mental health diagnoses [1].
- Service users and other people with mental health diagnoses "have only been tangentially involved in quality assessment and improvement strategies of the mental health services that they are receiving" [2].
- Policy concerning services for people with psychiatric disabilities is "developed with the near-total exclusion of the perspectives of the very individuals who are the recipients of such services" [3].

0.04%

of senior employees in cabinet-level federal departments have a mental health disability.

Leadership must be representative of those with firsthand lived experience.

0%

In 2020, individuals with diagnoses of major depression, bipolar disorder, schizophrenia, or PTSD made up 0% (0/502) of senior employees at the U.S. Department of Health and Human Services [4].

2.65%

In 2016, people with diagnoses of major depression, bipolar disorder, schizophrenia, or PTSD were included as only 2.65% of the Substance Abuse and Mental Health Services Administration's entire permanent workforce [5].

In addition, people with mental health conditions and/or psychiatric disabilities appear no more included within the current administration, at federal committee hearings, and within SAMHSA advisory committees on matters about them.

Critical Actions

- 01.** Involve people with mental health conditions and disabilities in quality assessment and improvement strategies of the mental health services they are receiving.
- 02.** Prioritize and center the voices of individuals with psychiatric disabilities and mental health diagnoses in policy conversations and decisions related to mental health.
- 03.** Ensure that people with mental health disabilities are represented in federal and governmental leadership, from SAMHSA advisory committees to senior-level cabinet positions.

1. <https://www.gao.gov>

2. Pincus, H. A., Spaeth-Rublee, B., & Ramanuj, P. P. (2017). Bringing Recovery and Consumers' Views Into the Mainstream of Mental Health Quality Measurement. *Psychiatric Services*, 68(11), 1182-1184. <https://doi.org/10.1176/appi.ps.201600222>

3. Letter from Bazelon Center for Mental Health Law et al. to Sen. Ron Wyden and Sen. Mike Crapo, Senate Finance Committee. Regarding Request for Stakeholder Input on Improving Access to Behavioral Health Services (Nov. 15, 2021). <https://www.finance.senate.gov/imo/media/doc/2021%2011%2015%20Feedback%20on%20Senate%20Finance%20BH%20RFI.pdf>

4. U.S. Equal Employment Opportunity Comm'n, Annual Report on the Federal Work Force Fiscal Year 2020. <https://www.eeoc.gov/newsroom/eeoc-issues-federal-workforce-report-2020>

5. U.S. Equal Employment Opportunity Comm'n Annual Report on the Federal Work Force Fiscal Year 2016. <https://www.eeoc.gov/federal-sector/reports/annual-report-federal-workforce-fiscal-year-2016>

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Goal 2: Promote Racial and Social Justice

Promote racial and social justice and equity in our movement for recovery-focused mental health services by protecting the rights of and promoting the inclusion of people of color, LGBTQIA+ individuals, and multiply marginalized people with mental health diagnoses.

"We don't seek help because people don't look like us"

2/3 of Black people in need of mental health services don't receive care [1].

6% of psychiatrists identify as Black [2].

Black, Indigenous, and other people of color significantly underutilize mental health services compared to their White peers. This is due to various reasons, such as the lack of Black and multiply marginalized mental health providers. Plus, when people of color do seek mental health services, they may receive racially biased and discriminatory treatment [1].

- "50% of people killed by law enforcement have a disability — primarily a psychiatric disability — with Black, Indigenous, and other people of color at the greatest risk." Yet, law enforcement still respond to the majority of mental health crises in the United States [3].
- People with psychiatric disabilities are 16 times more likely to be killed in encounters with police than non-disabled people [4].
- 55% of Black Americans with disabilities, primarily psychiatric disabilities, are arrested by age 28 [5].
- People with mental health conditions, especially those who are people of color, may avoid mental health treatment because of fear of stigma, cultural mistrust, and the significant lack of racial and ethnic representation across mental health services [6].

Heed the voices of people of color, people with mental health conditions, and those at the intersection.

Critical Actions

- 01.** Increase diversity in the mental health workforce by removing barriers to education, training, and certification.
- 02.** Ensure peer specialists and other mental health service providers reflect the composition of the communities they serve.
- 03.** Promote the inclusion of Black, Indigenous, and people of color at the highest levels of every hierarchy and center the voices of those who are the most impacted.
- 04.** Develop better solutions to support people of color with mental health conditions by recognizing the historic and current harmful impacts of police involvement in crisis care response.
- 05.** Involve individuals with lived experience, particularly those who are people of color, in the planning and implementation of alternatives.
- 06.** Expand culturally competent community-based and peer-led mental health services, including non-clinical services like supported housing, ongoing peer support, and supported employment.

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1. Legal Defense Fund & Bazelon Center for Mental Health Law (2023). *Community-based services for Black people with mental illness: Advancing an alternative to police*. <https://www.naacpldf.org/wp-content/uploads/2023-LDF-Bazelon-brief-Community-Based-Services-for-MH48.pdf>
 2. Association of American Medical Colleges, Physician Specialty Data Report 2021. <https://www.aamc.org/datareports/workforce/data/active-physicians-black-african-american-2021>
 3. Jensen, J. (2023). *We must find better ways to help people in mental health crisis*. Chicago Sun Times. <https://chicago.suntimes.com/2023/5/26/23736461/mental-health-crisis-911-calls-988-hotline-alternative-response-jordyn-jensen-northwestern-op-ed>
 4. Stout, C. (n.d.). *How mental illness affects police shooting fatalities*. International Bipolar Foundation. <https://ibpf.org/how-mental-illness-affects-police-shooting-fatalities/>
 5. McCauley, E. J. (2017). The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender. *American Journal of Public Health*, 107(12), 1977–1981. <https://doi.org/10.2105/ajph.2017.304095>
 6. Miller, N. S. (2022). *Racial disparities in mental health care: An explainer and research roundup*. The Journalist's Resource. <https://journalistsresource.org/home/racial-disparities-mental-health/>

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Goal 3: Increase Alternatives to Forced and Coercive Treatment

Increase the availability and accessibility of alternatives to forced and coercive treatment by advocating for the funding and development of peer-run programs; promoting appropriately funded accessible, affordable, and safe housing; and addressing the cycle of poverty.

Coercion and force do not work in mental health services and crisis response situations.

In fact, a 2017 Cochrane review found that involuntary commitment does not result in a "difference in service use, social functioning or quality of life compared with voluntary care" [1].

Instead, forced and coercive mental health services, like involuntary commitment, cause harm and further traumatize people with psychiatric disabilities, especially Black, transgender, and multiply marginalized people with mental health conditions [2]. Despite this:

- Politicians and legislators continue to prioritize involuntary hospitalization and other coercive measures for unhoused people and people with mental health diagnoses [2].
- Mental health policy initiatives and services associate psychiatric disabilities with violence, which leads to the prioritization of coercive measures that make it extremely difficult for people with mental health diagnoses to participate in their communities and live full lives [3].
- Federal policy continues to focus on the "narrow theme of 'access to treatment'" instead of, and with no regard to, "supported employment, supported housing, and peer support services" – all things that are critical to successful community living [3].

Increase mental health services developed and delivered by peers with lived experience.

78%

of people who participated in the peer respite program, Second Story, in Santa Cruz, California, were less likely than non-respite users to use inpatient and emergency services in the future [4].

100%

of people who attended the peer respite program Afiya in Massachusetts reported that, compared to their psychiatric inpatient stay, their experience was positive, welcoming, and offered opportunities for them to connect with others with similar experiences [4].

It is clear that mental health peer-run respite programs should be prioritized over inpatient hospitalization.

Critical Actions

- 01.** Advocate for the funding and development of peer-run programs, including peer-run crisis respites, jail diversion programs, and hospital diversion programs.
- 02.** Encourage the development of peer-led engagement strategies to prevent the development of coercive interventions that infringe on civil liberties.
- 03.** Address the cycle of poverty through employment and educational opportunities.
- 04.** Promote appropriately funded accessible, affordable, and safe housing, such as Housing First, peer-owned housing, and collective ownership models.
- 05.** Provide technical assistance at the state and local levels, with attention to sustainability of the nonprofits that administer these activities.

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1. Kisely, S. R., Campbell, L. A., & O'Reilly, R. (2017). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *The Cochrane database of systemic reviews*, 3(3), CD004408. <https://doi.org/10.1002/dm.1111>
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 3. Mathis, J. (2017). *The importance of framing federal mental health policy within a disability rights framework*. American Bar Association. https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/2016-17-vol-42/disability-rights-under-siege/the-importance-of-framing-federal-mental-health-policy-within-a/
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