PsiAN ADVOCACY TOOLKIT

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INTRODUCTION

PsiAN MISSION

The Psychotherapy Action Network is a global community of mental health professionals and stakeholders dedicated to promoting psychotherapies of depth, insight and relationship. PsiAN aims to restore these therapies to their fundamental place in the mental health landscape through education and advocacy regarding their personal, economic, and effectiveness in alleviating suffering and transforming lives.

PsiAN STRUCTURE

PsiAN has two components:

- A 501(c)3, called Psychotherapy Action Network (PsiAN), which is a non-profit ("private foundation") whose mission is to advocate to and educate the public, policymakers, and our profession about the value of therapies of depth, insight and relationship. Donations to PsiAN are tax deductible.
- A 501(c)4, called PsiAN Advocacy, which is our advocacy arm and under which we can lobby for legislation and take political positions. Donations to PsiAN Advocacy are not tax deductible.

PSYCHOTHERAPY ADVOCACY GOALS

PsiAN has put together this toolkit to be a source of both information and inspiration for you as you take on the very important task of advocating for therapies of depth, insight and relationship. It lays out the basics: how to approach advocacy and how to think about yourself in approaching legislators, as well as practical information about how the legislative and rulemaking process work. This version of the toolkit includes information on the standards of care cited in the Wit v UBH decision, providing talking points and information for you to use in communicating with legislators and their staff.

We invite you to speak with your elected representatives in your capacity as their constituent—you need not represent PsiAN, though you are certainly welcome and encouraged to let them know about our group, and may find your message amplified if your elected representative understands that your message is endorsed by a growing professional organization. But it's most important that our collective voice is heard through the development of many individual relationships. If you do wish to act as a representative of Psychotherapy Action Network, please check with us first.

This toolkit will be a living document, and we will add to it going forward on other topics. We'd also love to include your experiences about what you find that works well, so please stay in active touch and let us know.

WHY YOU'RE THE BEST PERSON TO DO THIS!

- You – yes, you! – are an authority on the topic, and can be effective in a way that is uniquely different than lobbyists – a uniquely informed professional.
- You know how to communicate, form relationships, cultivate trust – these are the skills that are needed to connect with lawmakers and advocate!
- You don't need to be trained in the law or lobbying. Of course, it will help to be informed about current laws from a lay perspective. But, you don't need to be an expert in the statutes and rules, etc. You just need to know what helps patients.
- You are educating legislators to think the way you do about therapy
- You are in a unique position to inform legislators about how laws impact you as a therapist and also how they impact those receiving services in the community

SUMMARY OF WIT v UBH DECISION

In February of 2019, Chief Magistrate Judge Joseph Spero of the United States District Court for the Northern District of California released his sharp and detailed rebuke of United Behavioral Health (UBH) for putting profits before people from 2011-2017 across four states: Connecticut, Illinois, Rhode Island and Texas. UBH was found liable for breach of fiduciary duty and liable for the plaintiffs' denial of benefits claim. This class action suit was brought on behalf of patients who had UBH insurance policies, but were denied coverage by UBH for residential treatment, substance use disorder, and outpatient treatment.

In the ruling, the Court explicitly noted that the internal guidelines used by UBH were dictated by their own financial considerations and failed to meet "generally accepted standards of care." It found that UBH's self-created guidelines repeatedly focused on coverage only for acute symptoms rather than more comprehensive treatment. Moreover, they were heavily influenced – indeed, ultimately controlled – by its finance department. UBH's medical experts were excoriated for having "serious credibility problems" related to the extent their testimony was marked by evasiveness and deception.

The Court looked to standards of care as defined by the American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS), along with several other professional organizations. Judge Spero determined that UBH's violated its fiduciary duty by utilizing criteria that were inconsistent with generally accepted standards of care and also violated a number of state laws that require the use of the ASAM criteria for substance abuse disorders. Judge Spero noted that, "The *only* reason UBH declined to adopt the ASAM Criteria was that its Finance Department wouldn't sign off on the change." UBH's financial managers had thereby exercised veto power over UBH's clinicians.

Standards of Care

In his ruling, Judge Spero chose not just to reference standards of care, but to spell them out:

1) It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms.
2) It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care
3) It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective
4) It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care
5) It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration
6) It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment
7) It is a generally accepted standard of care that the unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders
8) It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient

Implications

There are several implications from this ruling that are extremely important for state legislators to be aware of:

- Few state laws require medical necessity criteria to be consistent with or operationalized by generally accepted standards of care.
- If the largest insurance company in the country has been found to have developed its own guidelines for financial motives and refused to adopt ASAM criteria for this reason, a similar internal process may be found to be at work in other companies. Indeed, there is currently a class action lawsuit filed against Health Care Services Corporation (HSCS – the parent of BCBS IL, MT, NM, OK, and TX) alleging similar practices.
- The Court ruled that UBH's actions were essentially an end-run around the federal Mental Health Parity and Addiction Equity Act.
- The Court also spoke to the role of accreditation, noting that the AMA has (rightfully) argued that accreditation should not take the place of regulatory oversight. It found that

UBH had satisfied the accreditation process, but that didn't prevent them from placing financial interests over patient protections.

Why are we so interested in this ruling?

Judge Spero's decision brings the law to bear on a set of circumstances under which insurance companies illegally deny care, particularly of the treatment of underlying conditions. It also opens the door to one important part of a solution: his explicit inclusion of generally accepted standards of care in his findings can serve as a template for new state legislation that requires medical necessity determinations, and the criteria used to make these determinations, be consistent with these standards. Such legislation can have a significant impact on the scourge of undertreatment and its profound human and societal costs, going a long way towards protecting parity, respecting clinicians' treatment decisions, and providing patients with clear legal support for actually receiving the benefits they've paid for.

Standards of care, in brief

1) Treat the **underlying condition**, not only current symptoms
2) Treat **co-occurring** conditions
3) Treat at the least intensive level of care that is **safe** and **effective**
4) Err on the side of **caution**
5) Effective treatment includes services to **maintain function**
6) Determine **duration** of treatment based on individual needs
7) Take unique needs of **children / adolescents** into account
8) Make level-of-care decisions based on a **multidimensional assessment**

MAKING ADVOCACY AND LEGISLATION MEANINGFUL:

CASE VIGNETTES

A dialogue with legislators is often enhanced with a brief, well-articulated story about how a particular law impacts constituents. Legislators are most interested in the problems of their constituents, and therefore sharing your own practice experience plays a crucial role in influencing your elected representatives, and thereby influencing legislation. We all have cases from our practice and experience, and using your own examples will be the most powerful. As a reminder, clinical vignettes must be written or expressed in a way that protects the privacy and identity of specific patients.

Below are some sample vignettes illustrating the practical application of the eight standards of care coming from the Wit v UBH ruling. This process of sharing vignettes with legislators could be used in response to a court ruling, a proposed bill, a piece of active legislation, or revisions to department rules, etc.

Standard 1: Treat the **underlying condition**, not only current symptoms

> For many patients, anger management training to control outbursts and de-escalate conflicts is extremely helpful, but they are still tormented by feelings of rage and/or despair. A treatment example from my practice was a woman who went through anger management training several times before coming to me, still plagued by irrational feelings of anger. After a year of our working together in therapy she was at last able to find the underlying link – verbal abuse as a child – and to confront, work through, and resolve this painful issue. If untreated, feelings like these are likely to lead to serious depression and/or affect health/mental health in other ways.

Standards 2,3,5,8: 2) Treat **co-occurring** conditions; 3) Treat at the least intensive level of care that is **safe** and **effective; 5)** Effective treatment includes services to **maintain function;** 8) Make level-of-care decisions based on a **multidimensional assessment**

> The interplay of emotional problems, substance abuse, and life circumstances can be very difficult to treat when the approach isn't fully integrated. This was true for a family member of mine who began drinking heavily shortly after the birth of her first child. She denied being depressed, but during periods of sobriety, she expressed fears about her bond with her child and was preoccupied with shameful memories of her estranged mother's criticisms of her. She was admitted to alcohol rehab but psychotherapy wasn't available in this program. After completing rehab, she began psychotherapy as an outpatient, but only saw her therapist every week or two. Within a few months, she was back to drinking heavily. She yo-yoed for two years between unsuccessful alternating courses of alcohol rehab and outpatient psychotherapy, unable to find an integrated program that had all of the services she needed, and that her insurance covered. She became convinced that she couldn't be helped, and ultimately lost both her marriage and custody of her child.

Standard 4: Err on the side of **caution**

> Undertreatment can have devastating consequences, as was the case for a woman who entered therapy with a history of severe mood swings, suicidal ideation and self-harm. I determined that the appropriate level of care was therapy sessions two or three times a week to stabilize her and work towards resolution of her abrupt and very serious mood swings. Her insurance company only approved coverage for once weekly sessions. This frequency of treatment proved insufficient, and as a result she was hospitalized for suicidal ideation and self-harm on an average of one time per month, each time for 1 – 3 days. The client felt she was failing at managing her depression, and failing to maintain her work commitments, which were disrupted by the hospitalizations. The inadequate level of care worsened her depression, and in this despondent state she ended her life.

Standard 6: Determine **duration** of treatment based on individual needs

It's so important that preconceived ideas about how long it should take to resolve a problem don't dictate the length of therapy. This was true in the case of a client who came to therapy with long-standing anxiety and panic attacks. His primary care physician recommended a brief therapy to equip the client with tools and techniques to reduce his anxiety. The client was able to use breathing exercises and mindfulness techniques to bring down his anxiety once it peaked, but still his ongoing anxiety persisted and he wasn't sure why.

Because the therapy had diminished his symptoms, his insurance company questioned the validity of ongoing treatment. The therapist and client challenged the insurance company, and were able to extend the insurance coverage. After a year and a half of therapy, the client was able to link his panic attacks and anxiety to growing up with a single parent whose psychosis made her frighteningly unpredictable. With the opportunity to understand and work through these early experiences, the client ultimately became free of both his acute symptoms (panic attacks) and his underlying level of anxiety was greatly reduced.

Standard 7: Take unique needs of **children / adolescents** into account

Children's needs are different from adults and insurers must be responsive to this. They weren't in the case of a six-year-old who was brought to therapy by her mother because of her anxiety and hoarding behavior. She saved used candy wrappers and other bits of things and reacted intensely when asked to throw them out. The therapist worked with her twice a week in play therapy for six months, where together they understood and addressed the fears underlying her behavior. She stopped hoarding and her anxiety level dropped. The therapy sessions were submitted to her insurance company, and the insurance company asked for a review. The review focused on whether the therapist had used techniques that aligned with their own internal guidelines based on treating hoarding in adults.

Even though the services had been provided and the treatment was successful, the insurance company ultimately denied to pay anything, because the child hadn't been treated with *the insurance company's* recommended treatment techniques (for adults). The family then had to pay for the entire treatment out of pocket, despite having a good insurance policy. In fact, there are no formal, professionally generated treatment recommendations for hoarding behavior in children, and in this case the insurance company overrode the clinician's clinical judgment, despite the successful outcome.

MAKING ADVOCACY AND LEGISLATION MEANINGFUL:

FACTS FOR LEGISLATORS

Many legislators do not have all the facts about the limited effectiveness of short-term manualized therapy. You may find it helpful to reference these studies.

- Research supports the evidence base of psychodynamic therapy for depression, and also indicates that time-limited treatment is insufficient for a substantial number of patients encountered in psychiatric outpatient clinics.
    - Driessen E, Van HL, Don FJ, Peen J, Kool S, Westra D, Hendriksen M, Schoevers RA, Cuijpers P, Twisk JW, Dekker JJ Am J Psychiatry. **The efficacy of cognitive- behavioral therapy and psychodynamic therapy in the outpatient treatment of depression: a randomized clinical trial.** *American Journal of Psychiatry*, 2013 Sep;170(9):1041-50. doi:10.1176/appi.ajp.2013.120708

- Despite current general beliefs, research found no specific effectiveness of cognitive-behavioral therapy.
    - Irene Elkin, PhD; M. Tracie Shea, PhD; John T. Watkins, PhD; et al **National Institute of Mental Health Depression Collaborative Research Program; General effectiveness of treatments** *Arch Gen Psychiatry.* 1989;46(11):971-982. doi:10.1001/archpsyc.1989.01810110013002

- Brief, manualized treatments have actually been found to be "*ineffective* for most depressed patients most of the time". Whatever benefits there are, they are short-lived and don't endure; the majority of patients who receive CBT seek treatment again, within 6-12 months, for the same condition.
    - Shedler, J. (2015). **Where is the evidence for "evidence-based" therapy?** *Journal of Psychological Therapies in Primary Care, 4, pp. 47-59.*
    - Westen, D., Novotny, C.M., & Thompson-Brenner, H. (2004). **The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials.** *Psychological Bulletin, 130,* 631-663. Doi: 10.1037/0033-2909.130.4.631

- Psychoanalytic treatment is evidence-based, and is as effective as other purported 'Empirically Supported Treatments." Additionally, clients receiving psychodynamic therapy maintained their gains, as well as appeared to *continue to improve* post treatment. The perception that psychodynamic approaches lack empirical support does not accord with available scientific evidence and may reflect selective dissemination of research findings.
    - Jonathan Shedler, **The Efficacy of Psychodynamic Therapy.** *American Psychologist,* 2010 February - March, 98-109.
    - Steinert, C., Munder, T., Rabung, S., Hoyer, J., & Leichsenring, F. (2017). **Psychodynamic therapy: As efficacious as other empirically supported treatments? A meta-analysis testing equivalence of outcomes.** *American*

Journal of Psychiatry, 174, issue 10, p. 943-953. doi: 10.1176/appi.ajp.2017.17010057

- Researchers have found 56% percent of 'Empirically Supported Treatments' per the American Psychological Association fare poorly across most metric scores for power and replicability.
    - John Kitchener Sakaluk, Alexander J. Williams, Robyn E. Kilshaw, Kathleen Teresa Rhyner. **Evaluating the evidential value of empirically supported psychological treatments (ESTs): A meta-scientific review.**. *Journal of Abnormal Psychology*, 2019; 128 (6): 500 DOI: 10.1037/abn0000421

- Patients improve more rapidly when they get the kinds of treatments they prefer. For example, the response rate to their preferred treatment is 45-50%, as compared to a response rate of 7% when they receive medication but don't prefer medications, or a response rate of 22% when they receive therapy but don't prefer therapy.
    - Lin, P. , Campbell, D.G., Chaney, E.F. et al. **The influence of patient preference on depression treatment in primary care.** *Annals of Behavioral Medicine, Oct* 2005, 30, (2), 164-173. doi.org/10.1207/s15324796abm3002_9

Below are some basic mental health statistics (from NAMI) that may be helpful when talking to your legislators. (For state by state statistics, please see the tables from Mental Health America: Statistics by State)

- 1 in 5 Adults (20%) experience mental illness.
- 1 in 25 Adults (4%) experience serious mental illness
- 17% of youth (6-17) experience a mental health disorder
- Suicides and drug overdoses are increasing, contributing to the longest sustained decline in life expectancy in over a century, while life expectancy is increasing throughout much of the rest of the world[1]
- Mental health problems are getting worse, but medication alone is not the answer. More people are on medication than ever before, with 13% of the US population taking an antidepressant last month, and a 65% increase in people using antidepressants from 1999-2014[2]
- Maybe one reason meds are so popular because the pharmaceutical industry markets them and lobbies so well.
    - The pharmaceutical industry spends $240 million/year on lobbying and $30 billion/year on marketing[3]
    - For every $1 spent on R&D, $19 is spent on marketing[4]

12-month prevalence of any mental illness:

- 15% of Asian adults
- 16% of Black adults

[1] https://www.smithsonianmag.com/smart-news/us-life-expectancy-drops-third-year-row-reflecting-rising-drug-overdose-suicide-rates-180970942/

[2] https://www.apa.org/monitor/2017/11/numbers. By the numbers: Antidepressant use on the rise

[3] Center for Responsive Politics: https://www.opensecrets.org/industries/indus.php?ind=h04

[4] Light, D., Lexchin, J. (2012). Pharmaceutical research and development: what do we get for all that money? *BMJ* 2012;345:e4348. https://doi.org/10.1136/bmj.e4348.

- 17% of Hispanic or Latinx adults
- 20% of Caucasian adults
- 27% of adults who present as being mixed race or multiracial
- 37% of lesbian, gay and bisexual adults

12-month prevalence of common mental illnesses. (Many individuals have more than one.)

- 19% Anxiety Disorders
- 7% Depression
- 4% Dual Diagnosis
- 4% Post Traumatic Stress Disorder
- 3% Bipolar Disorder
- 1% Obsessive Compulsive Disorder
- 1% Schizophrenia
- 1% Borderline Personality Disorder

MAKING ADVOCACY AND LEGISLATION MEANINGFUL:

MAKING THE CASE FOR STANDARDS TO BECOME LAW

Tip: Don't worry about making all these points. Match your arguments with what you think is most salient for your legislator.

1. Implementing the standards of care into legislation has the power to promote a *patient-centered environment* where:

- The patient's health needs always come first.
- Patients can trust their doctors to use their best clinical judgment to provide the safest and most effective care, not burdened with concerns that insurers are undermining clinical treatment decisions.
- Patients don't have to fight with insurance companies to use their own insurance policies (which they, or their employers, have purchased), and for their right to coverage for agreed-upon treatment
- Insurance companies' authority to undermine clinician judgment and to place profits over patient care is limited by state standards which can readily be enforced by the state's Insurance Commissioner and/or by the court.

2. Implementing the standards of care into legislation has the power to promote a *regulatory environment*, where states have a bottom-line reference for evaluation of mental health treatment programs, making it possible to:

- Judge comparative effectiveness of mental health programs and policies
- Evaluate progress moving from mental illness to mental wellness
- Evaluate economic and social benefits against the costs of treatment

HANDLING OBJECTIONS: WHAT YOU CAN DO IF THEY SAY 'NO'

Throughout the advocacy process, there may be times when your efforts to initiate change are opposed by individuals or other institutions. When one expects and prepares for opposition beforehand, these moments can be less strenuous, and even lead to greater support for your cause. The following represents some potential sources and reasons for opposition. Keep in mind that the type and strength of opposition will depend on a number of factors.

The Who of Opposition

- Other lawmakers
- Lobbyists
- Professional organizations
- Other citizens
- Local media

The Why of Opposition

- Motive. It's possible that some may think that you only have your own paycheck in mind by advocating for psychotherapy and will question your motives. Be aware of how you present and frame your position.
- Time. Making a bill into law can sometimes take months or even years, and lawmakers may have other projects they want to push first. Ironically, a bill can die in committee in a matter of weeks.
- Credibility. Some may question your credentials or you could be opposed by someone who has "more" credentials. Keep in mind that flaunting a myriad of credentials can also work against you. Remember the importance of connections, not just credentials.
- Competing Relationships. Some legislators might have long-standing relationships with individuals (e.g., donors/supporters) who oppose a bill you are advocating for.
- Stigma. Unfortunately, there is still misunderstanding about mental health and substance use. Sometimes this stigma is against the profession or the people who need its services. Fortunately, a growing number of lawmakers are more supportive of these issues.

The How of Opposition

- "Die in Committee." Most bills are created in committees and these committees typically have a chair and other members. If the bill never leaves committee, it dies.
- Veto. Bills can be vetoed by the governor or voted down by the other house.
- Bill Alteration. By the time a bill becomes law, there have been many hands on it. These sometimes subtle changes to the bill can dramatically change its effectiveness and meaning.
- Personal Disparagement. This is the ugly side of politics. When oppositional forces lack strong defense, their tactics may turn to character slander. If you practice in a small town, the consequences of your advocacy work could negatively impact your reputation and business.

How Can I Respond to Opposition?

- Listen carefully to the opposition. This is what we're especially good at, and a skill that's crucial here. We need to agree to disagree long enough to identify the good from conflict. Listen long enough to find out where you both agree and build off that.

- Write, and enlist others to write, letters to the editor and participate in town halls to gather support. When needed, these outlets can be used to bring to light the actions of your opposition.
- Trust the legislator(s) you're working with and their staff. This isn't their first rodeo and they should be familiar with how to manage the legislative process to help the bill succeed.
- Enlist more lawmakers, especially those that belong to the committee that is drafting the bill (health and welfare etc.). If possible, have your legislator ally make an appointment with the governor to explain your cause. The governor has powerful sway with both the people and legislative body. If a bill becomes part of the governor's agenda, this can not only expedite the process but lead to greater chance of success.
- Respect the legislators' other duties and projects. Optics matter, and you don't want to be labeled (or label PsiAN) as self-interested by pushing a particular bill ahead of other important measures.
- Enlist an expert. Reach out to PsiAN or others to have an expert write a letter or speak before the committee or legislative body. Be strategic about this. When one defers to others too quickly or too often it can diminish their credibility.
- Monitor local newspapers and websites for reports on your efforts. You'll want to be aware of what the public is hearing about the bill. Media uses conflict to create storylines, so when possible, volunteer for interviews to create accurate media coverage.
- Read and prepare. Be ready to answer questions thoughtfully and accurately. Keep in mind that passionate anecdotes are sometimes more persuasive than data.
- Take care of yourself. Government activism can lead to many disappointments. Learn to manage the let-downs and support each other.
- Be patient. Some bills come around in different forms year after year and don't get passed. Remember that gridlock is often a government achievement and can result in a more robust, tried and true piece of legislation. Think of this as the work we do in laying the seeds for therapy. The results are not always immediate, but it softens the soil for change in the future.
- Always remember that no effort is wasted!

FAQs FOR LEGISLATIVE ADVOCACY

Acronyms:

AAPCSW: American Association of Psychoanalysis in Clinical Social Work
APA: In this document, refers to the American Psychological Association.
ASPPB: Association of State and Provincial Psychology Boards.
ASWB: Association of Social Work Boards
CSWA: Clinical Social Work Association
CSWE: Council on Social Work Education.
CMS: Centers for Medicare and Medicaid Services (part of the United States Department of Health and Human Services).
EPPP: Examination for Professional Practice in Psychology.
NASW: National Association of Social Workers

Note:

- The answers below relate primarily to constituent advocacy at the state level.
- The terms “lawmaker,” “legislator,” and “representative” might be used interchangeably to refer to elected members of the state senate and assembly.
- The terms “department” and “agency” might be used interchangeably.
- The terms “examining board” and “licensing board” might be used interchangeably.
- The terms “legislation” and “statute(s)” might be used interchangeably.

1. Why is advocating at the state level important?

Given our system of governance in the United States, where states’ rights are fundamentally protected, most laws are written at the state level. Exceptions, of course, are rules/regulations related to the services provided or funded by government agencies – Dept. of Veteran Affairs and the Centers for Medicare and Medicaid. In other words, it’s advocacy at the state level that is crucial, whether it be to inform new legislation or revisions to current law/rules. In addition, it is common for other states to adopt laws, especially from adjacent states, that are believed by lawmakers to be “good laws,” that is, laws that are viewed to be of benefit to the citizenry (e.g., “protect the public”).

This is clearly demonstrated by the history of the APA and ASPPB, which persuaded state psychology boards across the country (and Canada) that the EPPP was necessary to “protect the public.” This was accomplished one state at a time. It is likely the APA and ASPPB would have been unsuccessful advocating for a federal law that would have established passage of the EPPP as a national standard for licensure. Of course, there is an argument to be made that the history of the EPPP also demonstrates how individual states can be misinformed by large national professional organizations.

2. How to locate your legislators and determine if they sit on committees related to mental health

Most, if not all, states have a “find your legislator” feature on their state government website where you simply enter your residential address to locate both your state senator and assembly person. The websites for the respective houses of the legislature typically list their committees as well as identify the representatives that sit on each committee. It is helpful to be informed about which legislators sit on committees related to mental health but to also be informed about what committees your state representatives sit on.

3. How to make appointments with legislators

Contact information (phone/email) can be located by googling your elected representatives and locating their official government webpage. If direct email addresses are not provided, there should be a contact form that can be electronically submitted to your representative. Making an appointment should be as easy as calling/emailing to request an appointment, but keep in mind that even in small states some representatives can get hundreds of emails a month and you don’t want yours to get lost in the mix. Attending town hall meetings is an excellent way to learn about and make contact with your representatives and their staff.

Lawmakers welcome meetings with professionals who can inform them about their profession. Keep in mind, a representative’s constituency is made up of every profession that exists in their district – first responders, teachers, nurses, skilled trades, manufacturers, lawyers, the clergy, etc. – and it is impossible for them to have expertise in all these areas. They depend on their

constituents to keep them informed (i.e., a mutual, symbiotic relationship) on issues related to the various professions represented among their constituency.

Remember to check applicable election cycles and calendars. If an election is coming up, the legislator may be focusing much of their time on campaigning. This can be a great time to jump in and build a relationship with a representative. Volunteering to help campaign can pay off later as you work with your representative to craft legislation. If you choose a legislator to work with that is nearing the end of their term, make sure they are running for reelection.

4. What to bring to meetings with legislators

If you are meeting to address a particular piece of legislation or a bill idea, come prepared with general bullet points that communicate how the bill would impact you, your profession, and/or your clients/patients. Don't bring a portfolio of data (e.g., your CV, journal articles, etc.). First, develop the relationship. Second, briefly express your thoughts. This is also true of meetings where you want to recommend legislation that does not currently exist or to request your representative consider writing a bill that revises current statutes/rules. It's likely you'll get anywhere from 15-30 minutes for a meeting, at least initially and until a strong relationship has been developed.

5. How and when to follow up with legislators

Consider creating an "advocacy" folder where you keep documents related to issues for which you are advocating. For example, if you're involved in a couple different bills, create a folder for each bill. Create matching email folders as well. When time permits, review previous emails, especially if you haven't heard from your representative in a while. In most cases, it is not necessary to email more frequently than once every 1-2 months, unless you are invited to engage more actively on a particular piece of legislation.

Keep in mind, legislators have multiple bills they are working on at any particular time, not to mention having to attend political/re-election events. Be mindful of that. It will go a long way. You will be able to tell from their feedback and/or response whether they are interested in your ideas or feel they would benefit from your contribution. If they do not demonstrate the sort of interest you might hope for, it could be that they are less interested in a particular piece of legislation, are too busy, already feel they've been adequately informed, or your thoughts echo thoughts already being advocated for by another constituent or organization. And keep in mind, if the response from your representative is lacking, you can always go on the record at a public hearing. It is important to be diligent and organized. Even more important is to show respect and extend compassion.

6. When are rules written?

Rules are written by state agencies/departments and boards under the authority given to them by statute. Rules are written in order for agencies to implement the laws written and passed by the legislature. A department might revise or write rules to be compliant with federal law. A board might revise rules to be compliant with changes in state statute. A department/board might revise rules that are determined by the department or board to be outdated. Some rules are written over the course of months, others over the course of several years.

7. What is the relationship between legislation and rules?
Legislation (i.e., "statutes") give rule making authority to departments and boards and are what give rules the authority of law.

8. What are the different steps in the lawmaking process?
Legislation often begins with an idea an elected official believes would make a good law. They have to present a draft of their bill to their legislative leadership (e.g., Speaker of the House; Senate Majority Leader) for consideration. If the bill is approved by leadership, it is assigned to a legislative committee in each house. Once the bill has passed each committee it is then brought to a full vote in both the senate and the assembly. The bill must pass both houses before it is sent to the governor to either be vetoed or signed into law.

9. When is the best time to intervene with legislation? In committee or on the floor?
One can certainly advocate throughout the entire process, but constituents have the greatest potential to inform legislation during the drafting of a bill and during the public hearing on the bill in committee. Keep in mind, not all bills are referred to a committee (determined by the senate and assembly leadership). If a bill is referred to a committee, it is during the committee's public hearing on the bill that a constituent's voice can be formally heard (on the record). Amendments are often made to a bill while in committee. Once the Chair of the committee calls for a full committee vote on the finalized draft, and if it passes, it then goes to the respective house for all members of that house to vote for or against the bill. If it is passed by both houses, it goes to the governor, who may or may not sign the bill into law.

Advocating once the bill leaves committee can be done, but that is much more challenging and is benefited by relationships you have established with the executive branch (i.e., Office of Administration; Governor's Office).

10. How to figure out which mental health legislation already exists in your state
Identify the agency that has been given authority by the state legislature to promulgate/enforce rules related to mental health (e.g., Department of Health Services). Rules are found in what is often referred to as the *Administrative Code*. But it is also important to be familiar with state statutes that authorize agency rules. If you are unable to locate laws related to mental health in your state, you can contact your elected representatives and directly ask their office what laws in your state regulate mental health services, including your particular profession: psychology, professional counseling, clinical social work, marriage and family therapy, etc. Typically the agency rules and state statutes are cross referenced in their respective chapters, so accessing even one document (e.g., chapter of the administrative code that regulates department of health services) should point you in the direction of relevant statutes. Also keep in mind that addiction treatment is often included in separate statutes and/or agency rules than general mental health.

11. How to file a "witness slip"
A constituent can write their elected representatives in support of or opposition to a bill, as well as submit a public comment (in writing or in person) during the public hearing phase of a bill or revisions to rules. Most states have a legislative tracking system that allows constituents to be informed about new bills and/or new/revised agency rules.

12. The relationship between legislation and licensing boards

Statutes (legislative branch) give authority to licensing boards to promulgate rules for their profession – e.g., psychology, social work, psychiatry. Members of the licensing board are typically appointed by the governor (executive branch).

13. Who sits on state licensing boards?

This varies by state and by profession (e.g., psychology, social work, etc.), but typically a board is made up of 3-6 professionals licensed by the board as well as 1-2 public members. Similarly, Boards of Social Work differ from state to state in size and composition. In general they include social workers at varying licensure levels as well as one or more members representing the public.

14. What is the relationship between professional organizations and licensing boards?

Technically, it is whatever relationship that is allowed by law. For example, if a state requires individuals to graduate from programs accredited by a specific professional organization (e.g., APA, CSWE) in order to meet criteria for licensure, one could reasonably make the case that an official relationship is sanctioned by law.

In the field of psychology, nothing restricts members of a licensing board from also being members of APA, but there have been concerns raised about members of psychology licensing boards being members of ASPPB, for example, due to the potential conflict of interest of sitting on the licensing board that requires the passage of the exam (EPPP) created and sold by ASPPB. That said, this sort of dual relationship currently exists throughout the country. It is a known fact that APA has been lobbying for state boards to adopt the APA Model Act for State Licensure of Psychologists. There are various opinions about the APA's degree of influence at the state level. Constituent advocacy is one way to create accountability in the relationship between professional organizations and licensing boards.

ASWB has granted NASW the privilege of approving social work trainings for other organizations. Also, ASWB recently partnered with CSWE (which accredits social work schools and sets educational policy), NASW and CSWA to establish Standards for Technology in Social Work Practice. Beyond that, individual state boards may have informal relationships involving advocacy with one or more professional social work organizations or, in some cases, formal relationships.

ORGANIZING STRATEGIES

- Connect with others in your state. Gather a group of people who are concerned about the issue you want to address.

- Find a partner to visit your legislators to introduce yourself and share your areas of interest and expertise (e.g., suicide prevention, trauma treatment, treatment access, etc.)

- Check out the legislative calendar. Some of the time, legislators are in their respective capital cities. Other times, legislators have pre-scheduled events and meetings when away from the capital in their home districts.

- Share outcomes - with each other and with PsiAN! Sharing what works and what doesn't will help all of us.

- Use your social media accounts to post information and activity.

- Speak at conferences or local events/write articles.

- Show up at community events where a lawmaker or their staff will be present.

- In particular, getting to know legislative staff can be very helpful! Staff will have more time and are easier to access than lawmakers.

- Consider connecting with organizations outside of mental health that would benefit from this type of legislation (e.g., law enforcement, school districts, etc). These connections can be similar to garnering endorsements for your efforts. When, for instance, first responders (police, fire, EMT) become invested in the value of resources for themselves, they can become important political allies in this effort.

- If you're advocating for a particular piece of legislation, try to be aware of other groups also advocating for it and, when possible, collaborate on a common approach. Also, feel free to reach out to PsiAN, because we may have information on other groups, what they are working on, and how we might join together.