CPA POLICY PLATFORM

DRAFT 1.6

I. GENERAL PRINCIPLES

The CPA remains unrelenting in its effort to reduce the human suffering and social cost of mental and substance-related disorders by improving equitable (parity) access and effective whole-person treatment in comprehensive systems of care. Therefore, the CPA supports policies which:

STIGMA

GP 1: Eliminate stigma, the social ostracism that deters funding and the personal shame that deters treatment.

PARITY

GP 2: Align with the full implementation of federal and state parity (insurance non-discrimination) for mental and substance-related disorders.

INTEGRATION OF CARE

GP 3: Eliminate the fragmentation of funding and care that have historically segregated general health and mental and substance-related services.

GP 4: Eliminate barriers and administrative burdens that deter coordination and transfer of care in managed care programs.

GP 5: Establish consultation and coordination of care between county specialty mental health systems and general healthcare systems.

PSYCHIATRIC PHYSICIAN LEADERSHIP AND DECISION-MAKING IN ALL SYSTEMS OF CARE

GP 6: Ensure system cultures and administrative structures that support psychiatric leadership in clinical, policy and resource allocation decisions.

EVIDENCE-BASED CARE

GP 7: Mandate that services in all systems should be evidenced-based or, in absence of sufficient evidence, expert- and/or consensus-based.

GP 8: Mandate that treatment programs are designed with specific metrics to ensure fidelity and progress, and evaluated based on specific outcomes.

CONTINUITY OF CARE

GP 9: Assure that equitable funding and coordination of services to support the various levels of care in a comprehensive continuum of care for both mental and substance-related disorders.

CRIMINAL-JUSTICE SYSTEM

GP 10: Provide for early assessment, options for diversion to treatment, adequate treatment while incarcerated, and safe transition to community services on release, for all persons with mental and/or substance-related disorders.

ASSISTED OUTPATIENT TREATMENT (AOT)

Assisted Outpatient Treatment is a program, also known as Laura's Law, that is designed to primarily serve adults with severe chronic mental illness, who have had repeated hospitalizations, engaged in acts of violence, and are incapable of meaningfully participating in treatment. A petition is submitted to the Superior Court at the conclusion of an investigation by the county behavioral health department.

GP 11: Support county adoption of Assisted Outpatient Treatment,

GP 12: Support funding, including MHSA funding, for Assisted Outpatient Treatment.

GP 13: Support legal framework and procedures to ensure the use of medically necessary interventions, including psychotropic agents, for patients in Assisted Outpatient Treatment programs, including those individuals whose capacity for informed consent is impaired.

GRAVE DISABILITY IMPAIRS HEALTH CARE DECISIONS

GP 14: Support efforts to improve access to life-saving medical treatment for individuals whose serious psychiatric illness impairs their ability to recognize their condition and/or accept care. These efforts include legislation to: (1) expand the Lanterman-Petris-Short (LPS) Act statutory definition of "grave disability" to include inability to provide for necessary medical care because of impairment due to mental illness and/or substance use disorder; (2) Permit better access to life-saving medical treatment for patients who lack the capacity to refuse (i.e., "medical Riese" petition, a more efficient PC 3200 process, or a "medical incapacity hold" as a part of Business and Professions Code 2397); **(3)** Broaden the availability of appropriate treatment venues for medically-ill patients detained pursuant to LPS statutes: (i.e., "Single bed certification" in non-LPS hospitals); and **(4) provide necessary additional funding and resources to support the anticipated costs of care resulting from improved access.**

INSURANCE PROTOCOLS

Insurance plans use "best practice" protocols that are sometimes more cost-driven than care-driven. At best, protocols are based on an "average patient" with same diagnosis and, if applied inflexibly, will adversely impact patient care by restricting and/or overriding the physician's judgment for best individual patient care. At worst, protocols are distorted by the payer's market priorities and particular vendor arrangements. And, health plan-based protocols create unhealthy, asymmetric decision-sharing between the health plan, on the one side, and the patient and the physician on the other.

GP 15: Support physician involvement in all "best practice" recommendations and deference to the individual physician's best judgment for individual patients.

DRUG FORMULARIES

Drug formularies restrict and stratify medication access and set co-pays. Formularies are insensitive to individual patient needs and are often guided more by cost of medication than overall treatment value and outcome cost.

GP 16: Support physician involvement and an evidence-based, global benefit analysis for access to medication and deference to the physician's best judgment for individual patients.

HOSPITAL MEDICAL STAFF

An independent medical staff is essential for the exercise of medical judgment for establishing and maintaining standards of care and for credentialing and oversight of medical staff members. Hospital boards and owners are tempted to restrict—and have sometimes attempted to override—this independence in order to accomplish economic goals.

GP 17: Support medical staff independence in all hospitals.

CONFIDENTIALITY

Treatment does not work without trust, and trust requires protections for privacy. Privacy is especially important for psychotherapy.

GP 18: Protect confidentiality of medical records, with added protection for psychotherapy.

GP 19: Ensure that aggregate patient data collection does not include patient-identifiable information.

GP 20: Ensure that breaches of confidential patient information by government agencies have proper legal authority.

GP 21: Inform the public and policy makers regarding the need and purpose of confidentiality in medical treatment and psychotherapy.

PUBLIC SYSTEMS OF CARE

Public mental health systems are critical to the provision of psychiatric care to large numbers of patients. These systems must be driven by science and evidence-based policies, and funding streams must prioritize care to those with the most serious needs and must support clinically effective goals. In order to ensure that public mental health systems meet these

standards, psychiatrists within such systems must play significant roles in leadership decisions pertaining to clinical policies and resource allocation, and in clinical team decisions regarding individual patient care.

GP 22: Support stable and coherent funding for public mental health systems.

GP 23: Support priority service to adults with serious and persistent mental illness (SMI) as well as youth with serious emotional disturbances (SED), wherever they may be, including those who may be homeless or incarcerated.

GP 24: Support institutional frameworks and cultures that value the full range of physician psychiatric services and incorporate psychiatric physician leadership at all levels of operation.

Coordination of care is essential for the proper treatment of people with SMI and SED. This entails robust coordination among various human service sectors, including, but not limited to, mental health, general health, justice, police, jail, prisons, welfare, education, and housing. Most evidenced-based services emphasize care coordination as part of the needed care through mental health services.

GP 25; Support county-initiated cost benefit analyses which compare cost of care to absence of care and which account for fiscal impact related to general medical care, criminal-justice, welfare, incarceration, education and homelessness.

II. EXPANSION OF ACCESS TO QUALITY CARE

Access to care must be expanded despite a limited workforce. Absent clear principles and careful implementation, expanding access to care will inevitably reduce standards and coordination of care. Therefore, the CPA supports policies which:

EAC 1: Assure that quality, efficacy and safety of multidisciplinary teams by incorporating the following: (a) each team clinician is qualified, by virtue of education, training and licensure, for the role, responsibility and relationship he or she plays; (b) team roles, responsibility and relationships are clearly delineated; and (c) care is

coordinated, consultation is seamless, and referrals or transfers of care are expeditious.

EAC 2: Assure that, all clinicians who render medical care, have a fundamental medical education and meet uniform standards of education and licensure commensurate with the level of care provided.

EXPANSION OF WORKFORCE

Recent state and national workforce reports conclude that there is a severe shortage of professional staff and will be for the forseeable future. Therefore, the CPA supports policies which:

PSYCHIATRISTS

EAC 3: Increase number of residency training positions, especially in child and adolescent psychiatry; expand loan forgiveness programs for providing care in underserved areas; provide adequate reimbursement for patient care, including consultation and coordination of care; and assure institutional support for psychiatric leadership in all systems of care.

PRIMARY CARE PHYSICIANS

EAC 4: Assure grants and other enhancements for augmented training in general psychiatry; provide adequate reimbursement for patient care, including consultation and coordination of care; and establish capacity for direct referral for specialty care.

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

EAC 5: Support roles for psychiatric nurse practitioners and physician assistants in all mental health and substance-related treatment systems, private and public, with appropriate supervision and protocols.

EAC 6: Support grants and other enhancements, including loan forgiveness programs, for training and certification as psychiatric specialist nurse practitioner or physician assistant.

EAC 7: Support collaboratively developed, standardized and publicly available protocols for furnishing medication and a clear and specific,

written agreement with a psychiatrist who is responsible for ensuring appropriate psychiatric medical care.

NURSES

EAC 8: Support grants and other enhancements, including loan forgiveness programs, to support nurses who wish to advance their training to achieve certification as psychiatric nurse practitioner.

NON-MEDICAL PSYCHOTHERAPISTS

EAC 9: Support grants and other incentives, including loan forgiveness programs; support transfer of credit for current mental illness and substance-related training, for clinicians who wish to enter existing programs that provide the fundamental medical education required for licensure and certification as either nurse practitioner or physician assistant psychiatric specialist, as regulated by the Board of Nursing and Medical Board of California, respectively; and oppose the establishment of new boards and regulatory schemes for this purpose.

WORKFORCE TECHNOLOGIES

EAC 10: Support expansion of funding for telepsychiatry for purposes of assessment and consultation services.

EAC 11: Support expansion of funding for electronic and telephonic patient contact, consultation and coordination of care.

EAC 12: Support expansion of inter-operable electronic health records that maintain enhanced HIPAA protection.

III. CHILD & ADOLESCENT PSYCHIATRY

SYSTEM INTEGRATION

CAP 1: Increase collaboration between state-level and county-level departments of mental health for children and youth, whenever possible. These include but are not limited to: social services; foster care; probation; educational institutions; and regional centers for

children with developmental disabilities. Maintain this same integrated care for children placed out of county.

PAYMENT FOR SERVICES

CAP 2: Ensure that funding for children's services is preserved and expanded, and that access to funding sources is streamlined.

CAP 3: Expand the post-partum Medi-Cal benefit from a single postpartum visit at 6 weeks to care as appropriate to at least 18 months of age.

CAP 4: Expand funding programs for parents from pre-conception through age five, with special attention to screening and treatment for perinatal depression and anxiety.

CAP 5: Restructure substance use benefits to include parents of children on Medi-Cal and Covered California Plans, with a priority for parents of children less than 6 years of age.

CAP 6: Expand children's mental health benefits, especially school-based services.

CAP 7: Expand funding for interventional services, including Applied Behavioral Analysis (ABA) for children with Autistic Spectrum Disorder (ASD).

CAP 8: Expand funds and facilities for inpatient care for children and youth.

CAP 9: Fund perinatal care for undocumented women.

CAP 10: Fund mental health and substance use related services for all children, especially vulnerable populations of undocumented children and youth, children in the foster care system, and children in the juvenile justice system.

CAP 11: Services should involve families, including foster families and biologic families whenever possible.

SCHOOLS

CAP 13: Support transparency and oversight, data collection and reporting of state pupil mental health program funding for schools, especially with respect to the federal Individuals with Disability Education Act (IDEA), formerly managed under the AB 3632 program.

CAP 14: Eliminate the inflexible "zero tolerance" drug possession/use policy in schools.

PRESCRIPTION MEDICINE

CAP 15: Promote consistent common formulary for Medi-Cal Managed Care health plans.

CAP 16: Promote placing all drug formularies on an easily accessed, common website for easy comparison.

CAP 17: Relieve Treatment Authorization Request (TAR) burdens for psychiatrists prescribing medicines for children and youth, especially psycho-stimulants. A single standardized TAR for medications is ideal.

EDUCATION & TRAINING

CAP 18: Expand and fund fellowships in child and adolescent psychiatry.

CAP 19: Align psychiatry training with Affordable Care Act and other federal initiatives.

IV. COMMUNITY HOUSING

Although 6% of Americans suffer severe mental illness, the Substance Abuse and Mental Health Services Administration estimates that 20 to 25% of the homeless population suffers from some form of severe mental illness. Serious mental illness quadruples a person's chance of becoming homeless. Affordable and sometimes subsidized and supported housing is one crucial component of care. Therefore the CPA supports policies which:

CH 1: Provide for decent and affordable and housing in the community for those with mental and substance-related disorders.

CH 2: Advocate for supported housing and community based, comprehensive care that permits treatment in the community and in home-like settings.

V. MENTAL HEALTH SERVICES ACT

The Mental Health Services Act (MHSA, Proposition 63, 2004) established an additional 1% tax on personal incomes in excess of one million dollars, to be allocated to county mental health programs for specified priorities. The Act also established a Mental Health Services Oversight & Accountability Commission (MHSOAC) components of the MHSA. By 2018, the MHSA accounted for approximately 25% of the $8 billion-dollars California spends on mental health programs.

Although a substantial source of funding for 14 years, serious concerns remain regarding the process and procedures for allocation, the restricted use of funds and the still unmet needs of people afflicted by serious and persistent mental illness.

The CPA supports critical ongoing review--and regulatory modification as necessary--of the Mental Health Services Act (MHSA) and its funded mental health programs in order to assure the integrity of allocation decisions and the most effective use of resources.

The CPA supports principles upon which MHSA funding decisions should be based including those which:

MHSA 1: Support a transparent and open process of decision-making, consistent statewide, that is independent of ideological biases and preferences, and strongly focused upon clinically proven treatment.

MHSA 2: Prioritize services and programs based on independent assessment of community needs as determined by pre-defined measures of service gaps.

MHSA 3: Prioritize exclusively evidence-based programs that meet defined and clinically accepted standards for demonstrated effectiveness.

MHSA 4: Provide for independent monitoring of expenses and outcomes, with pre-defined metrics and public disclosure of data.

MHSA 5: Provide for close coordination and integration with general healthcare systems.

The CPA joins other mental health stakeholders in strongly supporting preservation of Mental Health Services Act (MHSA) funding for mental health programs. We believe, however, that MHSOAC must urgently address the following concerns in order to strengthen the integrity of the MHSA plan approval process to facilitate effective program planning. Therefore the CPA supports policies which:

MHSA 6: Provide for changes in policy to permit use of MHSA funds for those services most critically needed by individuals with severe mental illness, specifically including the full range of services related to inpatient psychiatric hospitalization, and to ensure that this funding is not withheld from individuals who are involuntarily detained or placed under Lanterman-Petris-Short (LPS) Mental Health conservatorships.

MHSA 7: Provide for a precise definition of "recovery-based services" and a credible demonstration of their evidence basis and, more generally, a clarification and accounting for how the MHSA requirement for "recovery-based services" aligns with the MHSA requirement for evidence-based services.

MHSA 8: Provide for clarification and demonstration of how the required MHSA stakeholder planning process ensures that the best, most cost-effective programs are funded.

MHSA 9: Provide for clarification and definition of the mechanisms that determine proper construction of stakeholder groups, the defined role and process for stakeholder participation in decisions, and the safeguards against stacking stakeholder groups and/or manipulating the decision-making process.

MHSA 10: Provide for clarification and demonstration of monitoring that assures that MHSA service recipients have timely access to key services, including crisis services, initial assessments, medication services, and acute inpatient hospitalization.

VI. SECLUSION AND RESTRAINT

Aggression and threats of imminent violence toward self or others may require emergency use of seclusion and restraints to prevent harm. Treatment team culture and protocols, staff training exercises and proper facility design greatly reduce the likelihood of events escalating to the point that such emergency measures are required.

Seclusion and restraint involve significant physical, medical, and psychological risks which necessitate close medical supervision, as defined by clear policies and procedures established by the medical staff. Post-event debriefing and attention to possible long-term consequences are integral to quality patient care.

Seclusion and restraints are never treatment and must never be used as persuasion or punishment, for convenience of staff, or as a substitute for less restrictive measures.

Therefore, the CPA supports policies which:

SR 1: Provide for collaboration with other organizations to improve safety of patients and staff and to improve the laws and practices governing seclusion and restraint.

SR 2: Mandate for the medical staff to develop clear policies and procedures for use of seclusion and restraints.

SR 3: Mandate that physicians be familiar with all regulations governing the use of seclusion and restraint, and all psychiatric staff be specifically trained in the use of behavioral techniques that reduce the likelihood of violence and detect and address emerging threats of harm.

SR 4: Mandate that seclusion and restraint require physician orders and medical supervision.

SR 5: Mandate that post-seclusion and restraint debriefing be required to improve care and to address possible long-term patient consequences.

VII. SUICIDE PREVENTION

Suicide is the 10th leading cause of death in the United States and the second leading cause of death (after accidents) for people aged 10 to 34 years.

Suicide is multifactorial and often unanticipated, even impulsive. Suicide is linked to mental disorders, particularly depression and alcohol abuse, but only about half of suicides had a known mental illness. Only one in five gave indication of suicide intent. A firearm is the method in about half of all suicides; two-thirds of all U S firearm deaths are suicide. Men are three times more likely than women to die of suicide.

Although tragically unpredictable in most cases, much can be done to reduce suicide, such as: public education; improving access to treatment; reducing the stigma that delays treatment; reducing known risks and enhancing protective factors, including firearm safety.

Therefore the CPA supports policies which:

SP 1: Provide for collaboration with other organizations to: (a) promote treatment for mental disorders; (b) create awareness that risk can be reduced; (c) coordinate state and local government agencies; and (d) advocate in support of suicide prevention policies.

VIII. GUN VIOLENCE

(revised, August 10, 2019)

Psychiatrists are particularly concerned with gun violence for several reasons, including that: (1) nearly two-thirds of gun deaths are suicide and suicide-prone individuals are much less likely to survive an impulsive attempt with a gun; (2) impulsive individuals who may be prone to violence are much more lethal with a gun; (3) the wrath and remedies that follow a mass shooting, whether committed by someone with mental illness or not, are nearly always deflected toward people with mental illness, not toward gun safety; and (4) the physician-patient relationship may involve discussions around gun safety.

This is of great urgency because the United States leads the world in mass gun deaths, which almost always involves a rapid-fire assault weapon, and accounts for almost one-third of the world's guns.

Gun deaths are proportional to the number of guns per capita and the United States leads in both, approximately twice that of its nearest competitor.

GUN VIOLENCE IS A PUBLIC HEALTH CONCERN

Americans are more likely to die from gunfire than from motor vehicle accidents. Guns are the second leading cause of death for children and adolescents. Gun violence is certainly a concern for all Americans.

The primary aims of public health science are the study and development of global strategies to reduce disease, injury and death.

A public health approach to motor vehicle accidents has helped to significantly improve motor vehicle safety. A similar approach to guns would undoubtedly do the same for guns in the U.S. as it has in many other countries. Therefore, the CPA supports policies which:

GV 1: Remove all barriers, including policies, that prohibit research.

GV 2: Highly prioritize funding for research on gun injuries and deaths.

SAFETY

All guns are inherently dangerous. Accidents and impulses are major factors in gun related injuries and deaths. Therefore, the CPA supports policies which:

GV 3: Mandate universal background checks for all gun purchases and transfers.

GV 4: Mandate that all gun owners pass a state or federally approved examination certifying basic knowledge of gun safety.

GV 5: Mandate that gun owners be legally accountable for access, loss and use of their guns.

GV 6: Mandate that age for gun possession be twenty-one.

GV 7: Establish state-wide or nation-wide uniform criteria for reporting convictions for crimes that restrict gun ownership

GV 8: Mandate that guns be equipped with a trigger lock and other effective safety measures approved by state and/or federal regulators and be subject to standard product liability.

GV 9: Prioritize the implementation of safety measures.

GV 10: Mandate that guns be stored in a lock-safe approved by state and/or federal regulators and subject to standard product liability.

GV 11: Assure that guns be banned in K-12 schools except for those carried by duly authorized security officers.

Assault weapons are designed for mass shootings and, given their vanishingly small utility in civilian life, the CPA supports policies which:

GV 12: Ban the sale of rapid-fire weapons.

GV 13: Ban conversion of weapons to rapid-fire function.

GV 14: Ban large-capacity ammunition clips.

GV 15: Ban the sale of armor-piercing ammunition.

GV 16: Ban the use of silencers, non-metallic weapons, and other devices which minimize detection.

NON-DISCRIMINATION AND DUE PROCESS IN GUN RESTRICTION

Gun restriction is reasonable when there is probable cause to believe an individual poses a threat to self or others, but restrictions based solely on mental illness is not. Therefore, the CPA supports policies which:

GV 17: Assure that gun restriction is based on probable cause related to a threat to self or others.

GV 18: Mandate that probable cause for gun restriction be based on an individualized assessment of risk of violence and never solely on the presence of mental illness.

GV 19: Mandate that Individuals whose gun rights have been restricted for probable cause are not reported to National Instant Criminal Background Check System (NICS) until the restriction is upheld by a judge.

GV 20: Mandate that names of persons subject to temporary gun restriction be included in a temporary no-purchase list, and that immediate removal of such names occur if the restriction is dropped, expires or is not upheld by a judge.

GV 21: Mandate that individuals whose gun-related rights have been restricted have a legal recourse for restoration of those rights.

PHYSICIAN-PATIENT RELATIONSHIP

Both confidentiality and the assessment of risk of violence are central to patient care, therefore the CPA supports policies which:

GV 22: Assure that gun violence, threat management, and gun safety issues be included in curricula for medical school and residency.

GV 23: Mandate that physicians be free to inquire about access and use of guns with their patients.

GV 24: Mandate that reporting requirements be clear and limited to specific, identifiable, imminent risk to self or others.

IX. MALPRACTICE INSURANCE

The cost of malpractice insurance adds to the cost of care. Frivolous lawsuits add to the cost of insurance without improving care.

MI 1: Endorse the Medical Injury Compensation Reform Act (MICRA) and its cap on non-compensatory ("pain and suffering") damages.

X. CANNABIS (MARIJUANA)

Marijuana poses a psychiatric risk for minors and youth and exacerbates problems associated with mental illness and substance use.

California's legalization, regulation and taxation of marijuana (Adult Use of Marijuana Act of 2016) is a double-edged sword. On the one hand, the Act's legalization reduces the perceived risk and expands access of marijuana but, on the other hand, the Act eliminates criminal profit, provides purity standards and creates tax revenue, a portion of which is required to go to marijuana research. Therefore, the CPA supports policies which:

RISK PERCEPTION

C 1: Provide for regulatory safeguards and public awareness campaigns that address risk; and counteract market pressure to portray marijuana use as risk-free.

RESEARCH IS NEEDED

Although there are several consensus-supported medical indications for marijuana constituents, and there may well be future discoveries, we will work to improve research and to deter market pressure to imply benefit where none is proven.

C 2: Provide for expansion of funding, including that from the Adult use of Marijuana Act, for research and substance-related treatment.

C 3: Provide public awareness campaigns that accurately portray the potential risks and benefits of evidence based treatment using marijuana.

FEDERAL REGULATION REGARDING CONTROLLED SUBSTANCES

C 4: Provide changes in federal law (such as rescheduling) that would permit marijuana research regarding epidemiology and the hazards and possible medical benefits of marijuana constituents.

ENFORCEMENT REMAINS IMPORTANT

C 5: Provide enforcement of regulations regarding sales and use, age requirements and driving standards.

C 6: Require both: (a) evidence of impairment and (b) breath or body-fluid evidence of marijuana components at levels known to be associated with intoxication and driving impairment, for conviction for driving under the influence of marijuana.

C 7: Oppose "zero tolerance" enforcement policies that jeopardize access to education for school-age children. Such students should have access to strategies of early intervention.

TREATMENT

C 8: Improve public awareness of marijuana use symptoms and hazards, particularly in children and young adults, and the special hazard it poses for people afflicted by mental illness and/or other substance abuse.

C 9: Provide for early identification and treatment of cannabis use disorders.

C 10: Provide for improved access and funding for treatment of cannabis use disorders.

XI. OTHER SUBSTANCE-RELATED DISORDER TREATMENT

OSDT 1: Assures that CURES (CA prescription drug monitoring program) data is accessible only for clinical treatment, evaluation (including consultations by clinicians who are not treating the patient), prescription verification, and for public health purposes.

OSDT 2: Incorporate data related to opioid treatment programs, namely, methadone and buprenorphine to be included in CURES.

OSDT 3: Ensure that CURES is functional, efficient, timely, user-friendly, and integrated into clinical work-flow by integrating them as much as possible with electronic health records and pharmacy dispensation systems.

OSDT 4: Ensure that CURES includes data related to all controlled substances.

OSDT 5: Ensure that enrollees in addiction treatment programs have access to comprehensive medical assessment and associated treatment for potential substance-related disorders and known

complications, avoid false advertising and adhere to the following standards: (a) accurately represent their ability to provide specific services and accurately identify services that are not supported by scientific evidence; (b) clearly communicate the treatment program's status with respect to licensing, certification, and compliance with regulatory requirements; (c) accurately represent the competence, education, credentialing, and licensure of the program personnel; (d) advocate for ethical guidelines and state legislation to prohibit patient brokering and payment for referrals, and other inducements for patient recruitment; (e) avoid marketing strategies that rely on disparaging claims made against differing treatment models or against other addiction treatment programs; (f) respect patient privacy and not exploit this vulnerable population in marketing efforts; (g) include scientific evidence to support claims about the success and efficacy of the treatment services they provide in marketing materials; (h) provide accurate estimates about the cost and extent of insurance coverage for treatment and for specific services; (i) distinguish educational programs from marketing programs.

OSDT 6: Provide for the development of materials for consumers to detect potential fraudulent marketing and patient recruiting practices relative to addiction treatment programs.

OSDT 7: Provide for full funding of evidence-based addiction treatment and recovery support services.

OSDT 8: Promote the use of medication assisted treatment (MAT) when medically indicated.

OSDT 9: Align with the understanding of addiction as a chronic disease, the concept of addiction care as long-term, chronic disease management, remission as a treatment goal, and recovery as an ongoing process.

OSDT 10: Provide for systematic evidence based screening of mental and substance-related disorders among incarcerated populations, especially opioid use disorders. Availability of the following treatments in institutions should include: (a) systematic medical assessment and associated treatment for substance-related disorders; (b) MAT; (c) extension of MAT for those who were in

ongoing care prior to arrest; (d) access to evidence-based medically managed withdrawal ("detox") during the period of withdrawal; (e) psychosocial treatments; and (f) post-release continuity of care.

OSDT 11: Provide incarcerated populations with scientifically based education related to substance-related disorders, including the impact of stigma, for all personnel of such institutions.

OSDT 12: Ensure that individuals with co-occurring mental and substance use disorders have access to evidence-based, integrated assessment and treatment for both types of disorders, including MAT. Such programs and services should be designed and operated with robust input from psychiatrists.