NAMI

National Alliance on Mental Illness

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State Mental Health Legislation 2014

Trends, Themes & Effective Practices

State Mental Health Legislation 2014: Trends, Themes & Effective Practices

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

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Executive Summary: The Momentum Slows

In 2014 momentum in the states to improve funding and quality of services for people living with mental illness slowed. While 29 states and the District of Columbia increased funding for mental health services, this was down from 36 states and DC in 2013. Moreover, when current state funding for mental health services is compared with state funding prior to the beginning of the recession in 2009, funding in many states is still down. Between 2009 and 2012, states cut $4.35 billion from their mental health budgets, literally decimating access to services for many people living with mental illness. This damage is a long way from being repaired.

Some states are particularly noteworthy for their cuts in 2014. Rhode Island cut $33.6 million in mental health funding, a reduction in overall funding of nearly 20 percent. Michigan, which mingles mental health and Medicaid dollars, cut $156 million for mental health and substance use services. Alaska cut mental health funding in both 2013 and 2014 in the wake of cuts of nearly 37 percent between 2009 and 2012. Other states that made further cuts in 2013 and 2014 after damaging cuts during the recession included Louisiana, Nebraska and North Carolina.

A number of states are clearly on an upswing in terms of mental health funding. 22 states and DC increased funding in both 2013 and 2014 although the overall increases are not nearly enough to make up for cuts between 2009 and 2012. For example, Florida appropriated a 4.31 percent increase to community mental health, which really just restored $15.2 million in cuts made since 2012. With Florida ranking 49th per capita in mental health spending in 2010, they still have a long ways to go. (See Appendix 1 for a comparison of enacted State Mental Health Authority Budgets for FY 2014 and FY 2015.)

Progress has been mixed as well in addressing some of the most serious problems and needs in mental healthcare. For example, there is a well-documented crisis in the lack of acute inpatient or crisis stabilization services for people experiencing psychiatric emergencies or urgent need. This has contributed to the problems with "psychiatric boarding" in emergency rooms as well as the overrepresentation of people with mental illness in the criminal justice system. While Virginia has acted to address this problem in the aftermath of the tragedy involving the family of a state legislator, most states have not.

In recent years some states—in a shortsighted attempt at achieving short-term cost savings—have imposed sharp restrictions on access to psychiatric medications in their Medicaid programs. Adding injury to insult after their mental health budget cuts, North Carolina imposed a restrictive preferred drug list and prior authorization protocol for mental health drugs as part of an effort to save Medicaid costs. In stark contrast, other states like Illinois and Colorado

acted to protect access to psychiatric medications, with Illinois going as far as exempting these medications from overall limits in their Medicaid program.

All these trends occur in a time of great transition in America's health care system, a transition with potential to positively impact access and quality of mental health care. Increased access to better mental health coverage through Medicaid Expansion and the Health Insurance Marketplace, combined with implementation of the federal mental health parity rule for private coverage has the potential to deliver better mental health care to more Americans than ever before. Medicaid Expansion in particular affords an opportunity to strengthen state mental health systems and provide life-changing care for people affected by mental illness, paving the way to recovery and independence for an estimated 6 million Americans[1] with mental health and substance use conditions.[2] Yet, more than half of those who would benefit live in states that have not yet expanded Medicaid at all.

There was quite a bit of activity on mental health issues during the 2014 legislative sessions in the states. Legislation was passed in certain states to improve the transparency of health insurance information, lessening the fragmentation and lack of coordination between inpatient and outpatient mental health care, increasing the mental health workforce, school based mental health services and early intervention for youth with mental health needs transitioning between childhood and adulthood.

Despite this, much of the legislation feels like tinkering at the edges. In many parts of the country, mental health systems are in a state of disrepair. Evidence of their broken condition can be seen all around us, in the ranks of homeless individuals, in the large numbers of people experiencing psychiatric crises in emergency rooms and in the more than 20 percent of inmates in county jails and state prisons with serious mental illness. Few policies enhanced housing or employment options despite supportive federal policies and financing opportunities. Solving these problems requires sustained attention and funding. Most importantly, states and communities need help and support from Congress. Yet sadly, despite much talk about the mental health crisis in America since Newtown, little of substance on mental health care has been accomplished in the sharply divided, partisan Congress in the two years that have ensued. The time for talk is past. Action is needed to address a major American crisis.

By highlighting themes, trends and effective practices in state legislation, this report is intended to inform NAMI leaders, their allies and state policymakers seeking to make mental health services available to all who need them. Appendices include summaries of enacted legislation arranged by topic. Effective practices are noted with a star to encourage replication, while potentially harmful legislation is flagged to alert advocates about the need to amend or defend against policies likely to negatively affect civil rights, access to care and quality of life for Americans affected by mental illness.

Methodology

This report is based on information obtained from a survey of state NAMI leaders regarding policy priorities in the 2014 state legislative sessions. The survey gathered information on the status of the state mental health authority budget, changes to Medicaid and legislation supported or opposed by NAMI State Organizations and NAMI Affiliates. Further information for this report was gleaned from state legislature websites and media coverage of mental health issues.

Disclaimers

This report is a summary rather than an exhaustive compendium of state mental health bills enacted during 2014 legislative sessions. Efforts were made to include only enacted legislation versus pending or vetoed legislation.

State Mental Health Budgets

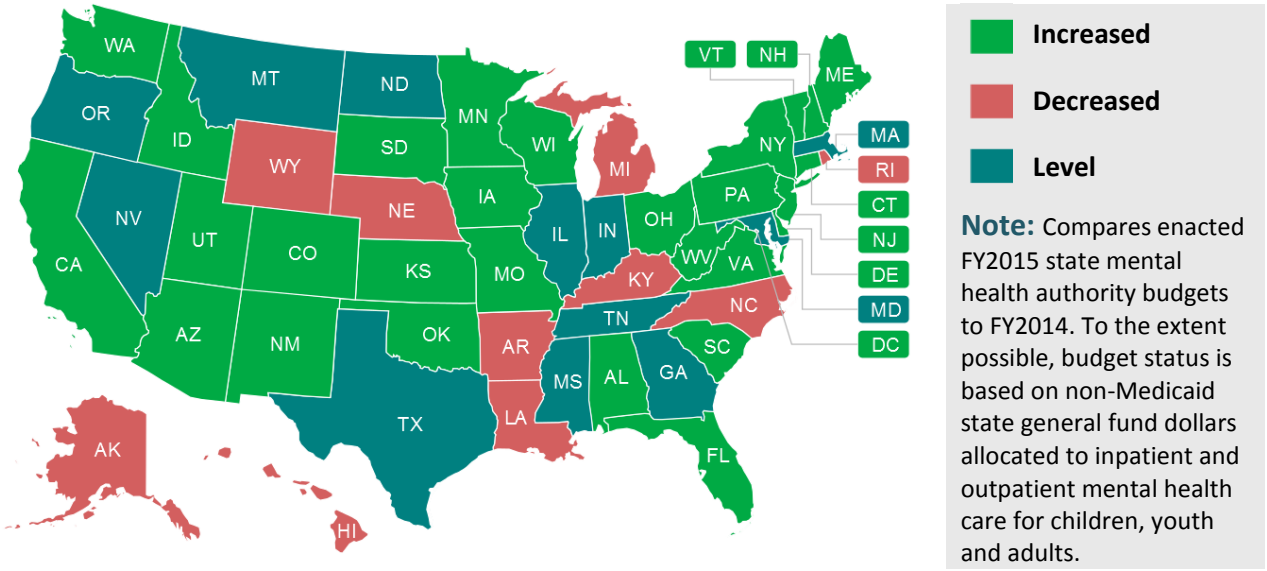
Funding drives the availability of mental health services. It determines the type of services offered and who will be eligible to receive them. The prospects for 2015 state mental health budgets eroded compared to 2014 despite the improving economy. Even in the face of alarming headlines and public scrutiny of inadequate service systems, seven states reduced mental health budgets. Rhode Island slashed $33.6 million, a 20 percent reduction in general funds compared to last year. The North Carolina Department of Mental Health took a $25 million (10 percent) hit on top of a $12 million projected reduction in Medicaid expenditures through restricted access to prescription medication. Louisiana sliced $27 million (10 percent) from the Department of Behavioral Health. Michigan, which combines Medicaid and state dollars, saw a loss of $156 million to behavioral health. Nebraska took a 4.7 percent reduction ($3.3 million) in behavioral health spending. After years of decline in their mental health budget, Alaska made yet another small cut in their 2015 budget.

On a more hopeful note, 29 states and DC increased mental health budgets for 2015. The Virginia General Assembly, in response to a high-profile crisis within the family of a state legislator, allocated $54.9 million to strengthen hospitals, civil commitment standards, crisis services, intensive community services and telepsychiatry. In the midst of behavioral health system redesign, the Iowa budget bill (HF 2463) extended state funds to support a county property tax levy. Missouri allocated $14 million to rebuild the state psychiatric hospital. New Hampshire enacted HB 1635, allocating $26 million for community services in response to a U.S. Department of Justice Olmstead settlement. The New Jersey budget includes a $7.2 million increase for community services related to an Olmstead settlement, $1.4 million for statewide expansion of the Involuntary Outpatient Commitment (IOC) program and a $6.9 million transfer

to Medicaid for mental health services to the newly eligible expansion population. While Florida appropriated a 4.31 percent increase to community mental health, this action simply restored $15.2 million in cuts made since 2012. Given that Florida ranked 49th per capita in mental health spending in 2010, further action is needed to help build the state's mental health system.

Eight states maintained mental health budgets compared to 2014. Illinois is in a precarious position, sustaining mental health services with a one-time allocation. Unless steps are taken during the coming session, the declining income tax rate in Illinois will leave a $4 billion budget hole in 2016. The four states with biennial sessions did not convene in 2014: Montana, Nevada, North Carolina and Texas.

Figure 1: State Mental Health Budgets FY 2015



Health Reform in the States: Divergent Paths

The Patient Protection and Affordable Care Act (ACA) has the potential to substantially improve access to care for 11 million previously uninsured Americans with mental health or substance use conditions.[3] However, with the first wave of ACA enrollment under way during the 2014 state legislative sessions, political debate was intense. States that were supportive of the ACA enacted bills to implement the law. Washington State enacted H 2572 to improve purchasing and develop a state innovation plan that stresses integration of behavioral health among other provisions.

Conversely, several states enacted legislation to impede ACA implementation. Although Arkansas broke new ground in 2013 by enabling the Medicaid expansion population to

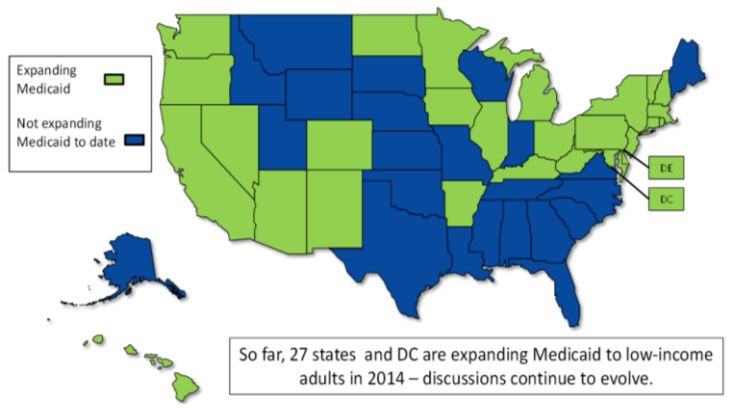
purchase private coverage on the Marketplace using federal Medicaid funds, the legislature passed HB 1053 in 2014 prohibiting use of state funds to promote ACA enrollment. Georgia (HB943) barred the state from accepting federal funds to expand Medicaid or establish a state health insurance exchange and terminated the University of Georgia Navigator program. Tennessee (HB937) prohibited the governor from expanding Medicaid without a joint resolution of the legislature.

In Missouri, a federal district court judge declared that the state was illegally obstructing federally designated enrollment navigators. The court required Missouri to repeal provisions of a 2013 bill (SB 262) that obstructed federal law.

Medicaid Expansion: Increasing Access to Care

Medicaid is a critical tool to provide health coverage for millions of low-income Americans living with mental illness. Traditionally, Medicaid has offered a broader array of mental health services than is available through other coverage, including crisis response, prescription medication, psychosocial rehabilitation and a range of recovery supports. Beginning in 2014 the ACA permits states to expand Medicaid eligibility to individuals and families living at or below 138 percent of the federal poverty level (FPL). At present, 27 states plus DC have expanded Medicaid coverage under the ACA.[4]

Medicaid Expansion[1]



One of the major trends in Medicaid over the past three years has been to expand Medicaid through Section 1115 waivers. The Section 1115 waiver is a tool whereby the U.S. Department of Health and Human Services (HHS) can approve experimental programs that would benefit low-income people not traditionally covered under Medicaid. Four states (Arkansas, Iowa, Michigan and Pennsylvania) have received approval to expand Medicaid through the waiver. Indiana has also submitted a waiver request to the Centers for Medicare and Medicaid (CMS) to expand Medicaid coverage through its Healthy Indiana Program.[5] States involved in the Section 1115 waiver project have taken a unique approach to Medicaid coverage using private health insurance plan options. Some have introduced cost-sharing or co-pay requirements for participants and limited certain types of coverage such as non-emergency medical transportation (NEMT). Services such as

Assertive Community Treatment (ACT), psychiatric rehabilitation and housing supports–which are covered in many existing Medicaid programs–may not be covered.

By signing into law SB 413, New Hampshire expanded its traditional Medicaid program to individuals living at or below 138 percent FPL beginning in August 2014. The plan, called the New Hampshire Health Protection Program (NHHPP), allows qualified working adults with access to health insurance through their employer to be covered through their employer-sponsored insurance with the state using Medicaid funds to pay the employee premiums and other costs of coverage. Those without access to employer-sponsored insurance will be enrolled in Medicaid managed care plans. In New Hampshire, Medicaid services have previously not covered substance use disorders (SUD). The NHHPP plan covers SUD treatment, though individuals in the traditional Medicaid program still do not have access to these services. Pending approval of a Section 1115 waiver, the NHHPP program proposes enrolling the newly eligible Medicaid population in private plans through the Health Insurance Marketplace. New Hampshire must reauthorize NHHPP by 2016 or the program will terminate.[6]

Time will tell how effective these programs will be. Certainly, they offer coverage to millions people with mental illness who would otherwise have no health insurance. Yet studies have shown that measures like cost-sharing agreements have the potential to reduce health care enrollment and limit access to necessary treatments. NAMI applauds states that take advantage of Medicaid Expansion, but remains adamant that Medicaid programs must provide people with the coverage necessary to achieve recovery.

Health Insurance Transparency and Parity

The majority of people in the United States rely on employer-based insurance to cover their health care costs. However, the Health Insurance Marketplace established under ACA opened new private options to many individuals who were previously unable to access or afford private health insurance. With implementation of the ACA, the nation's uninsured rate has dropped dramatically from 18 percent in September 2013 to 13.4 percent in June of 2014.[7] States are working to clarify provisions of the law and fill gaps through complementary health insurance legislation. Illinois increased transparency requirements for health insurance carriers by passing HB 3638, which stipulates that all health insurers must make information available about each plan's covered benefits. Carriers must publish provider directories where consumers can view the current provider network for each plan. The directory must include contact information, affiliations and note whether the provider is accepting new patients. This law will help people in Illinois, including those with mental illness, understand their benefits and manage their health care.

Landmark federal legislation came to fruition on July 1, 2014 when individual and small group plans inside and outside the exchange were required to abide by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) to ensure equal health coverage of mental illness and addiction compared to medical/surgical care. Though MHPAEA was an enormous victory for the mental health and addictions community, enforcement challenges remain. Mississippi enacted SB 2331 to address enforcement by requiring insurers to pay the same rates for outpatient mental health services as for other conditions. Given the severe mental health workforce shortage, this law creates incentives for providers to enter the community mental health field.

Crisis and Inpatient Care

Effective intervention at the point of crisis can set the course for recovery. In the event of a psychiatric emergency, crisis services play a critical role in delivering the specialized intervention necessary to de-escalate the immediate situation and connect the adult or child to ongoing mental health services as needed. People in psychiatric crisis who experience compassionate, respectful, person-centered care are more motivated follow up with recommended care. States enacted legislation to enhance crisis response services recognizing the need to improve access to 24/7 emergency mental health care. For example, Wisconsin (AB 460) provided grants to counties to develop mobile crisis response teams. Similarly, Minnesota enacted HF 3172 designed to reform existing mobile crisis teams to ensure earlier and more proactive assistance in the event of a crisis. This legislation also mandates that crisis response teams must work to engage people in voluntary treatment to the greatest extent possible.

Suicide Prevention

Tragically, each year suicide takes the lives of around 38,000 Americans. Every day at least 22 of our nation's veterans die by suicide[8] and suicide remains one of the top three causes of death among young adults.[9] Alarmingly, the number of suicide deaths in the United States has been growing in recent years.[10] Recognizing this crisis, a few states passed suicide intervention legislation. Washington passed HB 2315 that requires certain medical professionals to complete an approved training in suicide intervention. This same legislation also requires the State Secretary of Health to convene a steering committee that will develop a statewide suicide prevention plan.

Inpatient Care

Acute inpatient psychiatric treatment is essential for a recovery oriented, integrated system of care. Yet more than 3,222 psychiatric beds were lost from 2009 to 2012 when state mental health budgets were slashed to accommodate falling revenues. As of July 2014, there were 207 state-operated psychiatric hospitals nationwide serving 40,600 people at any given point.[11]

States have historically born a heavy burden for inpatient psychiatric care because federal law prohibits Medicaid from reimbursing inpatient psychiatric services to non-elderly adults in free-standing "Institutes for Mental Disease" (IMD). IMDs are inpatient facilities of more than 16 beds whose patient roster is more than 51 percent people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. Because of the IMD exclusion, state Medicaid programs routinely contract for psychiatric beds in general hospitals and many states have established community-based crisis stabilization units that are smaller than the 16-bed IMD exclusion limit. Indicating a potential policy change, the ACA authorized CMS to implement a three-year demonstration project examining whether Medicaid "can support higher quality care at a lower cost" by reimbursing acute psychiatric inpatient services in private psychiatric hospitals for adults age 19 to 64. The demonstration is under way in 11 states and DC until July 1, 2015.[12]

The shift to inpatient care in private hospitals has increased the complexity of finding a psychiatric bed. Virginia (H 1232) established a psychiatric bed registry to provide real-time information on the availability of beds in public and private psychiatric facilities and residential crisis stabilization units. Virginia also enacted a number of bills (HB 574, HB 478, HB 293) to lengthen the maximum time for custody in a psychiatric emergency and to clarify the roles of law enforcement and mental health providers.

Civil Commitment and Court-Ordered Outpatient Treatment

Involuntary inpatient and outpatient commitment has garnered much attention from state legislatures in recent years. NAMI believes that involuntary inpatient commitment and court-ordered outpatient treatment should be used as a last resort and only when it is believed to be in the best interests of the individual.[13] State legislation last year focused on protecting the rights of individuals who are civilly committed, clarifying and improving the civil commitment proceedings and encouraging community-based court ordered treatment.

Following a comprehensive review of civil commitment statute, Delaware passed HB 346 updating terminology, clarifying criteria for voluntary and involuntary treatment, and making a number of procedural improvements. To improve involuntary commitment proceedings, Wisconsin (AB 488) set forth a collaborative approach to ensure families the opportunity to have a court review the petition for involuntary care. Illinois SB 1724 requires that a copy of the second certification supporting involuntary commitment be given to the respondent—an individual with mental illness—and SB 3532 clarifies the respondent's right to an independent assessment.

Ohio (SB 43) clarified the state's current assisted outpatient treatment (AOT) standard. Prior to passage of this law, probate court judges had different interpretations about their ability to order certain individuals with mental illness into treatment in an outpatient setting. This new

law gives guidance to judges on who qualifies to be ordered into treatment. With SB 2256, Tennessee extended a pilot study of AOT until June 30, 2015. In California, the City of San Francisco, Orange County, Yolo County and Los Angeles County have fully adopted Laura's Law, a 2002 state law that allows counties to pursue AOT.

Minnesota's omnibus supplemental budget bill (HF 3172) appropriated funds to develop online training on the Civil Commitment Act (253B) to educate mental health professionals, attorneys, county staff and families about the civil commitment law to help ensure consistent application.

Transportation to Civil Commitment

Transportation to emergency civil commitment is left to law enforcement in most states, though it is not an ideal strategy for individuals and law enforcement entities alike. Being hand cuffed and detained in a law enforcement vehicle is humiliating and confusing for individuals who are simply in a mental health crisis and have committed no crime. Sheriffs protest the personnel hours required to transport individuals, often long distances, for civil commitment proceedings. In the supplementary budget appropriation, Minnesota (HF 3172) created a new mode of transportation—protected transport—allowing Medicaid to reimburse non-law enforcement personnel in unmarked cars to transport people for involuntary commitment. An alternative to using police or ambulance, protected transport is a safe and dignified way to transport people with mental illness who may be in crisis. Wisconsin AB 500 (2013) creates a pilot program in Milwaukee allowing a treatment director or designee to detain an individual for involuntary commitment. In those cases, the treatment director or designee must transport the individual to any of the facilities allowed for emergency detention and must approve evaluation, diagnosis and treatment.

Prescription Medications

Psychiatric medications, integrated with services and supports, can help people with even the most serious mental health conditions recover and lead fulfilling lives. Advances in research and development have led to the creation of more effective, efficient medications with fewer side effects. However, response to psychiatric medications can vary widely and determining the most effective medication strategy can be a lengthy process. NAMI is a strong supporter of policies that ensure access to the full range of psychiatric medications. Because medication is a crucial part of the service continuum, prescription drug policies should be considered within the broader context of the public service system. Utilization management strategies are needed that promote quality of care while containing pharmaceutical costs.

These strategies should include:

- Examination of prescription databases to manage polypharmacy.
- Investigation of fraud and abuse.
- Provider education initiatives targeted at high volume prescribers.
- Implementation of quality measurement programs.

Limiting access to psychiatric medications without regard to clinical viability shifts costs to emergency rooms, hospitals and criminal justice facilities at a high human price and dubious savings to the state.[14] Such practices fray the already threadbare mental health workforce as fewer psychiatrists agree to participate in Medicaid. A case in point, the North Carolina budget bill (SB 744) imposed a restrictive preferred drug list and prior authorization protocol as part of an effort to save $6 million in pharmacy costs in 2015 alone. If service encounters follow the pattern from other states that have implemented this policy in the past, mental health costs will increase in deep end settings.

In 2014, a number of states improved access to psychiatric medications in Medicaid. Connecticut (SB 394) restricted step therapy, a utilization management practice in which patients must fail on preferred drugs before being prescribed a medication that is not on the preferred drug list. In the omnibus Medicaid bill (SB 741), Illinois ensured timely access to treat serious mental illness by exempting antipsychotic medication from the Medicaid prior authorization requirement for patients with fewer than five prescriptions. Maryland enacted SB 622 requiring Medicaid to establish a process for providers to override fail-first protocols.

During a psychiatric crisis, individuals may refuse medications that could alleviate symptoms and promote safety and stability. Maryland passed HB 592 to redefine state standards under which a hospital may administer medication over an individual's objection if the person was involuntarily admitted for psychiatric treatment.

As part of an insurance transparency bill (HB 3638), Illinois now requires health insurers to maintain a medication exception process that allows consumers and providers to request any clinically approved prescription drug not covered on the plan's formulary when the drug is subject to a potentially ineffective or harmful step therapy requirement. Colorado (HB14-1359) and Idaho (H 534) enacted legislation requiring health insurance carriers with prescription drug coverage to offer medication synchronization services to align refill dates for multiple prescriptions.

An acute mental health workforce shortage, particularly in rural areas, has prompted alternative strategies in many states. Illinois enacted SB 2187 granting limited prescribing rights for psychologists who complete rigorous training. To meet anticipated demand in light of successful ACA enrollment, Kentucky enacted SB 7 allowing Advanced Practice Registered

Nurses (APRN) with at least four years of experience to prescribe independent of physician supervision, although they will still need a collaborative agreement to prescribe controlled substances.

Mental Health Care Delivery Strategies

States are adopting innovative service delivery strategies to meet increased demand and accommodate sweeping changes set in motion by health reform. Integrated care, workforce recruitment, expanded treatment authority for allied professions, use of peer support specialists and telehealth were all reflected in state legislation enacted in 2014.

Integrated Care

Individuals with mental illness are at increased risk for heart disease, diabetes and other chronic illnesses. Barriers to quality, accessible healthcare often result in undiagnosed or poorly treated conditions. Whole person care in an integrated community health or mental health clinic improves adherence to care, promotes better overall health and mental health and saves costs. Kentucky (HB 527) added primary care to the list of services to be provided by community mental health centers and making these services Medicaid reimbursable at the rates set for primary care centers. Mississippi (SB 2829) provided community mental health centers with the option to treat the primary care needs of their clients, though no state funds were appropriated.

An estimated 8.9 million adults in the U.S. have co-occurring mental illness and substance use disorders, yet only 7.4 percent receive treatment for both conditions and more than half get no treatment at all.[15] Adopting a trend designed to remedy the situation Maryland enacted HB 1510 to integrate mental health and substance use services in one state authority.

Workforce Shortage

A critical shortage of mental health professionals[16] prevents individuals and families from getting needed treatment in a timely manner. People living in communities of color and in rural or frontier areas are especially affected by mental health workforce shortages.[17]

This crisis is driving states to provide educational loan forgiveness and financial incentives to attract mental health clinicians to underserved communities. Nebraska (LB 901) requires the University of Nebraska Medical Center's Behavioral Health Education Center to fund five one-year doctoral-level internships within 12 months and increases the number of internships to 10 within 36 months. Interns will be placed in rural and underserved communities where their presence will improve access to behavioral health services. Wisconsin (AB 454) authorized a grant program to encourage up to 12 psychiatrists to practice in underserved regions. As noted,

some states such as Illinois (SB 2187) and Kentucky (SB 7) are addressing the shortage of psychiatrists by permitting other types of providers to prescribe mental health medications.

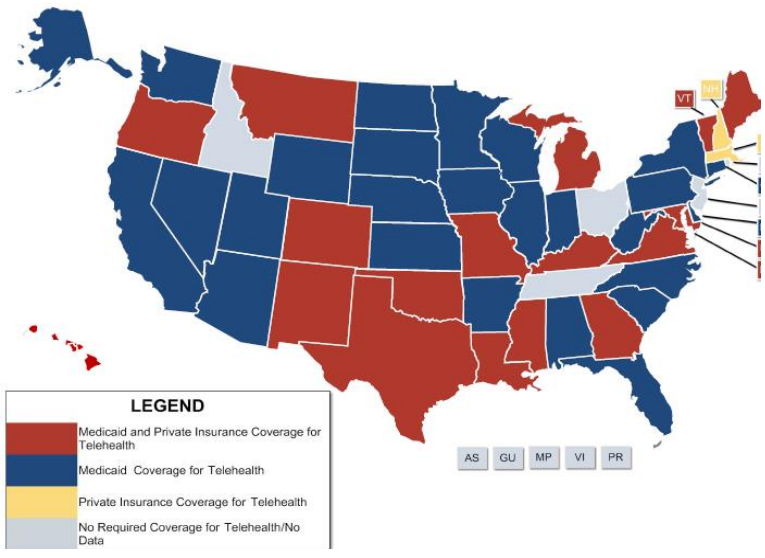
Peer Support Specialists

Peer support is an evidence-based, cost-effective practice with the capacity to enhance mental health workforce capacity by providing the "quantity time" needed to promote recovery. Peer support specialists are trained and credentialed to use the wisdom gained from personal experience to help clients navigate the challenges of daily life, link the person to appropriate services and provide emotional support. Peer support specialists have been employed effectively to defuse psychiatric crises, reach the hard to engage and minimize the need for high cost emergency and inpatient care. Recognizing the opportunity, Wisconsin passed AB 455 to establish peer-run respite centers.

Telehealth

Telehealth is a promising approach to delivering mental health services for underserved areas. Telemedicine permits health care providers at remote locations to employ technologies such as video conferencing, telephone and electronic communications to deliver services directly to patients in places where no providers are available. While general telehealth legislation is moving forward in many states, only a few have passed legislation harnessing telehealth technology to address the mental health workforce shortage. For example, Wisconsin passed AB 458 that would permit children to receive mental health consultation and treatment in-home via telehealth providers. Ohio passed HB 123 that requires the state Medicaid authority to establish standards to bill Medicaid for telehealth and HB 83, which requires the state board of psychology to adopt rules governing the use of telepsychology for the purpose of protecting people who receive telepsychology services.

Figure 3: States with Coverage for Telehealth Services



Telehealth is permitted in most states (see map), yet Medicaid and private billing practices and licensure requirements have not kept pace with technology.

NAMI supports service delivery through telehealth with two caveats:

1. Telehealth should not be used when in-person care is feasible and preferable to the client.
2. Telehealth is a new area of practice requiring research, training and credentialing to establish quality telehealth standards for mental health care.

Housing and Employment

A place to call home and meaningful work are central to quality of life for people living with mental illness. Supportive housing and rapid rehousing are cost-effective models that combine housing with services to increase housing stability and markedly reduce shelter use, hospitalizations and criminal justice system involvement.[18] Supported employment—which has demonstrated similar value—emphasizes rapid placement, individual preference and integration with treatment.

People affected by mental illness often face housing discrimination. Even homeless shelters have been known to turn potential residents away due to mental illness. To combat this problem, New Jersey passed S 1888 and S 1889 that prohibits emergency shelters from refusing to provide services to people with mental illness unless a person poses a danger to self or others. In addition, emergency shelters are prohibited from turning people away unless the shelter is at maximum capacity. Minnesota (HF 3172) designated funds to provide home ownership opportunities for families evicted because they have a child with a disability.

Most people with mental illness would like to work, and can do so given evidence-based supported employment. Yet, close to 80 percent of the 7 million Americans in the nation's public mental health system are unemployed.[19] As the job market grows, states are beginning to recognize the opportunity to improve access to supported employment and supported education services. Wisconsin passed AB 459 to fund statewide implementation of the Individualized Placement and Support (IPS) model of supported employment. Iowa passed HF 2463 to clarify that supported employment services should focus on individual choices and preferences. Despite considerable research indicating effectiveness, availability of supported employment lags far behind the need. NAMI urges states to enact policies and allocate resources to increase access to supported education and employment.

Children, Youth and Young Adults

Mental illness is a condition that typically strikes early in life. Half of all long-term mental illness begins by age 14 and three quarters emerges by age 24.[20] Children and youth who receive

prompt, effective mental health care demonstrate surprising resilience, overcoming major challenges to thrive in school, home and the community. States recognized the critical need and substantial savings to be gained from better access to mental health services for young people by enacting legislation on early intervention, system of care, custody relinquishment and services for transitional youth.

In the supplemental budget bill (HF 3172), Minnesota appropriated funds for grants to community mental health centers to provide care to young adults age 18 to 21. Grants are based on the percentage of Community Mental Health Center (CMHC) clients under age 21 who are uninsured and have incomes below 275 percent of the FPL. Community outreach programs were charged with identifying new and underserved populations, identifying family risk factors and assessing family education needs.

Pediatricians are in a unique position to identify and treat children at the first sign of distress. Wisconsin funded a psychiatric consultation initiative (AB 452) to guide pediatricians treating children with mental health needs.

Nebraska adopted a resolution (LR 31) establishing the Nebraska Children's Commission to assist families and children in need of behavioral health services. Wisconsin AB 458 specified that qualifying Medicaid families must be allowed to participate in in-home therapy even if the child is enrolled in a day treatment program. Iowa (HF 2463) allocated funding to maintain two "System of Care" pilot sites after federal funding expired.

Child Custody and Foster Care

Children with serious mental health conditions deserve prompt, high quality treatment and support. However, intensive children's mental health care is often inadequately covered under traditional, employer-based health insurance. Because children in foster care often have access to a range of intensive mental health services unavailable in other types of coverage, families struggling to find help for children with serious mental health conditions face the heartbreaking prospect of relinquishing their children to state custody solely to access needed care. The practice of custody relinquishment is widespread, absolutely devastating to families and children and a waste of public dollars. This practice is particularly egregious when alternative strategies such as multi-systemic therapy have demonstrated robust effectiveness.

Illinois enacted an effective practice, the Custody Relinquishment Prevention Act (HB 5598), requiring the state to identify children who may be at risk for custody relinquishment and help such children receive appropriate care. In addition, the law prohibits the state from suggesting that parents terminate their custody rights simply to place a child in temporary out-of-home care for therapeutic reasons. Utah enacted legislation (HB 21) to define the system of care and require cross-system collaboration for minors in state custody with complex mental health

needs. Minnesota (HF 2402) mandated screening prior to out of home placement and strengthened trial home visit standards for children placed in state custody for the purpose of treatment.

Early Intervention in Psychosis, Transitional Youth

In an exciting new development, Congress required states to allocate 5 percent of their 2015 federal mental health block grant for early intervention with young people experiencing psychosis. Untreated psychosis has a devastating effect on the life trajectory for young people, yet many experience these symptoms for years before they are accurately diagnosed and treated. Based on ground breaking international research that identified an integrated array of effective early intervention services, the First Episode Psychosis (FEP) set-aside has the potential to transform lives and signals a new day in mental health service delivery.

While most states are just beginning to bring these programs to scale, gaps between the child and adult mental health systems still engulf young people during the years when symptoms of psychosis peak. South Carolina enacted an effective practice (H 3567) by extending eligibility for children's mental health services from age 18 to age 21. A Connecticut budget appropriation (HB 5371) established outreach programs and drop-in centers for homeless youth.

School-Based Mental Health Training and Services

Because children and youth spend more time at school than any other environment outside the home, educators are in a prime position to identify children with mental health needs. Acknowledging the opportunity, states enacted laws on school culture, mental health training for school personnel, anti-bullying, reducing restraint and seclusion and resources for college student mental health.

Mental health privacy standards often obstruct necessary coordination between educators, families and mental health providers. By enacting HB 1204, Indiana recognized that a nuanced approach can protect privacy while enhancing mental health and educational services to benefit the child.

Massachusetts enacted HB 4376 establishing a "safe and supportive school" framework by integrating services to address physical and mental health, reduce bullying and truancy, improve education for foster and homeless youth, provide inclusion for students with disabilities and promote positive behavioral approaches. Minnesota increased the "safe schools levy" (HF 3172) for Intermediate School Districts to pay for school mental health personnel, improving school climate and school-linked services in which community mental health providers deliver care at the school. However, with HF 2397, the state diminished attention to youth by making it optional for school districts to have a "community transition committee" to examine service needs of youth with disabilities.

Bullying, including cyberbullying, has serious mental health consequences for children, whether they are victims, perpetrators or witnesses. With the exception of Montana, every state has enacted anti-bullying legislation, a trend that continued in 2014 legislative sessions. California AB 1455, Massachusetts (H 3909) and Michigan (SB 74) now authorize school officials to refer bullying victims, perpetrators and witnesses to school support service staff for counseling and services. Minnesota (HF 826) and Illinois (HB 4207) require school districts to develop policies prohibiting bullying on school premises and when using electronic technology on and off school grounds.

Suicide is the third leading cause of death for youth under age 18. Pennsylvania enacted HB1559 mandating four hours of training on youth suicide awareness and prevention every five years for professional educators of grades 6 through 9.

Children with disabilities, including those with mental health conditions, are disproportionately subjected to restraint and seclusion at school. Policymakers labor under the mistaken impression that teachers need "all of the tools in the toolbox" to deal with challenging students despite strong evidence that Positive Behavioral Interventions and Supports (PBIS) are far more effective at improving behavior and maintaining safety for the child, other students and school personnel. Hawaii enacted an effective practice (HB 1796) prohibiting seclusion, promoting positive school culture and restricting aversive interventions such as restraint to imminently dangerous situations. Under HF 3172, Minnesota required schools to report restraint and seclusion and to train staff in reducing aversive practices.

Virginia enacted two bills on mental health crisis response at colleges and universities. HB 206 requires institutions of higher education to have a website dedicated to mental health resources for students. HB 1268 requires violence prevention committees to outline circumstances under which all faculty and staff are to report behavior that may represent a physical threat to the community, and to notify family members or guardians.

Mental Health Care Standards

Ensuring a uniform standard of care rooted in effective mental health practice is fundamental to producing positive outcomes for people living with mental illness. No national core competency standards currently exist for mental health providers, nor are credentialing requirements standardized between states.[21] NAMI calls upon states and the federal government to set the bar high, requiring availability of high quality mental health care for all who need it. Virginia (SB 261) strengthened standards of care by directing the state mental health authority to review requirements for qualifications, training and oversight of individuals

designated by community services boards to perform evaluations of people who are subject to emergency custody orders.

Health Information Privacy

Confidentiality laws are intended to safeguard trust within the therapeutic relationship, yet families often need information to support the person's recovery and can provide information to facilitate care. Recent high profile incidents have demonstrated the harm caused by overzealous application of health information privacy standards.

At the federal level, the Health Insurance Portability and Accountability Act (HIPAA) sets standards for confidentiality and privacy of patient records. Guidance from the federal Office for Civil Rights (OCR) under HHS clarifies a more permissive standard than has generally been understood pertaining to sharing information on mental health treatment.[22]

Each state has laws and regulations that further govern the confidentiality of medical records. Two states passed legislation that aligned state confidentiality standards with HIPAA. Hawaii enacted SB 2869, repealing stringent language governing the release of developmental disability records and mental health records and replacing it with more permissive language to conform to HIPAA standards. Wisconsin enacted AB 453 amending state health privacy laws to more closely track HIPAA regulations. Many states also have a "duty to warn" standard that requires health care providers to disclose information to relevant authorities if a patient has communicated information that indicates an imminent physical threat to themselves or another person. Colorado enacted HB 14-1271, broadening a physician's duty to warn, if a patient communicates an imminent physical threat toward an institution or structure.

Gun Ownership and Mental Health Records

Recent years have seen a number of high profile episodes of violence involving firearms in the hands of individuals with untreated mental illness. Mental health advocates, including NAMI, have urged states not to perpetuate stereotypical assumptions about the connections between mental health and violence. NAMI supports current federal law requiring states to report involuntary commitments to the National Instant Criminal Background Check System (NICS), yet cautions against policies that further intrude on the therapeutic relationship between individuals and their service providers. In 2014, a number of states passed legislation to restrict purchase and ownership of firearms. Rhode Island (HB 7939) authorized the district court to transmit information on adjudication of commitment to NICS, but also provided for restoration of gun ownership rights by establishing a five-member "Relief from Disqualifiers Board." Similar laws were enacted in Alaska (HB 366), Arizona (HB 2322), Hawaii (HB 2246), Massachusetts (H 4376), Ohio (SB 7) and South Dakota (HB 1229).

Criminal Justice and Mental Illness

One of the most disgraceful consequences of our nation's failure to invest in adequate mental health care is that large numbers of people with mental illness become involved in the criminal justice system, which is ill-equipped to handle the needs of these individuals. Although law enforcement agencies increasingly adopt the Crisis Intervention Team (CIT) model promoted by NAMI, few officers are well-versed in crisis intervention techniques and many communities offer few options to divert individuals into mental health care. Court systems are unprepared to deal with mental health issues and people with mental illness fail to receive the treatment they need in jails and prisons. Many people with mental illness rotate in and out of the criminal justice system, frequently for small, nonviolent crimes. NAMI has long advocated for reforms to these systems and many states are working toward change.

Wisconsin enacted AB 450 that establishes a system of grants to train law enforcement officers in CIT. In the budget bill (HF 3172) Minnesota established a study committee to evaluate the state's criminal justice response to people with mental illness who have been arrested or are at risk for arrest. The committee is tasked with assessing programs that would divert individuals from the criminal justice system into mental health care.

Several states also passed legislation that addressed court system response to individuals with mental illness. Arizona passed HB 2457 to permit establishment of county level mental health or veterans courts. New Hampshire passed HB 1442 that grants circuit courts and superior courts within the state the authority to establish mental health courts. Mental health treatment courts and veterans courts are post-arrest interventions designed to divert individuals from incarceration and connect them with housing, treatment and supportive services.

State Policy Recommendations for 2015

Strengthen public mental health funding. Public mental health systems are the funders of last resort for youth and adults living with mental illness who do not have access to private insurance or other sources for paying for mental health services. Historically, these systems have been responsible for serving individuals who require high intensity services and are most at risk of falling through the cracks. In recent years, capacity to provide these services has been eroded by sharp cuts in funding in many states. In virtually every state, the need for mental health services far exceeds the availability of these services. Funding cuts of recent years must be restored and invested in evidence-based, recovery oriented services that can prevent the highly expensive and damaging consequences of not receiving timely mental health treatment.

Hold public mental health, Medicaid and private insurers accountable for providing appropriate, high quality services and outcomes measurement. Mental health has lagged behind the rest of the health system in measuring quality and determining outcomes of services

provided to individuals affected by mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA) has attempted to address this gap through the development of its Uniform Reporting System (URS) that measures outcomes of mental health and substance use services across ten domains. However, the URS has not proven to be an effective tool in measuring outcomes across states because reporting by states is voluntary and because measurement criteria vary broadly from one state to another. In Medicaid, mental health services are monitored, but the few outcomes measured are too narrow to be meaningful and do not focus on the quality of life issues of concern to beneficiaries. Moreover, state Medicaid programs rarely make their data publicly available. As stated in NAMI's 2009 *Grading the States* report, "in an environment of limited…resources, funding anything but the most effective services simply is not sustainable." This is even truer today as more and more states contract with private corporations to manage mental health services and as steps are taken to integrate mental health services into mainstream health systems.

Implement Medicaid expansion in all states with adequate coverage of mental health services. Extending Medicaid eligibility to 138 percent of the Federal Poverty Level provides coverage to millions of people living with mental illness who would otherwise have no health insurance. Currently only 27 states and the District of Columbia have chosen to expand Medicaid, leaving many people with mental illness without any coverage. A proactive approach to addressing untreated mental illness would be enhanced through Medicaid expansion in all states. Additionally, it is important that these Medicaid expansion ("alternate benefit") plans cover mental health services and supports with proven effectiveness in reducing adverse outcomes and fostering recovery.

Adopt initiatives for statewide implementation of effective practices to serve people living with mental illness. Effective practices include Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (F-ACT) programs to serve people with high intensity, complex needs. First Episode Psychosis (FEP) programs help young people with emerging psychosis launch successfully into adult roles. Cognitive behavioral therapy (CBT) initiatives treat a range of mental illnesses effectively. Peer and family support programs strengthen the ability of natural supporters to promote recovery. Crisis Intervention Team (CIT) programs establish partnerships between law enforcement and mental health systems. Statewide models are already in place for all of these practices. For example, 11 states currently have statewide CIT initiatives. Oregon and New York State are implementing FEP programs on a statewide basis. It is crucial that funding for these effective practices be aligned through Medicaid and other public and private payers.

Conclusion

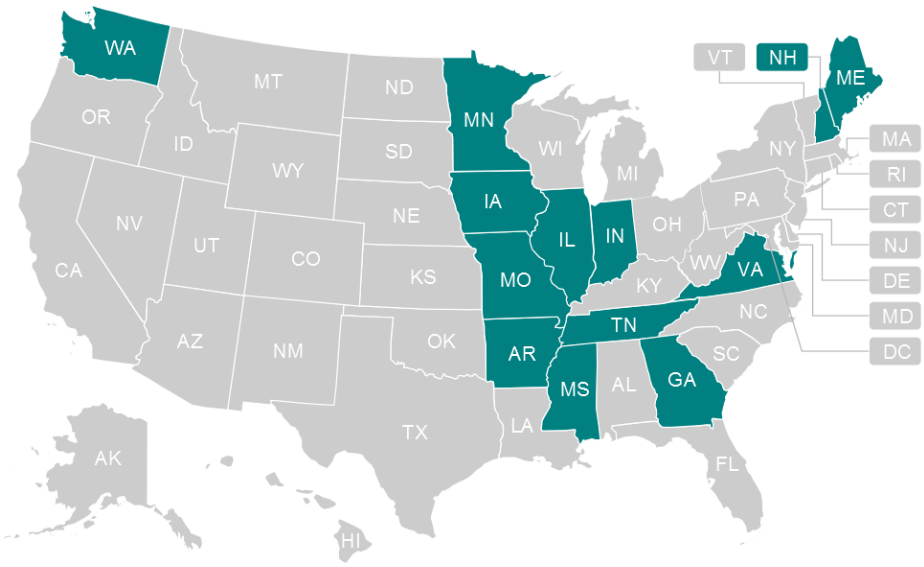
The way is open to shape the mental health system of the future. States that engage in thoughtful planning, targeted investment, faithful implementation and robust monitoring will seize current opportunities and set a sustainable course. System innovation offers immense promise to shift the life trajectory from ensnarement in disability and dependence to offering individuals and families affected by mental illness a springboard to fulfilling, productive life. NAMI calls on state policymakers to enact policies and invest resources in strategies that work.

Note: Appendices are arranged by issue with links to legislation, chapter numbers and bill summaries. Gold stars denote bills considered to be effective practices while bills posing potential threats to the interests of individuals and families living with mental illness are marked with red flags.

Appendix 1: State Mental Health Authority Budgets–Enacted

	FY2014	FY2015
Alabama	Level funding	Increase
Alaska	Decreased	Decrease
Arizona	Increase	Increase
Arkansas	Decreased	Decrease
California	Increase	Increase
Colorado	Increase	Increase
Connecticut	Increase	Increase
Delaware	Increase	Increase
District of Columbia	Increase	Increase
Florida	Level funding	Increase
Georgia	Increase	Level funding
Hawaii	Increase	Decrease
Idaho	Increase	Increase
Illinois	Increase	Level funding
Indiana	Level funding	Level funding
Iowa	Increase	Increase
Kansas	Increase	Increase
Kentucky	Increase	Decrease
Louisiana	Decreased	Decrease
Maine	Decreased	Increase
Maryland	Increase	Increase
Massachusetts	Increase	Level funding
Michigan	Increase	Decrease
Minnesota	Increase	Increase
Mississippi	Increase	Level funding
Missouri	Increase	Increase
Montana	Increase	Level funding
Nebraska	Decreased	Decrease
Nevada	Increase	Level funding
New Hampshire	Increase	Increase
New Jersey	Increase	Increase
New Mexico	Level funding	Increase
New York	Level funding	Increase
North Carolina	Decreased	Decrease
North Dakota	Level funding	Level funding
Ohio	Increase	Increase
Oklahoma	Increase	Increase
Oregon	Increase	Level funding
Pennsylvania	Level funding	Increase
Rhode Island	Increase	Decrease
South Carolina	Increase	Increase
South Dakota	Increase	Increase
Tennessee	Increase	Level funding
Texas	Increase	Level funding
Utah	Increase	Increase
Vermont	Increase	Increase
Virginia	Increase	Increase
Washington	Increase	Increase
West Virginia	Level funding	Increase
Wisconsin	Increase	Increase
Wyoming	Decrease	Decrease

Appendix 2: Health Reform, Medicaid and Health Insurance Transparency



State	Bill	Chapter	Description
AR	HB 1053/ SB 111	276	Restricts ACA-related activities by providing that the State Insurance Department shall not allocate, budget, expend or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or the Health Care Independence Program.
GA	HB 943	529	The "Georgia Health Freedom Law" prohibits any agency or state action to expand Medicaid or accept any federal grant money to establish a state-run health exchange. The bill also terminates the University of Georgia Health Navigator program.
IL	HB 3638/ SB 2585	98-1035	Provisions to enable consumers to compare marketplace plans. Requires all health insurers to make information available about a plan's covered benefits. Additionally, plans must publish their provider directory where a consumer can view the provider network for each plan; the directory must include contact information, affiliations and if the provider is accepting new patients.
MO	SB 262		On Jan. 23, 2014, a northern Missouri federal district judge declared that Missouri was illegally obstructing federally designated "navigators" and the state law, SB 262 enacted in 2013, was preempted by the federal ACA. The injunction applies only in Missouri and is one of the first cases since enactment of the ACA when an operational state law was halted due to contradiction with the federal law.
NH	SB 413	3	Establishes the New Hampshire Health Protection Program (NHHPP). NHHPP expands Medicaid to individuals at or below 138 percent of the poverty level. NHHPP covers substance use services for individuals in the newly Medicaid population. In 2016, this plan calls for individuals in the newly expanded Medicaid population to be moved into private plans in the Health Insurance Marketplace, pending 1115 waiver approval from CMS.
TN	HB 937/ SB 804	662	Prohibits the Governor from making any decision or obligating the state in any way with regard to the expansion of optional enrollment in the medical assistance program pursuant to the Patient Protection and Affordable Care Act, unless authorized by joint resolution of the General Assembly.

State	Bill	Chapter	Description
VA	SB 542	752	Requires navigators to be registered with the State Corporation Commission and certified by the federal Department of Health and Human Services.
WA	H 2572	223	Seeks to improve 'the effectiveness of health care purchasing. Establishes state innovation plan terms: "(a) Improve health overall by stressing prevention and early detection of disease and integration of behavioral health, (b) Developing linkages between the health care delivery system and community, and (c) Supporting regional collaboratives for communities and populations, improve health care quality, and lower costs.''

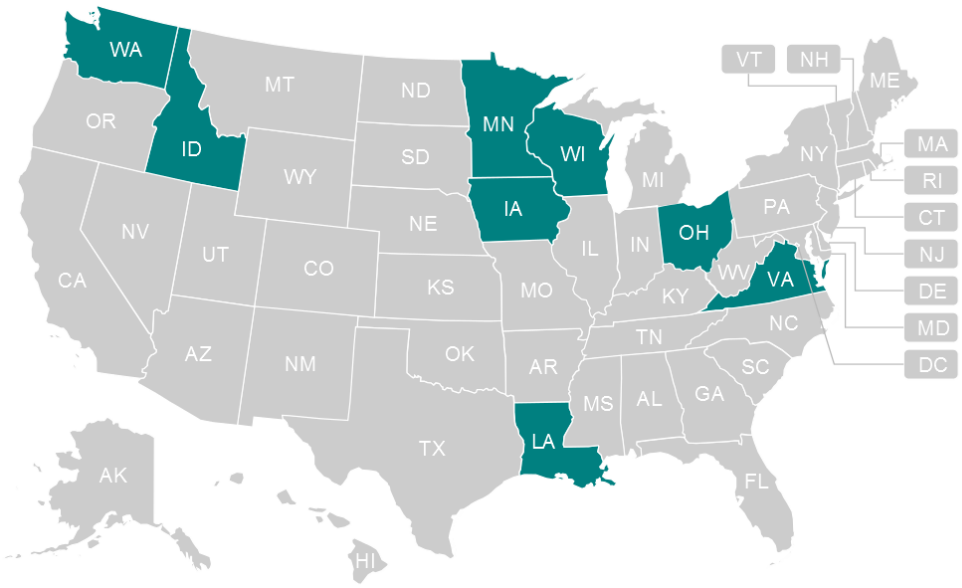
Medicaid

State	Bill	Chapter	Description
IN	SB 0080	53	Establishes a mental health Medicaid advisory committee to study, advise and make recommendations to the state.
IA	HF 2463	1140	Gives community mental health centers the option of being reimbursed using cost reports or an alternative method established by the state's managed care contractor. Pending federal approval, would extend hospital presumptive eligibility to federally qualified health centers.
MN	HF 3172	312	Requires the Commissioner of Human Services to prepare a report on the rate setting methodology in Medicaid for Intensive Residential Treatment Services and Assertive Community Treatment. The report must include stakeholder perspectives and concerns about rate setting methodologies for other mental health services to be considered in the future.

Health Insurance Transparency and Parity

State	Bill	Chapter	Description
IL	HB 3638	098-1035	Requires all health insurers to make information available about a plan's covered benefits. Additionally, plans must publish their provider directory where a consumer can view the provider network for each plan; the directory must include contact information, affiliations and if the provider is accepting new patients.
ME	LD 347	597	Expands health insurance coverage for autism spectrum disorders to persons 21 years of age and under. This bill applies to individual, group health and group health maintenance organization insurance policies, contracts and certificates issued or renewed on or after January 1, 2014.
MS	SB 2331	308	Provides that the rate of payment for outpatient services for mental illness shall be the same as other conditions. This law only applies to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed on or after July 1, 2014.

Appendix 3: Crisis Intervention and Suicide Prevention



Crisis Intervention

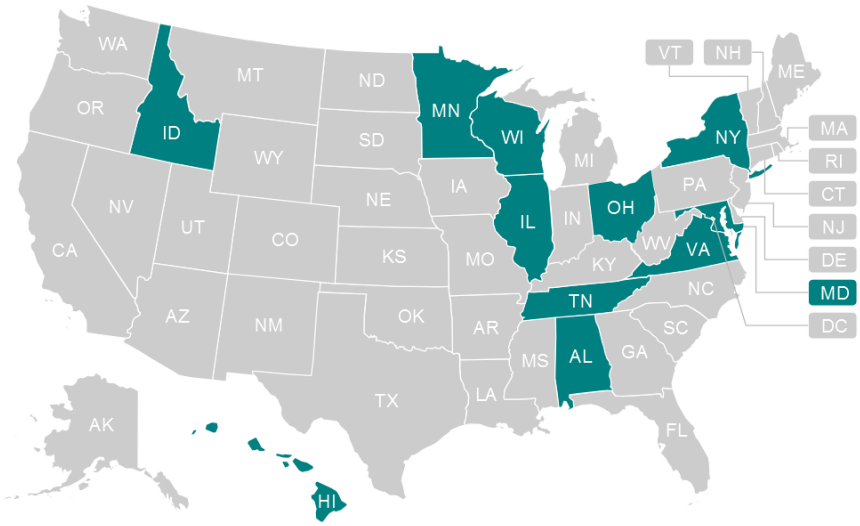
State	Bill	Chapter	Description
ID	SB 1352		Adds to existing law to establish Behavioral Health Community Centers and to provide for governance, evaluation and funding for crisis centers.
IA	HF 2379	1044	Directs Department of Human Services (DHS) to write rules for crisis stabilization programs. Clarifies that these programs are not required to be licensed as hospitals, health care facilities, sub-acute mental health care facilities or assisted living programs.
MN	HF 3172	312	Changes were made to mobile mental health crisis response services to ensure they provide earlier and more proactive assistance to people experiencing a mental health crisis and that they engage with families and caregivers. Crisis teams must work to engage people in voluntary treatment and even the treatment plan must include information about how that will be done.
VA	HB 1222	601	Provides that the Secretary of Public Safety and the Secretary of Health and Human Resources shall encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises in all jurisdictions. The information shall be disseminated to law-enforcement personnel, other first responders, hospital emergency department personnel, school personnel and other interested parties.
VA	SB 261	364	Directs the Department of Behavioral Health and Developmental Services to review requirements for qualifications, training and oversight of individuals designated by community services boards to perform evaluations of individuals subject to emergency custody orders and to make recommendations for changes to such requirements. The Department shall report its findings by December 1, 2014.

State	Bill	Chapter	Description
WI	AB 460	132	Requires the Department of Health Services to award matching grants to counties or regions comprised of multiple counties to establish certified crisis programs. The certified crisis programs must create mental health mobile crisis teams to serve individuals having mental health crises in rural areas
WI	AB 500	235	Establishes a two-year pilot program that authorizes certain mental health professionals in Milwaukee County to carry out emergency detentions.
WI	AB 360	158	Makes changes to several provisions of the laws relating to emergency detention of, and involuntary commitment for treatment of, persons with who are mentally ill, developmentally disabled or have a substance use disorder.

Suicide Prevention

State	Bill	Chapter	Description
LA	SB 539	582	Requires the Department of Health and Hospitals to offer training in suicide prevention, assessment and intervention to certain licensed health professionals in the state.
OH	HB 149		Designates September 10 as "Ohio Suicide Prevention Day."
WA	HB 2315	71	Requires certain health professionals to complete an approved training in suicide prevention.

Appendix 4: Civil Commitment, Inpatient Care and Transportation to Civil Commitment



State	Bill	Chapter	Description
AL	SB 318		For the purposes of sale and lease of real property, the Mental Health Finance Authority is exempt from certain requirements of the competitive bid process under the State Department Land Division of Conservation and Natural Resources.
HI	HB 1723	156	The administrator or attending physician shall provide notice of intent to discharge when a civil commitments court order is due to expire or when the patient is no longer a proper subject for commitment. The family court is required to conduct a timely hearing prior to the termination of a standing commitment order. If the patient voluntarily agrees to further hospitalization, the administrator shall provide notice of the patient's admission to voluntary inpatient treatment.
ID	HB 519	111	Amends existing law to provide for the use of restraints against the medical advice of a licensed physician.
IL	SB 1724	98-0865	Requires that copy of second certificate supporting involuntary commitment be provided to respondent.
IL	SB 3468	98-0975	Provides for peace officers to take minors into custody and transport to a mental health facility when the peace officer has reasonable grounds to believe that the minor is eligible for admission and is in a condition that immediate hospitalization is necessary in order to protect the minor or others from physical harm.
IL	SB 3532	98-0853	Provides that a respondent entitled to secure an independent examination by a physician, qualified examiner, clinical psychologist or other expert of his or her choice in an involuntary admission proceeding or in a proceeding seeking the administration of psychotropic medication or electroconvulsive therapy. If none is available the respondent may request that the court order said examination. Compensation must be paid by the respondent's county of residence unless the respondent lives out of state.
MD	SB 882/ HB 1267	352	Establishes an Outpatient Services Programs Stakeholder Workgroup. Directs the Department of Mental Hygiene to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders and make recommendations on whether the standard should be clarified in statute or regulations. Department shall convene a workgroup to study and make recommendations about ACT, AOT and other outpatient programs that include targeted outreach, engagement and services.

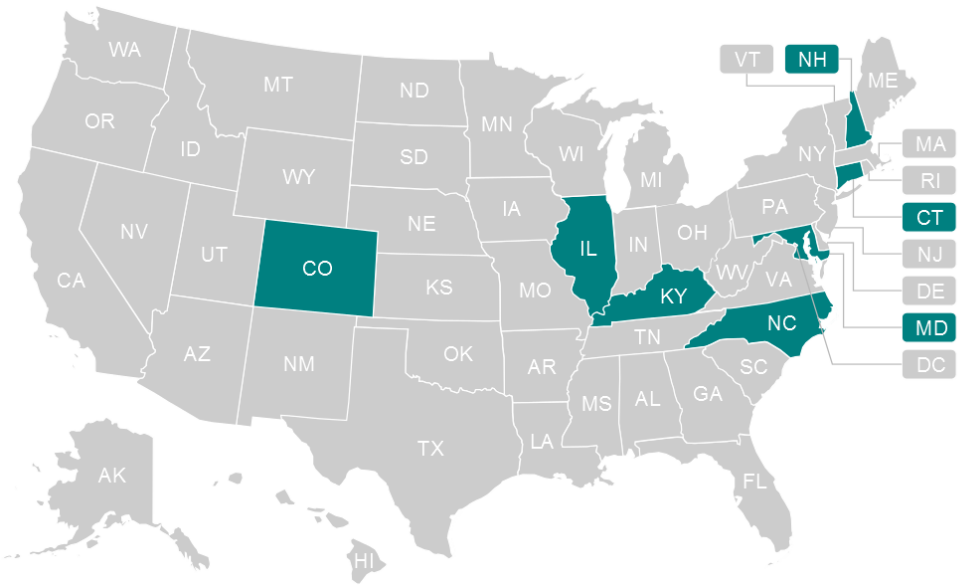
State	Bill	Chapter	Description
MD	SB 882/ HB 1267	352	Establishes an *Outpatient Services Programs Stakeholder Workgroup.* Directs the Department of Mental Hygiene to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders and make recommendations on whether the standard should be clarified in statute or regulations. Requires the Department to convene a workgroup to study and make recommendations about ACT, AOT and other outpatient programs that include targeted outreach, engagement and services.
MN	HF 3172	312	Allocates $35,000 to develop an online training program to promote better clarity and interpretation of the civil commitment laws for county and hospital staff and mental health providers, to understand, clarify and interpret the Civil Commitment Act under Minnesota Statutes.
NY	S05986B /A.8294	Pending	Enacts the "Freeze Unsafe Closures Now Act" to delay the closure and consolidation of state facilities operated by the office of mental health and the office for people with developmental disabilities
OH	SB 43		Expands the state's current assisted outpatient treatment (AOT) standard. Ohio law previously utilized a four-prong test to determine whether an individual met the criteria for court-ordered outpatient treatment. SB 43 amends these criteria, potentially making it easier for courts to order AOT.
TN	SB 1502		Adds licensed physician assistant with a master's degree and expertise in psychiatry To the list of professionals authorized to perform the duties of a physician under portions of involuntary admission to inpatient mental health treatment.
TN	SB 2256		Extends an Assisted Outpatient Treatment pilot program until June 30, 2016.
VA	HB 293	773	Provides that an individual for whom a temporary detention order is issued shall be detained in a state facility unless the state facility is able to identify an alternative facility that is able and willing to provide temporary detention. The bill also provides that under no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention unless an alternative facility has agreed to accept the individual.
VA	HB 478	761	Describes conditions by which a magistrate may issue an emergency custody order of a minor, including probable cause to believe that (i) because of mental illness, the minor (a) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats, or (b) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control; and (ii) the minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.
VA	HB 574	499	Extends the period that a person may be held pursuant to a temporary detention order from 48 hours to 72 hours. A community services board required to monitor a person who is the subject of a mandatory outpatient treatment order shall acknowledge receipt of the order within 5 business days. If the case is transferred, the CSB serving that jurisdiction shall acknowledge transfer within 5 business days.
VA	HB 584	329	Provides that in cases in which the evaluation report prepared by a qualified mental health expert indicates that the defendant requires treatment, the report shall state whether inpatient or outpatient treatment is recommended.
VA	HB 1232	774	Directs the Department of Behavioral Health and Developmental Services to establish an acute psychiatric bed registry that will provide real-time information on the availability of beds in public and private psychiatric facilities and residential crisis stabilization units for individuals who meet the criteria for temporary detention.
WI	2013 AB 360	158	Changes provisions relating to emergency detention, and involuntary commitment of, persons with mental illness, developmental disability or drug dependency.

State	Bill	Chapter	Description
WI	2013 AB 435	161	Changes provisions for inpatient mental health treatment of minors: 1. eliminates the need to file a petition for review of an admission of a minor under age 14; 2. eliminates the need to file a petition for a minor age 14 or older who voluntarily participates in inpatient treatment for mental illness; 3. eliminates the petition requirement at the expiration of the 12-day time period if the admission was voluntary on the part of the minor and the parent; and 4. eliminates the provision that allowed for no more than one short-term (up to 12 days) voluntary admission of a minor every 120 days.
WI	2013 AB 488	340	Related to involuntary commitment proceedings and limited appearance by corporation counsel.

Transportation to Civil Commitment

State	Bill	Chapter	Description
MN	HF 3172		Supplemental appropriations bill created a new mode of transportation - protected transport. An alternative to using police or ambulance, protected transport is a safe and dignified way to transport people with mental illness who may be in crisis.
ID	HB 519	111	Amends existing law to provide for the use of restraints against the medical advice of a licensed physician.
IL	SB 3468	98-0975	Permits a peace officer to transport a minor to a psychiatric hospital based upon "reasonable grounds" without personal observation.
VA	H 478	761	Permits a magistrate issuing an emergency custody order for a minor to authorize transportation by a parent, family member or friend of the minor, a representative of the community services board or other transportation provider, when the magistrate deems appropriate that the proposed alternative transportation provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner.
VA	HB 323	317	Provides that a magistrate may specify any willing law-enforcement agency that has agreed to provide transportation to execute a temporary detention order and transport the person who is the subject of the order.
WI	AB 500		Created a pilot program in Milwaukee allowing a treatment director or designee to detain an individual for involuntary commitment. In those cases, the treatment director or designee must transport the individual to any of the facilities allowed for emergency detention and must approve evaluation, diagnosis and treatment.

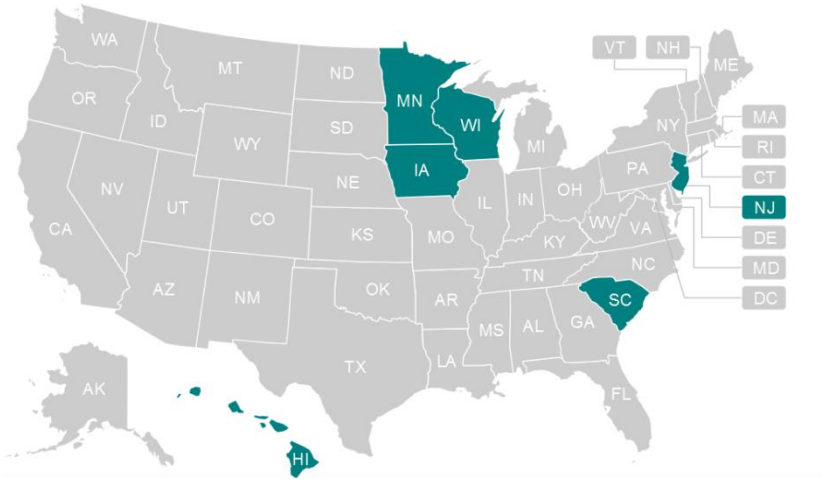
Appendix 5: Prescription Medications



State	Bill	Chapter	Description
CO	HB 14-1359	221	Requires health plans with prescription drug coverage to offer medication synchronization services that align the refill dates for multiple prescription medications. Carriers are permitted to develop their own medication synchronization plans but are required to: 1) Apply the normal copayment amount applicable under the health coverage plan when a prescription drug is dispensed in a quantity less than the prescribed amount as long as the prescription drug is dispensed in accordance with the carrier's medication synchronization services by a network pharmacy; and 2) Provide a full dispensing fee to the pharmacy that dispenses the medication.
CO	HB 14-1083	32	Allows acute treatment units (ATU) providing medically supervised behavioral health treatment services to procure, store, order, dispense and administer prescription medications and to receive a supply of emergency kits or starter doses from a registered prescription drug outlet or licensed hospital for patient treatment.
CT	SB 394	14-118	Places certain requirements on insurers for the use of step therapy for prescription drugs.
IL	SB 741	98-0651	Eliminates prior authorization requirement under the 4-script policy for anti-psychotic drugs.
IL	HB 3638	09-135	Requires insurance carriers to maintain an exception process that allows covered persons to request any clinically approved prescription drug when: 1) the drug is not covered based on the plan's formulary; 2) the plan is discontinuing coverage of the drug on the plan's formulary; or 3) subject to a step therapy requirement that has been ineffective for the patient or likely to cause an adverse reaction in the patient. Insurers must approve or deny the request within 72 hours of receipt. In expedited cases, carriers must either approve or deny the request within 24 hours.
KY	SB 7	314	Allows advanced practice registered nurses (APRNs) with four or more years of experience to prescribe routine medications without being required to have a written agreement with a physician. APRNs will still need a written agreement to prescribe controlled substances.

State	Bill	Chapter	Description
MD	SB 622	316	Requires the Maryland Health Care Commission to work with payers and providers to attain benchmarks for overriding a payer's step therapy or fail-first protocol.
MD	SB 620	314	Expands a hospital's ability to administer medication over an individual's objection if the person has been involuntarily admitted for psychiatric treatment. Previous law permitted hospitals to administer such treatment only when a person demonstrated that they were a threat to self or others while in the hospital. HB 592 permits administration of medication over objection when an individual might be a danger to self or others if released from the hospital, or when medication would eliminate the symptoms that "resulted in the individual being committed" to the hospital. Administration of medication over objection is permitted only in situations where the person has been involuntarily admitted to a hospital and where a clinical panel of doctors ascertains such treatment is appropriate.
NH	SB 0421	213	Establishes a committee to study the law requiring all exceptions to prescription drug benefits under the managed care law to be approved within 48 hours.
NH	HB 0584	120	Requires insurers to allow covered persons to purchase their 90-day supply of covered prescription drugs at the pharmacy of their choice.
NH	SB 0091	226	Prohibits insurers from requiring use of a prescription drug for an indication not approved by the Food and Drug Administration unless certain circumstances exist.
NC	SB 744	100	Restrictive preferred drug list and prior authorization requirement as part of a strategy to save $12 million in mental health pharmacy costs, $6 million in FY2015.

Appendix 6: Housing and Employment Supports



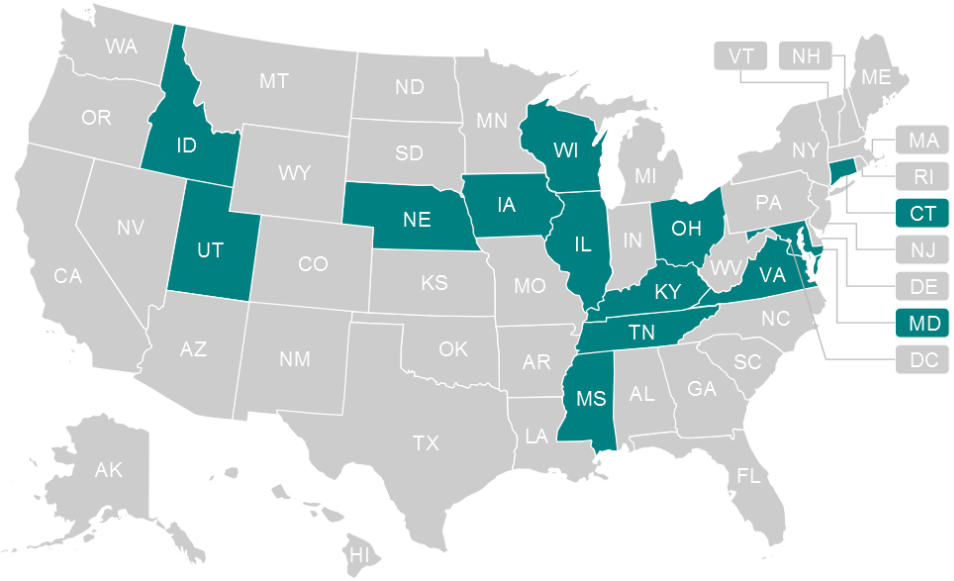
Housing

State	Bill	Chapter	Description
HI	HB 2224	193	Establishes a registry for clean and sober homes, including housing for people with co-occurring mental health issues, within the Department of Health. Appropriates funds. Amends the county zoning statute to better align functions of state and county jurisdictions with federal law.
MN	HF 3172	312	$500,000 is now available to provide homeownership opportunities for families who have been evicted or been given notice of an eviction due to a having a child with a disability in the home.
MN	HF 2402	291	Requires the Commissioner of Mental Health to establish a mental health certification for adult foster homes. To achieve certification, foster homes must engage in training and development.
NJ	S1888	203	Establishes that emergency homeless shelters may not refuse to admit individuals based on mental illness unless the individual poses a danger to self or others.
NJ	S1889	204	Prohibits emergency shelters from refusing services to individuals for a minimum of 72 hours, unless the shelter is filled to capacity.
SC	H 3098	170	Long term care facilities: Requires a resident or his representative to provide the administrator of the facility fourteen days written notice of voluntary relocation to another facility, to allow the facility to charge the resident the equivalent of fourteen days occupancy for failure to give this notice and to require the facility to cease charging a resident fourteen days after giving notice or when the bed is filled.

Employment

State	Bill	Chapter	Description
IA	HF 2463	1140	Clarifies that supported employment should be person centered, respecting individual choice and preference.
WI	AB 459	131	Creates a program within the Department of Health Services (DHS) for individual placement and support (IPS) for individuals with mental illness and provides funding for the program.

Appendix 7: Mental Health Care Delivery Strategies



Integrated Care

State	Bill	Chapter	Description
KY	HB 527		Adds primary care to the list of services to be provided by community mental health centers and making these services Medicaid-reimbursable at the rates set for primary care centers.
MD	HB 1510	460	Integrates mental health and substance use services under the authority of the Behavioral Health Administration within the Department of Health and Mental Hygiene.
MS	SB 2829		Provides community mental health centers (CMHC) with the option to treat the primary care needs of their clients. The provision is optional because no state funds were appropriated.

Workforce Shortage

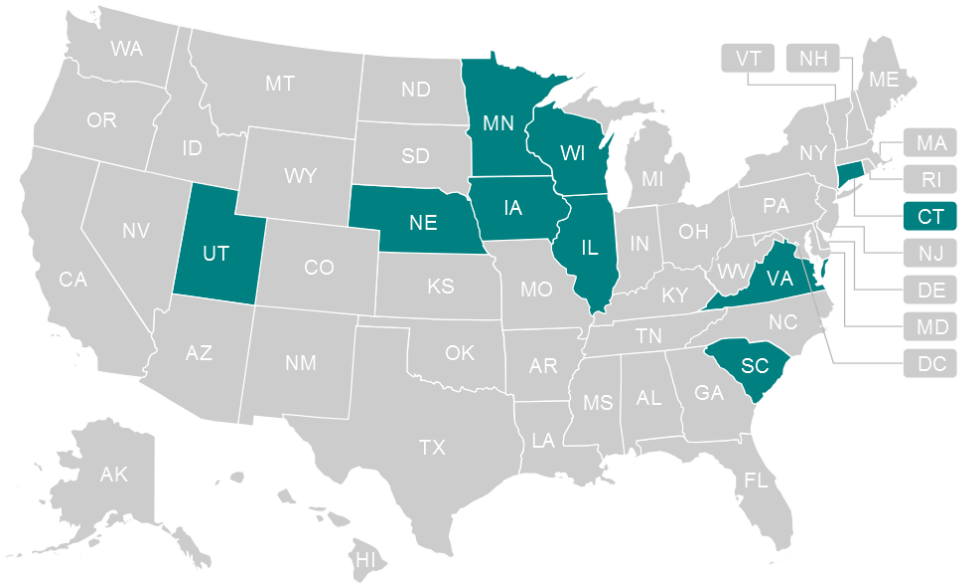
State	Bill	Chapter	Description
CT	SB 408		Adds Medicaid coverage for services provided by psychologists in private offices to Medicaid recipients age twenty-one and over as an optional state service under the Medicaid program.
ID	SB 1362	279	Adds to existing law to establish a loan repayment program for physicians, psychologists and mid-level practitioners at certain state hospitals.
IL	SB 2187	98-0668	Allows psychologists that meet rigorous training and education requirements to be granted limited prescribing rights. Provides for exceptions for certain medications and patients with significant medical conditions.
IA	HF 2378	1043	Allows for provisional licensing for doctorate level of psychologists.
KY	SB 7		Allows advanced practice registered nurses (APRNs) with four or more years of experience to prescribe routine medications without being required to have a written agreement with a physician. APRNs will still need a written agreement to prescribe controlled substances.

State	Bill	Chapter	Description
NE	LB 901		Requires the University of Nebraska Medical Center's Behavioral Health Education Center to fund 5 one-year doctoral-level internships. The number of internships will increase to 10 within 36 months. Interns to be placed where their presence will improve access to behavioral health services for rural and underserved areas of Nebraska. Requires DHHS to establish a mental health first aid training program.
OH	HB 232		Modifies the laws governing professional counselors, social workers and marriage and family therapists.
UT	HB 143		Allows for a license in advanced practice registered nursing in the psychiatric mental health specialty. Removes a provision that requires the applicant to complete clinical practice requirements before licensure.
VA	HB 540	497	Clarifies provisions governing issuance of a provisional license to a private provider by the Department of Behavioral Health and Developmental Services, providing that a provisional license may be issued at any time when a provider is temporarily unable to comply with all licensing standards and clarifies situations in which certain sanctions may be imposed upon a provider.
WI	2013 AB 454	128	Creates a grant program administered by the Higher Educational Aids Board (HEAB) designed to encourage primary care physicians and psychiatrists to practice primary care medicine or psychiatry in underserved areas in Wisconsin. Provides $1,500,000 general purpose revenue in 2014-15 for the program, to be divided equally between grants for physicians and grants for psychiatrists. HEAB must award grants to up to 12 physicians and up to 12 psychiatrists annually.
WI	2013 AB 455	129	Requires the Department of Health Services (DHS) to contract with peer-run organizations to establish peer-run respite centers for individuals experiencing mental health conditions or substance abuse. Appropriates a total of $250,000 to DHS for this purpose in the 2013-2015 fiscal biennium.

Telehealth

State	Bill	Chapter	Description
IL	SB 647	098-1091	Requires that health insurance carriers reimburse services provided through telehealth and sets forth many important protections for both patients and physicians providing services, such as preventing the use of telehealth services when a patient chooses an in-person consultation and banning any requirement that the physician must document a barrier to an in-person consultation for coverage of services to be provided through telehealth.
MD	SB 198	141	Requires specified provisions of law relating to coverage of and reimbursement for health care services delivered through telemedicine to apply to the Maryland Medical Assistance Program and managed care organizations; authorizes the Department of Health and Mental Hygiene to allow coverage of and reimbursement for health care services delivered in a specified manner and subject to the limitations of the state budget.
OH	HB 83		Modernizes the state's psychology and school psychology licensing law. Adds the definition of telepsychology and requires the state board of psychology to adopt rules governing the use of telepsychology for the purpose of protecting the welfare of recipients of telepsychology services.
TN	SB 2050/ HB1895	675	Requires that health insurance carriers reimburse services provided through telehealth so long as certain criteria are met.
WI	AB 458	130	Allows children with serious emotional disturbances to receive in-home care through telehealth without needing to show failure first in outpatient therapy. Also permits families to participate in in-home telehealth sessions and permits providers to be reimbursed for telehealth services if certain criteria are met.

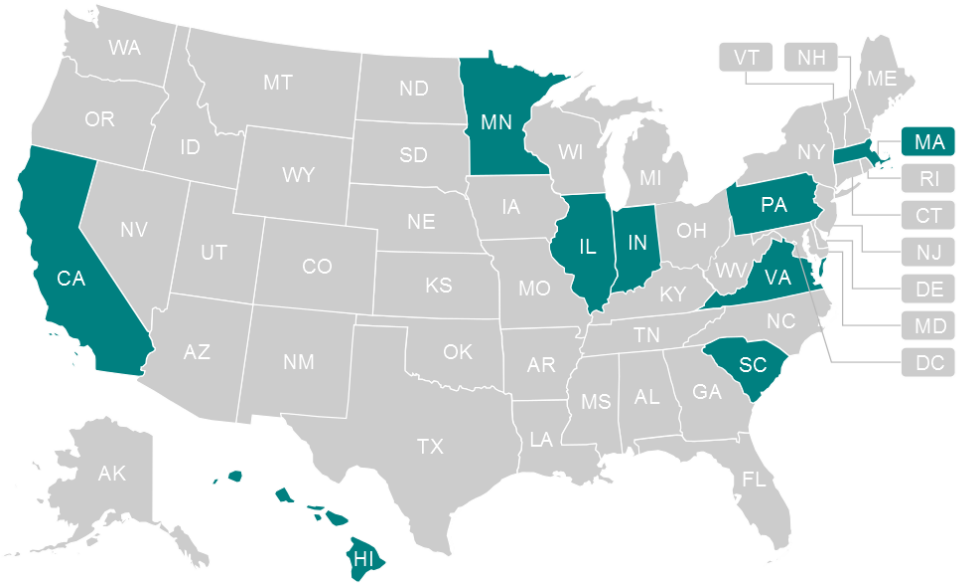
Appendix 8: Children, Youth and Young Adults



State	Bill	Chapter	Description
CT	HB 5371	14-7	Requires state agencies to develop certain programs in order to provide more efficient and effective services to youth, adolescents and young adults in the state who suffer from behavioral or substance abuse issues.
CT	HB 5596	14-47	Department of Children and Families (DCF) funded $1 million to fully establish two regional teams that provide outreach and a drop-in center with walk-in access to crisis intervention and ongoing support services.
IA	HF 2463	1140	Budget bill maintains current funding for the system of care pilots for children Central Iowa and Community of Care in NE Iowa.
IA	HF 2473	1141	Changes options for adjudicated delinquent youth, including placement in group foster care. States that a child's need for placement in shelter or inpatient mental health and substance abuse treatment program does not impact a consent decree.
IL	HB 5598	098-0808	Requires the Division of Mental Health, the Department of Children and Family Services and all other relevant state agencies to partner through an interagency agreement to intercept families on the verge of relinquishment where the sole purpose of the relinquishment is for the child to receive mental health treatment for a serious mental illness, and connect them to mental health services under the most appropriate state agency to prevent custody relinquishment.
MN	HF 2402	291	The county screening team must conduct the out-of-home placement screening within 10 working days for children needing residential treatment who are on a prepaid Medial Assistance plan.
MN	HF 3172	312	In early childhood family education law, inserts “cognitive and social” for the term “mental” in referring to a child’s development. The community outreach plan must focus on identifying new and underserved populations, identifying child and family risk factors and assessing the family and parenting education needs in the community. Programs must help families obtain a health and developmental screening for their child before the age of three.

State	Bill	Chapter	Description
MN	HF 3172	312	Appropriates $300,000 in funding for 2015 and $175,000 each year in on-going funding to give grants to community mental health centers to provide care to children and young adults under age 21 who are uninsured. The money will be distributed based on the percentage of clients with children under 21 who are uninsured and have income below 275% of poverty.
NE	LB 853	43	Extends services and support including accessing young adult empowerment opportunities such as peer support groups.
NE	LR 31		Resolution re-authorizes the Children's Behavioral Health Oversight Committee until the beginning of the 103rd Legislature, Second Session. The committee was created in 2009 to oversee programs created in the wake of the state's safe haven crisis to assist families and children in need of behavioral health services. The Legislature has since created the Nebraska Children's Commission to take up the committee's work.
SC	H 3567	173	Adds the term "young adults" in the definition of children and adolescents who are in need of mental health treatment in a residential facility. The bill also increases the eligibility age from under 18 to under 21.
UT	HB 21		Defines system of care. Requires the executive director of the Department of Human Services (DHS) to establish a system of care for minors with or at risk for complex emotional and behavioral needs. Requires local substance abuse and mental health authorities to cooperate with the DHS in promoting the system of care model.
VA	HB 183	20	Requires domestic and juvenile court judges to consider a juvenile's social history including physical, mental and social conditions prior to committing the individual to the Department of Juvenile Justice. Requires the Department to develop a set of social guidelines to serve as consideration prior to the 2015 general assembly.
WI	2013 AB 452	127	Directs the Department of Health Services (DHS) to administer a child psychiatric consultation program and allocates $500,000 per year for this purpose. Primary care pediatricians will be given the proper tools to treat children with mental health needs. DHS will contract with an organization to provide consultation, referral support and second opinions on diagnoses and medication, among other services.

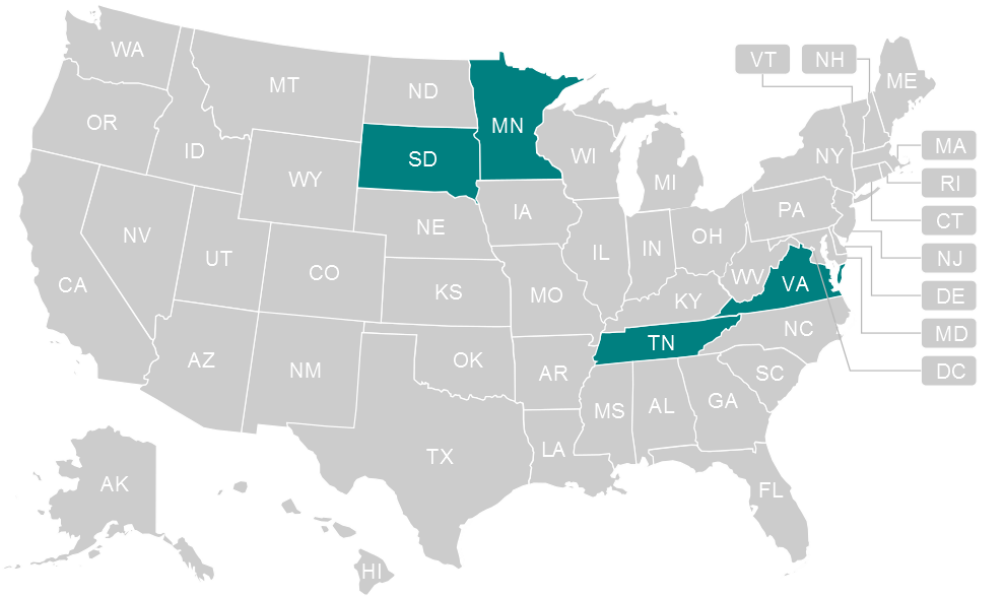
Appendix 9: School-Based Mental Health



State	Bill	Chapter	Description
CA	AB 1455	229	Authorizes the superintendent of a school district, the principal or designee to refer a victim, witness or other pupil affected by an act of bullying committed to the school counselor, school psychologist, social worker, child welfare attendance personnel, school nurse or other school support service personnel for case management, counseling and participation in a restorative justice program, as appropriate.
HI	HB 1796	206	Prohibits seclusion and reduces restraint in public schools; 2) Ensures safety of all students and personnel and promotes positive school culture and climate; 3) Protects students from physical and mental abuse and aversive behavioral interventions that compromise health and safety. Limits use of restraint in public schools to when a student's behavior poses an imminent danger of property or physical injury to the student, school personnel or others and only as long as the danger persists.
IL	HB 4207	98-0801	Prohibits a student from being subjected to bullying through the transmission of information from a computer that is accessed off school property, or from the use of technology or an electronic device that is not owned by a school district. School intervention is only required where there is a substantial disruption to the educational process or orderly operation of a school and only in cases where school personnel receive a report that bullying occurred specifying that the district is not required to monitor non-school related activity.
IN	HB1204	PL-41	Provides that if the parent, guardian or court appointed special guardian of a child asks a health care provider to disclose certain mental health information to the child's school, the health care provider shall provide the information to the child's school. Requires a school leader to sign a confidentiality agreement concerning release of the information. Prohibits a superintendent or school leader from excluding a student who was found to be mentally or physically unfit for school attendance if a physician, psychologist or psychiatrist certifies that the student is fit for school attendance.
MA	HB 4376	284	Provides for a "safe and supportive school" framework that integrates services to address behavioral and emotional issues, physical health, reduce bullying, truancy matters, children's mental health, social and emotional learning, foster care and homeless youth education, inclusion of students with disabilities and positive behavioral approaches. School resource officers shall be assigned to schools.

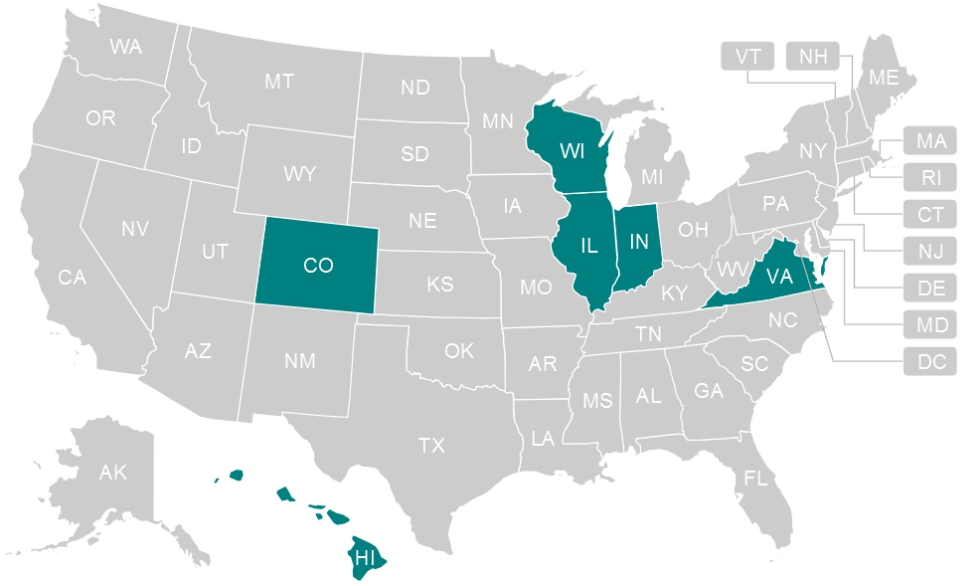
State	Bill	Chapter	Description
MA	H 3909	71	Requires school districts, charter schools, approved private-day schools, residential schools and collaborative schools to develop bullying prevention plans that will ensure they remain safe and supportive places for the Commonwealth's students to learn and thrive. It also includes procedures for collecting, maintaining and reporting bullying incident data.
MN	HF 2397	272	Makes optional, rather than requires, school districts to have a "community transition committee" to examine issues related to transition-age youth with disabilities. No requirement to meet regularly or to provide a yearly report to the Commissioner of Education.
MN	HF 3172	312	Appropriates $250,000 to help school districts reduce the use of prone restraints. The annual report to the legislature found that just a few children account for a high percentage of the use of prone restraints pointing to the need for districts to bring in experts to help them figure out how to meet the child's needs.
MN	HF 3172	312	Modifies the seclusion and restraint law. School must include in their plan information on the how they will provide de-escalation training to staff. There will be an annual report, due each February, on progress being made on reducing the use of seclusion and restraints and any policy recommendations. The summary data reported by the department and schools must include the use of reasonable force.
MN	HF 3172	312	The safe schools levy was increased for Intermediate School Districts from $10 to $15 per adjusted pupil units. These funds can be used to pay for school support personnel, for costs associated with improving the school climate and for costs related to co-locating and collaborating with mental health professionals who are not district employees or contractors.
PA	HB 1559	71	Provides for youth suicide awareness and prevention and for child exploitation awareness education. Will make mandatory 4 hours of training on youth suicide awareness and prevention every 5 years for professional educators of grades 6-9.
SC	H 3365	252	Provides for a school safety task force to study and make recommendations for the provision of mental health services in schools.
VA	HB 206	558	Requires each four-year public institution of higher education in the Commonwealth to create and feature on its website a page with information dedicated solely to the mental health resources available to students at the institution.
VA	HB 1268	799	Requires the violence prevention committee of each public institution of higher education to establish policies and procedures that outline circumstances under which all faculty and staff are to report threatening or aberrant behavior that may represent a physical threat to the community. The bill also requires each violence prevention committee to include notification of family members or guardians, or both, as a sufficient means of action in the committee's policies and procedures for the assessment of individuals whose behavior may present a physical threat, unless such notification would prove harmful to the individual in question.

Appendix 10: Standards of Care



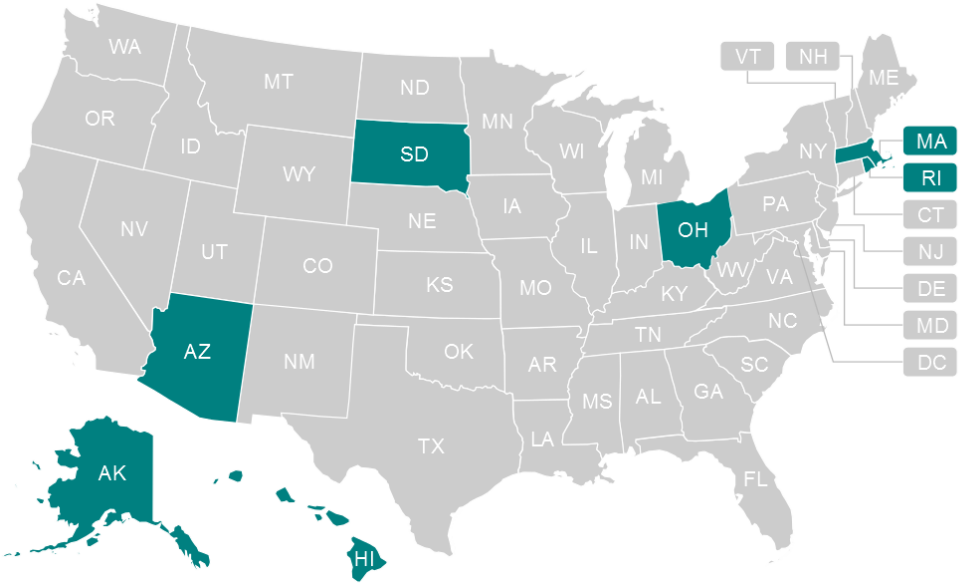
State	Bill	Chapter	Description
MN	HF 2950	262	Allows a day treatment programs for children to offer group psychotherapy for a minimum of three children at a time rather than four.
SD	HB 1198		Allows medication, electroconvulsive therapy, or such other necessary medical treatment to be extended after the first ten days of treatment for one additional ten day period if a petition within the first ten day period is filed and approved.
TN	SB 1782/ HB 1495	695	Authorizes community mental health centers and federally qualified health centers to employ physicians, except anesthesiologists, emergency department physicians, pathologists or radiologists.
TN	SB 2479/ HB 2441	809	Changes the scope of practice for psychologists to include forensic evaluation, parent coordination and telepsychology.
VA	SB 261/ HB 1216	364	Directs the Department of Behavioral Health and Developmental Services to review requirements for qualifications, training and oversight of individuals designated by community services boards to perform evaluations of individuals subject to emergency custody orders and to make recommendations for changes to such requirements.

Appendix 11: Health Information Privacy



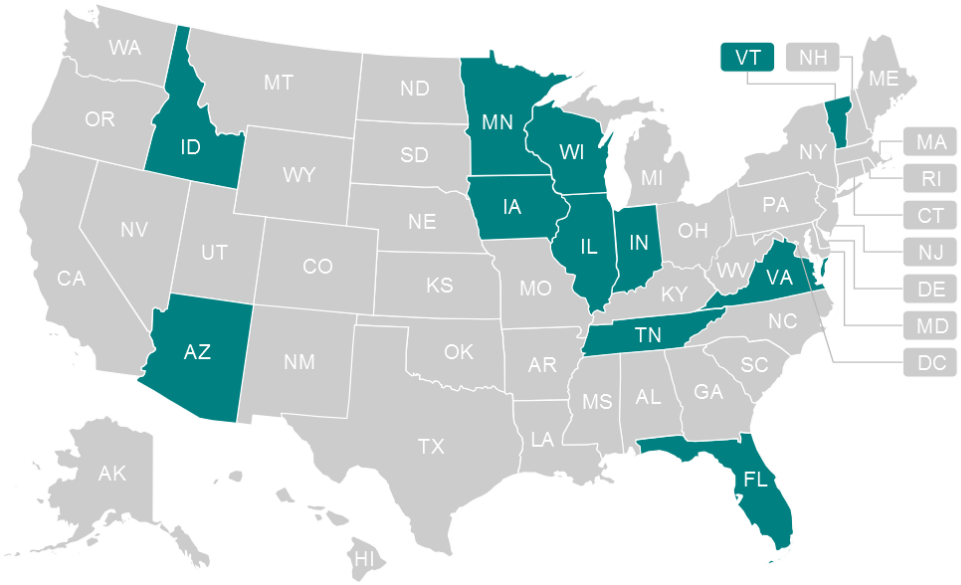
State	Bill	Chapter	Description
CO	HB 14-1271	109	State currently has a "duty to warn" standard that requires health care providers to disclose information to relevant authorities if a patient has indicated an imminent physical threat to self or others. Bill extends this duty to warn and immunity from liability to threats against physical institutions.
HI	SB 2869	214	Updates and streamlines state health care privacy laws by replacing existing laws regarding the use and disclosure of developmental disability and mental health records by health care providers with standards set out in the Health Insurance Portability and Accountability Act of 1996.
IL	HB 4694	098-0908	Amends the MHDD Confidentiality Act to broaden the description of records which are disclosed in a coroner's death investigation. Makes such disclosures mandatory.
IN	HB 1204	41	Provides that if the parent, guardian or court appointed special guardian of a child requests a health care provider to disclose certain mental health information to the child's school, the health care provider shall provide the information to the child's school. Requires a school leader to sign a confidentiality agreement concerning release of the information. Prohibits a superintendent or school leader from excluding a student who was found to be mentally or physically unfit for school attendance if a physician, psychologist or psychiatrist certifies that the student is fit for school attendance
VA	HB 585	408	If a criminal defendant has been found incompetent by a court and ordered to receive either inpatient or outpatient treatment to restore competency, then any relevant psychiatric treatment or other relevant records must be made available to director of the community services board, behavioral health authority or inpatient facility charged with treating the defendant within 96 days.
WI	AB 413	238	Changes state confidentiality laws on patient health care records and mental health treatment records to more closely track the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Appendix 12: Record Reporting and Gun Ownership



State	Bill	Chapter	Description
AK	HB 366	73	Stipulates provisions to report an involuntary mental health commitment to the National Instant Criminal Background Check System; seal records of mental health proceedings; and request relief from a disability resulting from an involuntary commitment or an adjudication of mental illness or mental incompetence.
AZ	HB 2322	261	Requires reporting involuntary commitments to the National Instant Criminal Background Check System (NICS)
HI	HB 2246	87	Requires courts to forward information about civil commitment orders to the Hawaii criminal justice data center. The criminal justice data center will then be required to forward this information to the FBI for the NICS database.
MA	HB 4376	284	Restricts ability to purchase weapons, including pepper spray for individuals who are committed to psychiatric facilities for mental health or substance abuse reasons. Also provides for a "Safe and Supportive School Framework."
OH	SB 7		Requires a court to report certain information to a specified local law enforcement agency for entry into the appropriate National Crime Information Center file if the court approves the conditional release of a person found incompetent to stand trial or not guilty by reason of insanity or orders a person convicted of an offense of violence to receive a mental health evaluation or treatment for a mental illness.
RI	H 7939 SUB A	423	Authorizes transmittal of mental disability information to NICS by district court. Establishes relief from disqualifiers board to consider petitions for relief from firearms prohibitions due to commitment adjudications.
SD	HB 1229		Requires reporting involuntary commitments to the National Instant Criminal Background Check System (NICS).

Appendix 13: Criminal Justice and Mental Health



State	Bill	Chapter	Description
AZ	HB 2467	37	Permits the establishment of county veterans' courts or mental health courts.
FL	HB 53	193	Authorizes DOC to provide inmates with ID cards upon release from prison.
IA	SF 2296	1066	Requires the state to pay mental health treatment costs for defendants found incompetent to stand trial. Costs will fall to the Department of Corrections for defendants deemed a threat to public safety or to the Department of Human Services if the defendant is not deemed a threat to public safety.
ID	SB 1351	288	Makes it a felony to batter health care workers while they are performing their duties or because of their profession.
IL	SB 2800	098-0944	Reinstates a provision that requires a defendant who has been judged unfit to stand trial, and who is in treatment, to be returned to the county jail prior to a hearing re-examining the defendant's fitness to stand trial.
IL	SB 2801	098-1025	Eliminates secure/non-secure distinction in state hospitals for forensic patients, shortens length of confinement for unfit misdemeanants, clarifies that medication petitions may be filed for person facing felony. Requires videotaping fitness exams.
IN	HB 1228	184	Requires community corrections programs to use evidence-based practices (EBPs) to help reduce recidivism.
MN	SF 685	171	Civil commitment and competency examinations will be conducted simultaneously for people in jail who are potentially not competent to stand trial when both the person's defense attorney and the prosecuting attorney agree it is appropriate. Also at this time, an attorney will be appointed to defend the person during any subsequent civil commitment proceedings.
MN	HF 2576	246	Allows a court to seal court records, executive branch records and Bureau of Criminal Apprehension (BCA) records. Requires private businesses and screening services to delete expunged records and permits juvenile records to be expunged.
MN	SF 2423	234	Requires the head of each correctional facility in Minnesota to ensure that any women who is incarcerated and is either pregnant or has given birth within the past six months has access to a mental health assessment and if needed, access to evidenced-based mental health treatment, including treatment for postpartum depression.

State	Bill	Chapter	Description
MN	HF 3172	312	Requires the Commissioner of Human Services to establish a work group consisting of a broad array of stakeholders (prosecutors, law enforcement, mental health advocates, mental health professionals, criminal justice professionals, judges etc.) to study issues related to individuals with mental illness who may be arrested or subject to arrest.
TN	SB 2023	926	Provides that inmates in public institutions may have their medical assistance suspended but not terminated and allows a temporary reinstatement of that assistance for care received outside the institution that lasts for more than 24 hours. Prior to release public institutions are permitted to help individuals re-establish medical assistance.
VT	H 225	180	Mandates that the Law Enforcement Advisory Board (LEAB) will establish statewide policies concerning the use and calibration of electronic control devices, such as Tasers. All officers who carry such a device must receive training. Also requires the Criminal Justice Training Council to coordinate training with the Department of Mental Health relating to law enforcement officers and mental health crisis team response.
VA	SB 357	739	Establishes that a court may order a competency evaluation of a defendant if there is evidence that the defendant lacks capacity to understand the proceedings. Once the evaluation has been conducted a report shall be prepared by the evaluator recommending inpatient or outpatient treatment.
WI	AB 450	126	Establishes a system of grants to train law enforcement officers in crisis intervention training (CIT).

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