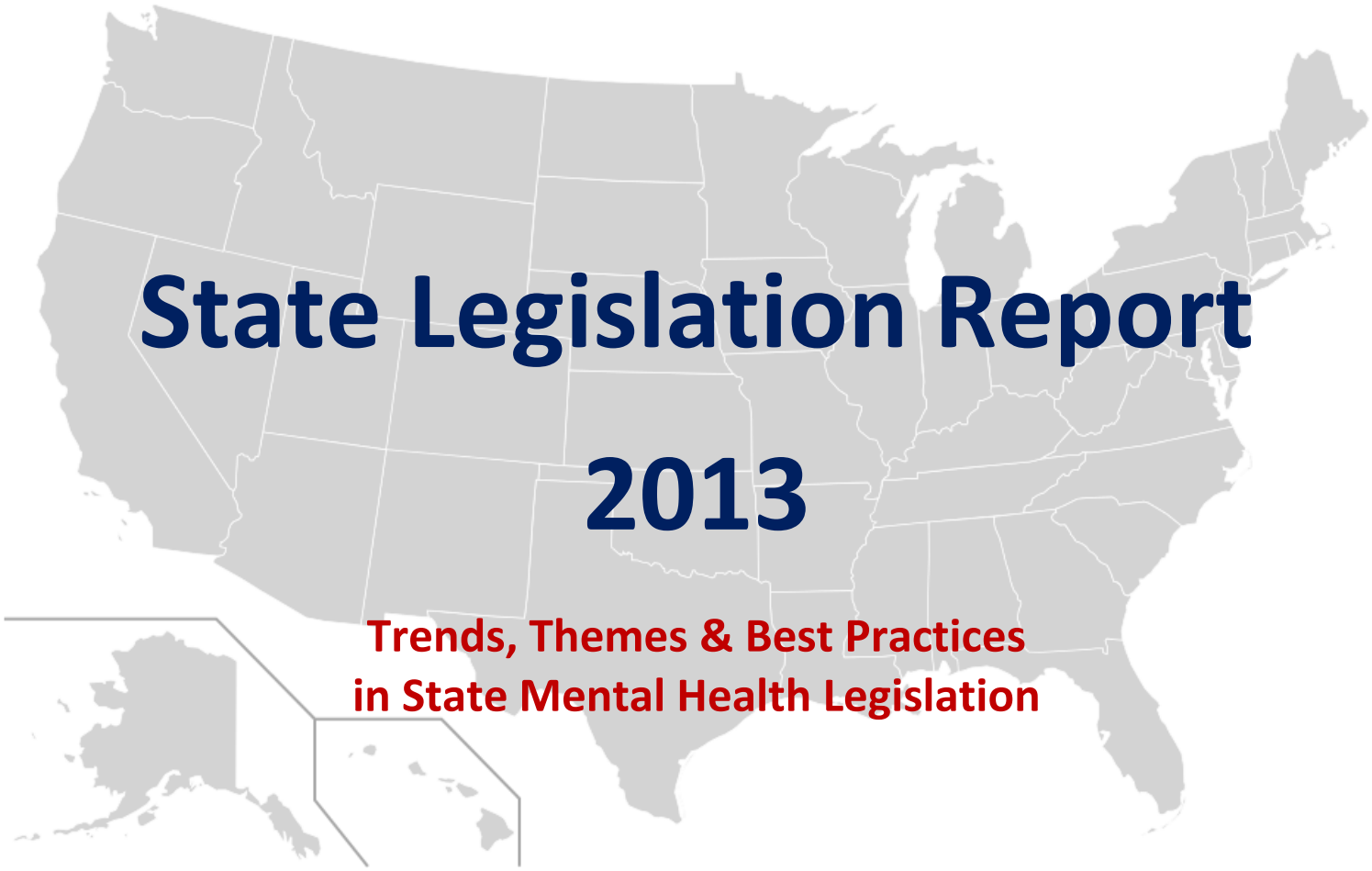
National Alliance on Mental Illness



State Legislation Report

2013

Trends, Themes & Best Practices in State Mental Health Legislation

Oct. 28, 2013

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State Legislation Report, 2013:
Trends, Themes and Best Practices in State Mental Health Legislation

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.

Acknowledgements and Gratitude

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Introduction: Mental Health Under the Spotlight

Mental health was a hot topic in 2013 state legislative sessions. Converging factors motivated state lawmakers to enact a wave of legislation with implications for people living with mental illness.

The improving economic outlook allowed state legislatures to begin rebuilding state mental health budgets. After years of attempting to meet rising demand with diminishing resources, public mental health systems are stretched to the breaking point. With few exceptions state legislatures acknowledged the need, increased or maintained mental health appropriations or enacted legislation to monitor and improve mental health service delivery.

Many provisions of the Patient Protection and Affordable Care Act (ACA) are set to take effect in 2014 and much of the 2013 legislative sessions revolved around a push to expand Medicaid under this law. Medicaid is essential to the financing and delivery of public mental health services and Medicaid expansion has the potential to offer coverage to an estimated 2.7 million uninsured people affected by mental illness.[1] Many governors recognized the economic merits and health benefits offered by Medicaid expansion.

In all states under the ACA an estimated 2.65 million people with mental illness will qualify for subsidies to buy private health insurance in the Health Insurance Marketplaces during the initial six month enrollment period which opened Oct. 1, 2013.[2] The ACA requirement for all Qualified Health Plans to provide mental health benefits in compliance with federal mental health parity law will benefit an estimated 62 million Americans[3] prompting mental health parity legislation in a number of states.

Striking just before state legislative sessions convened, the mass shooting in Newtown, Conn. riveted the nation's attention on the eroded condition of mental health services in this country. *Now is the Time*, the White House report produced in response to the tragedy, recommended strengthening gun ownership background check systems, making schools safer and increasing access to mental health services.[4] NAMI advocated for strategies to identify and treat emerging mental health issues at the earliest opportunity, mental health training for school personnel, school-based mental health services and improved mental health services for transitional youth. In the face of overreaching legislative proposals, NAMI emphasized that the vast majority of people with mental illness are no more violent than the general population. However, NAMI acknowledged that a small subset of people with mental illness are more prone

[1] Substance Abuse and Mental Health Services Administration. (2012). *Enrollment under the Medicaid Expansion and Health Insurance Exchanges: A Focus on Those with Behavioral Health Conditions in each State.* http://www.samhsa.gov/healthreform/enrollment.aspx.
[2] Ibid.
[3] Beronio, K., Po, R., Skopec, L., Glied, S. (Feb. 2013). *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans* http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm
[4] White House (Jan. 16, 2013) *Now is the Time; the president's plan to protect our children and our communities by reducing gun violence.* White House. http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf

to violence[5] (specifically young men with untreated psychosis who abuse alcohol or drugs) and advocated for more robust implementation of existing standards for clinician duty to warn and mental health reporting requirements related to gun ownership. NAMI opposed legislation that expanded requirements based on stereotypical assumptions about mental illness and violence or threatened the civil liberties of people who engage in mental health care.

Many legislatures in the 2013 session recognized the importance of stronger and more responsive public mental health service systems and the risks of allowing the system to erode. Mental health legislation was enacted in 2013 along the following themes:

- Mental health system improvement.
- Crisis and inpatient care.
- Community mental health.
- Criminal justice and mental health.
- Civil rights and stigma reduction.

By highlighting themes, trends and best practices in state legislation, this report is intended to equip NAMI leaders and their allies to leverage gains made during 2013 state legislative sessions. Positive legislation is starred to encourage advocates to replicate this legislation in their communities. Potentially harmful legislation is flagged to alert advocates to the need to amend or repeal policies likely to negatively impact civil rights, access to care or quality of life for individuals and families affected by mental illness.

Methodology

This report is based on information obtained from a survey of state NAMI leaders covering legislative advocacy in 2013 state legislative sessions. The survey gathered information on the status of the state mental health authority budget, health reform implementation and legislation supported or opposed by NAMI organizations. 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 2013 legislative sessions. Efforts were made to include only enacted legislation as opposed to bills that were proposed, but did not pass the legislature or were vetoed by the governor.

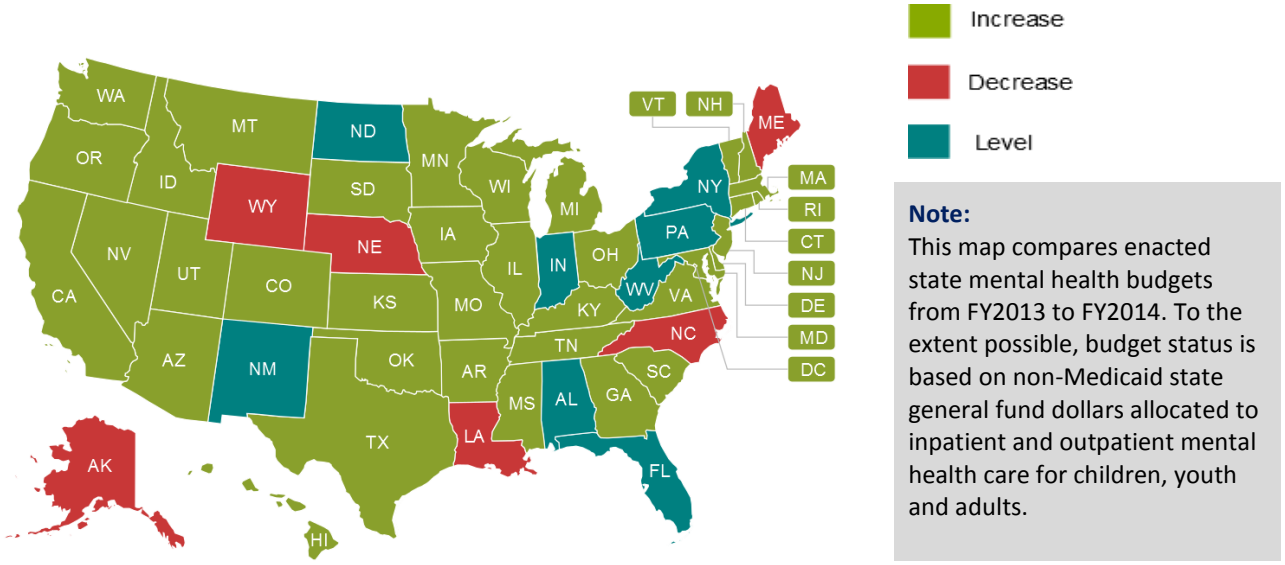
[5] National Alliance on Mental Illness. (March, 2013) *Violence, Mental Illness and Gun Reporting Laws: Where We Stand.* http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=153162

Rebuilding State Mental Health Budgets

State mental health budgets were gutted during the recession. With reductions totaling $4.35 billion from FY2009 to FY2012,[6] public mental health systems struggled to meet rising demand with diminishing resources. As the 2013 legislative sessions convened economic prospects brightened somewhat based on projections for 5.3 percent combined growth in state revenue.[7]

Realizing the risks of failure to provide adequate public mental health services, governors and legislatures in many states began the process of restoring state mental health budgets. Most states either increased or maintained state mental health authority budgets at current levels. Of special note is Texas which allocated a $259 million increase over the previous biennial budget, the largest mental health budget improvement in the state's history.[8] South Carolina reversed previous cuts to its mental health budget while Illinois restored $32 million that had been cut in 2011 due to an administrative error. In California, an additional $143 million was allocated to create crisis and triage positions throughout the state.[9] As part of a 21.6 percent increase necessary to implement the ACA, Oregon allocated $67 million in the 2014-15 biennial budget for psychiatric residential treatment and children's mental health.[10] While these increases are encouraging, much remains to be done to restore drastic cuts in state mental health budgets nationally between 2008 and 2012.

Figure 1: State Mental Health Budgets FY 2014



Note:
This map compares enacted state mental health budgets from FY2013 to FY2014. To the extent possible, budget status is based on non-Medicaid state general fund dollars allocated to inpatient and outpatient mental health care for children, youth and adults.

[6] Joel E. Miller, et al., Nov. 2012. *The Waterfall Effect: Transforming the Cascading Impact of Medicaid Expansion on States*, National Association of State Mental Health Program Directors.
[7] NCSL (Aug. 2013) *2013 Presents a Dichotomy for State Budgets*. NCSL News. http://www.ncsl.org/press-room/2013-presents-a-dichotomy-for-state-budgets.aspx
[8] Grissom, B (May 18, 2013) With Consensus and Money, State Takes on Mental Health Care. *The New York Times*. http://www.nytimes.com/2013/05/19/us/with-consensus-and-money-state-takes-on-mental-health-care.html?pagewanted=all&_r=2&
[9] Buchanan, W (June, 27 2013) Governor Brown Proudly Signs Balanced Budget. *SFGate*. http://www.sfgate.com/news/article/Gov-Brown-proudly-signs-balanced-state-budget-4628307.php
[10] Gray, CD (Jul. 3, 2013) *House Passes $15 Billion Budget for Oregon Health Authority*. The Lund Report. http://www.thelundreport.org/resource/house_passes_15_billion_budget_for_oregon_health_authority

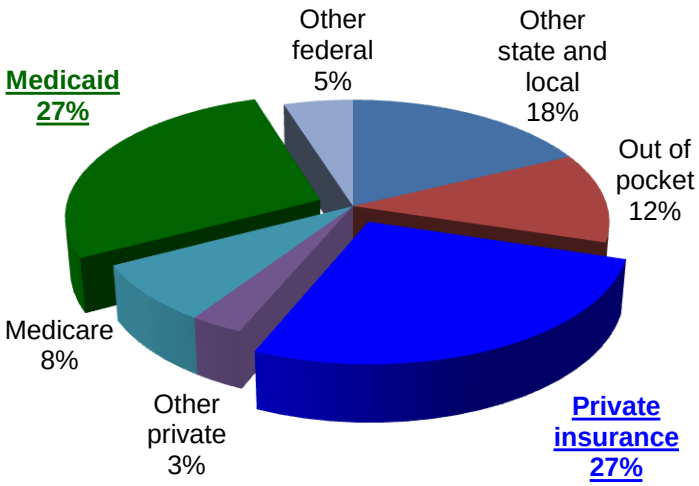
Not every state moved to increase general fund allocations to mental health. North Carolina proposed a $20 million reduction to the mental health budget and, after public outcry, reduced cuts to a certain extent.[11] Following precipitous general fund cuts amounting to 32 percent from 2009 to 2012, Alaska continued with a 3.4 percent reduction in the FY2014 mental health budget. Wyoming reduced mental health and substance abuse allocations by $4.8 million as part of an overall 8 percent cut to the Department of Health.[12]

Along with additional financial resources, 13 state legislatures enacted policies to monitor and improve mental health service delivery. Utah (**HB 57**) is a bellwether, requiring the state mental health authority to promote integrated health care programs that address substance abuse, mental health and physical health care needs as well as evaluate the effectiveness of integrated programs and encourage local mental health authorities to do the same. Wyoming (**SF 60**) is proceeding with Medicaid reform, strengthening mental health services for people living with serious and persistent mental illness or serious psychological distress. *See Appendix 1*

The Promise of Health Reform: Increased Coverage, Increased Access to Care

Implementation of the ACA has great potential to improve access to care for millions of uninsured Americans who live with mental illness. Health reform will have significant effects on the two major systems of mental health financing and delivery: Medicaid and private health insurance.

Figure 2: Mental Health Financing



Source: Garfield (2011*) Mental Health Financing in the US: A Primer*. Kaiser Commission on Medicaid and the Uninsured

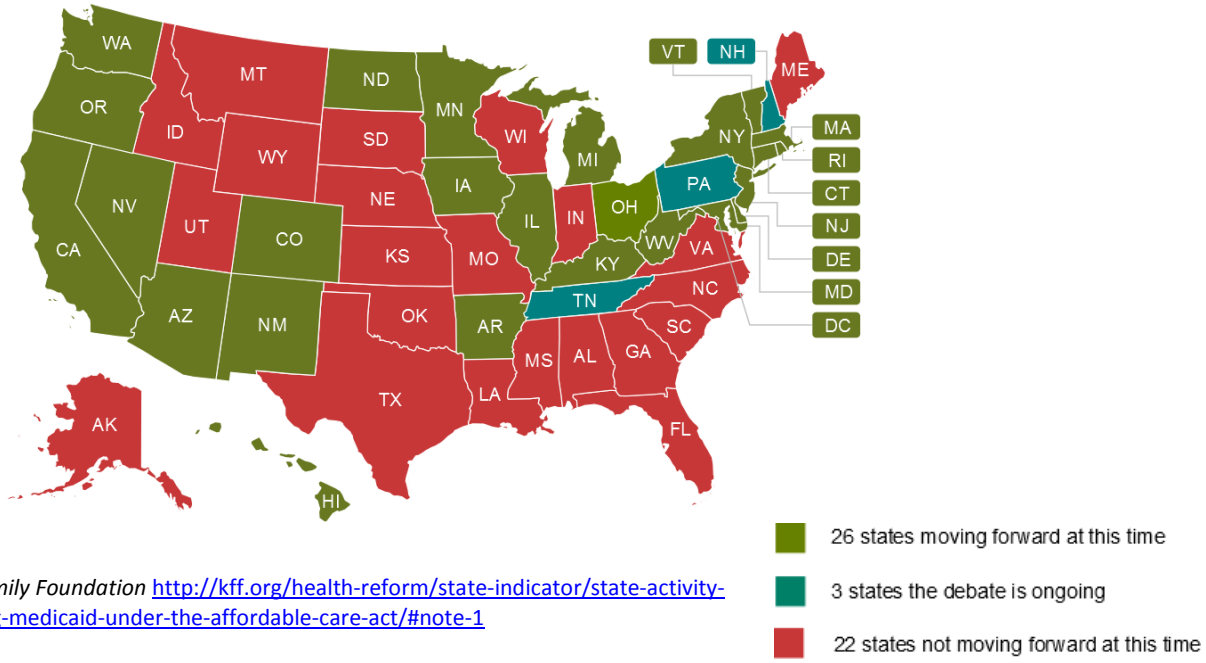
Medicaid Expansion

Medicaid is the most important public health program for mental health service delivery, currently financing 27 percent of all mental health services. Medicaid provides access to community mental health care that would otherwise be unavailable to millions of low-income adults and children. Expanding Medicaid to 138 percent of poverty, as allowed under the ACA, is the best strategy available to strengthen the mental health system. The Supreme Court decision that permitted rather than required states to expand Medicaid left state legislatures with a choice. The issue of whether or not to expand Medicaid was hotly

[11] Dihoff, D. (July, 2013) Heard in the Halls, Final Report on the 2013 Session. NAMI North Carolina. http://naminc.org/public/heard-in-the-halls/
[12] Nicholson (Nov. 12, 2013) Fiscal Plateau: Lawmakers trim budget to match declining revenue http://wyofile.com/gregory_nickerson/riding-the-budget-bronco-legislature-to-debate-cuts-in-2013-session/

debated in many 2013 legislatures. While 25 states and the District of Columbia recognized the advantages of expanding Medicaid, 22 state legislatures have deferred to date.

Figure 3: Status of Medicaid Expansion Decisions (10/24/13)



Source: *Kaiser Family Foundation* http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#note-1

Health Reform: Private Insurance and Health Insurance Marketplaces

Private health insurance, primarily sponsored by employers, covers an estimated 27 percent of mental health services delivered in the U.S. Private insurance typically includes a narrower range of mental health benefits than Medicaid, but tends to pay better rates and consequently offers access to a broader network of providers. Unlike Medicaid, private health insurance reimburses inpatient psychiatric care for non-elderly adult beneficiaries and tends to cover a wider selection of prescription medications.

Health Insurance Marketplaces opened for enrollment in every state on Oct. 1, 2013 with coverage beginning as soon as Jan. 1, 2014 *(See Appendix 2).* The ACA requires mental health coverage in compliance with the Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). This means all health insurance policies sold through the new Health Insurance Marketplaces must include mental health coverage equivalent to medical or surgical benefits. Moreover insurers offering individual or small group plans through the marketplaces must offer the same benefits in individual and small group plans sold on the open market. As a result, an estimated 62 million Americans will benefit from federal parity provisions.

Mental health parity legislation was enacted in several states in recognition of the strengthened parity provisions in the ACA. Maryland passed two pieces of legislation that outlined mental health parity. **HB 1216** requires health maintenance organizations that issue or deliver specified health insurance policies or contracts to provide notice of specified benefits for mental illness and substance abuse. **HB 1252** requires that criteria and standards used for conducting utilization review for mental health and substance abuse benefits comply with MHPAEA. Connecticut, Louisiana and Texas were among states enacting legislation on health insurance and parity. *See Appendix 3*

Reaction to Tragedy: Legislation after Newtown

Occurring just prior to the beginning of the legislative session in most states, the shooting at Sandy Hook Elementary School in Newtown, Conn. provided a major impetus for lawmakers to propose legislation which would impact children and adults living with mental illness. Mental illness came to the forefront of the nation's attention when medical records revealed that the shooter's mother was increasingly concerned about his deteriorating mental health and had been dissatisfied with the lack of school services dating back to middle school.[13] A tipping point on the heels of several recent mass shootings, the Newtown tragedy shaped the debate about the lack of access to mental health services and the barriers that many families and individuals face in light of the nation's fragmented and grossly inadequate mental health system.

Early Identification and Intervention

After the Newtown tragedy NAMI advocated for policies supporting early identification and intervention, training for school personnel, families and the public, mental health services in schools and increased access to care. States' legislation was aimed at providing increased mental health screening services for several populations primarily to identify emerging mental illness in children and adolescents and to ensure adequate access to care. In addition, several states enacted related legislation focused on early intervention, school-based services and staff training to prevent potential tragedies such as the Sandy Hook shootings.

Examples of legislation targeting early identification and mental health screening included **LB 556** enacted in Nebraska to develop behavioral health screenings and to provide education and training on children's behavioral health. Nevada passed **AB 386** to establish a pilot program for the administration of mental health screenings to students enrolled in selected secondary schools. *See Appendix 4A*

Several states focused on interventions with transition age youth. Minnesota enacted **HF 359** requiring that case management services continue to be available to youth living with mental illness after they turn 18. Before discontinuing case management a county must develop a

[13] Griffin, A. & Kovner, J. (2013, June 30). Adam Lanza's medical records reveal growing anxiety. *The Courant*. http://www.courant.com/news/connecticut/newtown-sandy-hook-school-shooting/hc-adam-lanza-pediatric-records-20130629,0,7137229.story

transition plan that includes plans for health insurance, housing, education, employment and treatment. Virginia (**SB 1342**) now requires the governing board of each public four-year institution of higher education to establish a written memorandum of understanding with its local mental health system and with inpatient facilities in order to expand the scope of services available to students seeking treatment. *See Appendix 4B*

Understanding that schools are close to the action when mental health challenges emerge, a number of states focused on training teachers, school personnel, students and families to identify signs of suicide and other mental health issues. Texas enacted **SB 460** to require training for public school teachers and students in recognizing and responding to signs of suicide or mental health disorders and the inclusion of mental health concerns in coordinated school health efforts. In Utah, **HB 298** will require school districts to offer an annual seminar to parents with information on mental health, depression and suicide awareness. Minnesota passed two bills to strengthen school-linked mental health services (**HB 2756**) and Oregon enacted **HB 2756** calling for removal of seclusion rooms from all public schools. *See Appendix 5*

Mental Illness and Violence Prevention

In the face of an avalanche of state legislation aimed at maintaining public safety, mental health advocates staunchly opposed strategies likely to have a chilling effect on willingness to seek care or that would erode the civil liberties of people who engage in mental health care. The New York Secure Ammunition and Firearms Enforcement (SAFE) Act of 2013 (**S 2230**) became the first piece of legislation enacted in 2013 to broaden clinician duty to warn and increase requirements to report mental health records for the purpose of limiting firearms purchases. Highly controversial due to the sweeping nature of its mandated strategies, the SAFE Act set a precedent for similar bills in other states which focused on increasing requirements to report mental health information to the National Instant Criminal Background Check System (NICS), more public access to civil commitment records and expanding the duty of clinicians to warn about potential dangerousness. Under the SAFE Act, clinicians providing mental health services must report threats of violence to law enforcement officials.

Advocates, including NAMI, cautioned against unintended consequences of these broader standards and instead advocated for more robust implementation of existing laws. Nevertheless gun ownership and duty to warn legislation was debated, amended and ultimately enacted in many states. Duty to warn legislation included **SB 789** in Tennessee which requires mental health professionals to report any patient who makes an actual threat of bodily harm against a reasonably identifiable victim or victims to local law enforcement, who must then report the individual to NICS. Arkansas enacted **HB 1746** requiring mental health service providers to warn law enforcement about any credible threat by a patient. *See Appendix 6*

Despite an onslaught of complaints from opponents that the legislature was infringing on second amendment rights, the Connecticut legislature enacted **SB 1160** which strictly limits firearms possession and requires reporting of mental health information for gun permits. Connecticut's law requires reporting of all people who receive inpatient psychiatric treatment, including those who enter hospitals voluntarily. Colorado enacted **HB 1229** which requires

background checks for purchases and transfers of firearms and limits possession of firearms. *See Appendix 7*

Mental Health Crisis and Inpatient Treatment Legislation

A number of states also enacted legislation addressing civil commitment, court-ordered outpatient treatment (assisted outpatient treatment), crisis response, mental health facilities and suicide prevention.

Civil Commitment, Assisted or Court-Ordered Outpatient Treatment

Legislation on involuntary inpatient and outpatient commitment was prevalent in the 2013 session. Strategies varied widely, covering rights of individuals who are civilly committed, improving outpatient treatment programs and encouraging community-based court ordered treatment.

A few examples of civil commitment legislation include **SF 406** in Iowa, which expands the scope of providers qualified to authorize inpatient admission from solely examining physicians to other professionals including physician assistants and psychiatric advanced registered nurse practitioners. Indiana passed **HB 1130** which allows law enforcement to detain and transport persons with mental illness who are gravely disabled. Similarly, **HB 16** in Montana clarified that the emergency detention standard in the civil commitment process includes individuals who are substantially unable to provide for their basic needs. Washington passed three civil commitment bills: **HB 1114** to strengthen rights of people with mental illness during civil commitment and criminal incompetency procedures, **SB 5480** requiring consideration of a person's history of symptoms or behavior when making a civil commitment decision and **SB 5732** which improves planning and care coordination associated with discharge from inpatient civil commitment.

In Nevada, **AB 287** broadened the use of assisted outpatient treatment by permitting courts to order outpatient treatment when it is determined that a person has a mental illness and is likely to harm self or others if left untreated. The law mandates that courts must place individuals in the most appropriate course of community-based treatment available. By passing **SB 310** Hawaii established an assisted community treatment program for individuals not deemed dangerous to self or others. **HB 1423**, enacted in Virginia, stipulates that—pending the conclusion of a course of voluntary or involuntary treatment—the community services board in any county where an individual is to reside may petition the court for an order of mandatory outpatient treatment.*See Appendix 8*

Crisis Response Services

In a mental health crisis, psychiatric crisis response services help people stabilize, access care and resume daily activities. Elements of a comprehensive crisis response system are reflected in Colorado's legislation (**SB 266**) to establish (1) A 24-hour telephone crisis service to perform assessment and referrals; (2) walk-in crisis services and crisis stabilization units with the capacity for immediate evidence-based clinical intervention, triage and stabilization; (3) mobile

crisis units linked to the walk-in and crisis respite services; (4) residential and respite crisis services that include a range of short-term crisis residential services, including but not limited to community living arrangements; and (5) a public information campaign. *See Appendix 9*

Mental Health Facilities

Public inpatient mental health facilities were dramatically reduced during the recession as states struggled to stretch resources in the face of rising demand for services. From 2007 to 2012 the number of patients served in state psychiatric facilities dropped by 30,079 (17 percent).[14] State legislation related to psychiatric inpatient care concerned donation of property to community mental health services (AR **SB 801**), staff functions (IA **SF 406**), complaint investigations (MO **HB 351**), a study of inpatient capacity (MT **HJ 16**), geropsychiatric facilities (ND **HB 1089**), deinstitutionalization (RI **S680B**) and limitations to restraint and seclusion (TX **SB 1842**). *See Appendices 10 and 11*

Suicide Prevention

After a period of stability the U.S. suicide rate increased sharply during the recession as Americans grappled with the stresses of unemployment.[15] With the enactment of (**SB 72**), Kentucky established mandatory training requirements in suicide assessment, treatment and management for: social workers, marriage and family therapists, professional counselors, fee-based pastoral counselors, alcohol and drug counselors, psychologists and occupational therapists. Other states enacting suicide prevention legislation included Alaska (**SB 37**), Oklahoma (**SB 181**), Utah (**HB 154**) and Washington (**HB 1376**). *See Appendix 12*

Community Mental Health Legislation

Increased scrutiny of mental health services also prompted lawmakers to enact legislation on long standing community mental health policy needs. In addition to the child and youth policy mentioned earlier, issues included: family involvement in care, health information privacy, prescription medications, provider credentials, standards of care, supports for housing and employment and the use of technology to increase service capacity.

Family Involvement in Care

Understanding that informed and engaged families can lead to better mental health outcomes for children and adults, South Carolina enacted **SB 117** which strengthens requirements for health care providers to give individuals the opportunity to authorize disclosure of information to designated family members or others. Tennessee passed **SB 442** which allows family members and friends to transport individuals in mental health crisis to regional mental health institutes for civil commitment when safety would not be compromised. *See Appendix 13*

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[14] Substance Abuse and Mental Health Services Administration (SAMHSA), Uniform Reporting System. http://www.samhsa.gov/dataoutcomes/urs/

[15] Reeves, A; Stuckler, D; McKee, M, Gunnell, D; Chang, SS; Basu, S (Nov. 2012) Increase in state suicide rates in the USA during economic recession. *The Lancet*, vol. 380 -9856, pp. 1813 – 1814. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2961910-2/fulltext

Health Information Privacy

In addition to duty to warn, other standards governing the release of mental health treatment information were debated in the 2013 legislative session. Of concern, Tennessee enacted **SB 28** which allows a court hearing a child custody case to order disclosure of mental health information. As amended, the bill restricts release of confidential mental health information for the purpose of litigation and requires return or destruction of records at the conclusion of the case. Oklahoma (**SB 581**) increased those allowed to access court records related to treatment to include: a person having a valid power of attorney with health care decision-making authority, a person having valid guardianship with health care decision-making authority, a person having an advance health care directive, or a person having an attorney-in-fact as designated in a valid mental health advance directive. *See Appendix 14*

Prescription Medications

People who get the right treatment have greater success in managing their mental illness. In order to choose the treatment regimen that will work best and enhance adherence, individuals and their prescribers need access to the full range of medications. In an effort to contain costs a number of states enacted legislation limiting access to psychiatric medications in public programs. Arkansas set a troubling precedent with (**HB 1185**) which authorizes a pharmacist to substitute a therapeutically equivalent, less costly medication, upon authorization by the prescriber. The pharmacist must inform the patient of the right to refuse the substitution. The term "therapeutically equivalent" extends beyond substituting a generic for its brand name equivalent to substituting a chemically different medication from the same class. A second bill in Arkansas (**SB 965**) modified, but did not extinguish concerns about the first bill.

Within its budget bill (**SB 402**) North Carolina imposed prior authorization and a restricted Preferred Drug List (PDL) for mental health medications prescribed to Medicaid and Health Choice recipients. The budget bill specifically includes off-label prescriptions for treatment of Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) in youth.

On a more positive note, New York retained its "provider prevails" standard for prescribing psychiatric medications despite efforts to enact a more restrictive standard (**A. 3006**). *See Appendix 15*

Provider Credentials

Bills governing provider licensure and scope of practice were enacted in a number of states. Louisiana (**HB281**) authorized development of a behavioral health license to facilitate the provision of integrated mental health and substance use care. Minnesota (**HF 358**) added family peer specialists (FPS) to the list of mental health practitioners covered by Medicaid for children's mental health services. FPS must be parents of a child living with mental illness and they must undergo specialized training. Oklahoma (**HB 1109**) provided for certification of peer recovery support specialists who are employed by a behavioral services provider. *See Appendix 16.*

Standards of Care

This category of legislation ranges from policies for treatment of specific diagnoses to strategies to increase access to and quality of care. Pennsylvania (**SB 5**) is promoting integrated health homes through the establishment of a community-based health care program to expand access to preventive care, disease management, behavioral health and pharmacy services. With enactment of **SB 7** Texas charged local mental health authorities with ensuring provision of assessment services, crisis services and intensive disease management practices for children and adults. The legislation requires local mental health authorities to incorporate jail diversion strategies into disease management practices to reduce involvement of people living with serious mental illness in criminal justice systems. *See Appendix 17*

Supports: Housing and Employment

Decent, safe, affordable housing and meaningful employment are crucial to recovery from serious mental illness. Despite repeated communication from the U.S. Department of Justice (DOJ), North Carolina's reliance on large adult care homes as residences for people with mental illness resulted in a 2011 U.S. DOJ ruling to move adult group home residents with mental illness to independent housing and to provide supports necessary to enable those individuals to live successfully in the community. Unfortunately the ruling came during a time of budgetary constraint. After some brinksmanship, the North Carolina budget (**SB 402**) allocated $4.6 million to group homes to replace loss of personal care Medicaid funding and provided for a tiered special assistance rate to vary based on intensity of need. The state also enacted **HB 5** to provide temporary, short-term financial assistance to (1) group homes serving residents determined not to be eligible for Medicaid-covered personal care services as a result of changes to eligibility criteria and (2) special care units serving residents who qualify for Medicaid-covered personal care services. *See Appendix 18*

Minnesota passed two bills to strengthen evidence-based supported employment. **SF 1607** encourages the use of evidenced-based practices, such as the Individual Placement and Support (IPS) model, in the *Extended Employment for People with a Serious Mental Illnesses* **(**EE-SMI) program while the omnibus budget bill, **HF 1233/SF 1034** extends $1 million in state funding for the program. *See Appendix 18*

Telehealth Technology

Advances in communication technology offer an increasingly effective strategy to deliver specialty mental health care to underserved areas, address workforce shortages and to integrate health and mental health care. Three states passed legislation to allow delivery of mental health services through telemedicine: Idaho (**HB 32**), Indiana (**SB 554**) and Utah (**HB 56**). *See Appendix 19*

Criminal Justice and Mental Illness

Disproportionate numbers of people with mental illness are involved in the criminal justice system[16] often as a result of untreated or undertreated mental illness. NAMI has long worked to oppose unnecessary arrests and incarceration, advocating for diversionary strategies such as crisis intervention teams (CIT) and mental health courts. High profile violent acts by people living with mental illness make the task more difficult, and in 2013 lawmakers debated a variety of bills focused on the nexus between criminal justice and mental health. Legislation was enacted addressing law enforcement, the courts, incarceration, probation and parole and juvenile justice.

Law Enforcement

Legislation was enacted in several states addressing procedures used by law enforcement officials to intervene when people display signs of mental illness. For example, Ohio (**SB 7**) required that if a person convicted of an offense requires a mental health evaluation or treatment, the court shall report to the local law enforcement agency, which shall report the information to the national crime information center supervised release file. Law enforcement legislation also encompassed bills focused on the mental health status of law enforcement personnel. Missouri (**HB 404**) now allows psychological stress to be recognized as an occupational disease for purposes of workers compensation. In possible violation of the Americans with Disabilities Act (ADA) Tennessee (**SB 175**) revised law enforcement officer qualifications to require certification that the applicant is free from any psychiatric impairment that would affect the ability to perform an essential function of the job, with or without a reasonable accommodation. *See Appendix 20*

Courts

Legislatures dealt with a variety of bills concerning criminal courts and defendants with mental illness. Arizona (**HB 2310**) developed standards for the design, training and procedures to establish and implement mental health courts, while Missouri (**SB 118**) created a veterans treatment court to handle cases involving substance abuse or mental illness of current or former military personnel. Without officially establishing a veterans' court South Dakota (**SB 70**) now requires magistrates and circuit judges to be trained on evidence-based principles, including use of behavioral health assessments and allows the court to consider treatment options when imposing a sentence if a defendant who is a military service member or veteran pleads guilty or no contest. *See Appendix 21*

Incarceration

Jails and prisons are neither designed nor funded to provide mental health treatment, yet with the erosion of public mental health services they have increasingly become de facto mental health facilities. Without appropriate treatment inmates with mental illness decompensate, are vulnerable to abuse and are disproportionately segregated in solitary confinement. Legislation

[16] James, DJ., and Glaze, LE., (Sep. 2006) Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates,* NCJ 213600.

enacted in Maine (**LD 1433/HP 1022**) raises concerns about unequal justice. The bill provides that a person who is in prison for an offense and is found not criminally responsible by reason of insanity for another offense must finish the first prison term before beginning the commitment ordered by the court for the second offense. *See Appendix 22*

Release, Probation, Parole

Thoughtful release planning and progressive probation or parole procedures increase the likelihood of successful re-entry for prisoners living with mental illness. Montana enacted (**SB 11**) to revise the probation and parole system to work more effectively with prisoners who have a serious mental illness. The legislature also passed **HB 68** creating a re-entry task force pilot project to reduce recidivism. HB 68 requires the department, in consultation with the reentry task force, to develop partnerships with and contract with community-based organizations that provide needed services to released inmates in areas such as mental health, chemical dependency, employment, housing, health care, faith-based services, parenting, relationship services and victim impact. *See Appendix 23*

Juvenile Justice

As with the adult system, involvement with juvenile justice often represents the failure to identify and treat emerging mental illness. As part of the examination of the mental health system as a whole, states enacted legislation to study, improve and integrate juvenile justice systems with efforts of other child serving systems.

The most far-reaching legislation was enacted in Minnesota. **SF 671/ HF 724** commissions a working group to examine juvenile justice and mental health. The group is composed of NAMI Minnesota, commissioners of human services, corrections and education; a district court judge designated by the Supreme Court; the Minnesota County Attorneys Association; the state public defender; the Indian Affairs Council; the Minnesota County Probation Officers Association and the Minnesota Association of Community Corrections Act Counties. The work group will examine early identification and response, changes needed to ensure coordinated quality service delivery; changes to rules and statutes to remove barriers to achieving outcomes; an implementation plan to achieve integrated service delivery across systems and across the public, private and nonprofit sectors and financing mechanisms that include all possible revenue sources. NAMI Minnesota is required to report to the legislature on the results. *See Appendix 24*

Rights Protection and Advocacy

Concern for civil rights of people who live with mental illness was a constant undercurrent for much of the legislation described in this report. However, a few additional bills addressing rights protection are included in this section. An interesting piece of legislation in Oklahoma (**SB 755**) establishes the role of “treatment advocate” to include: guardians, persons granted general health care decision-making authority or those designated as health care proxies in an advance directive for health care, or persons granted durable power of attorney with health

care decision-making authority. The law provides for release of information to the treatment advocate. *See Appendix 25*

Stigma Reduction

Two states passed bills addressing language and practices that have the effect of stigmatizing people living with mental illness. Tennessee (**SB 1376**) changed how the state code refers to people who live with mental illness to comply with ADA standards. West Virginia (**SB 193**) repealed the law permitting sterilization of persons deemed mentally incompetent. *See Appendix 26*

Summary

Sweeping changes in public and private health care delivery systems and improving state economies provided opportunities in 2013 to strengthen public mental health services. Reminded forcefully about the essential value of a robust mental health service system, lawmakers in many states began to replenish resources that had been lost during the recession. Despite these advances, public mental health systems remain woefully underfunded.

2014 State Policy Recommendations

The following recommendations represent 2014 NAMI state policy priorities that should be considered by state mental health advocates.

Actively engage in outreach and enrollment. The success of the Health Insurance Marketplaces and Medicaid expansion will depend on robust outreach and enrollment from Oct. 1, 2013 to March 31, 2014. States should ensure that people living with mental illness are enrolled in the most appropriate type of coverage for their health and mental health care needs. Obstruction of enrollment by governmental officials is reprehensible and must cease.

Comply with mental health parity. The ACA requires mental health as an essential health benefit on par with medical/surgical benefits for all Qualified Health Plans and Medicaid Alternative Benefit Plans. States should monitor compliance with federal parity requirements, hold insurers accountable and impose meaningful sanctions for noncompliance.

Expand Medicaid. As this report goes to press 25 states and DC have opted for Medicaid expansion. All remaining states should expand Medicaid in a manner that fully complies with the ACA to include requirements for essential health benefits, out-of-pocket cost limitations and consumer protections.

Increase integrated care. Integrated mental health, addiction and primary care for children and adults with multiple chronic conditions improves overall health, reduces costs, prevents duplication and gaps in care and makes more efficient use of service providers. States should create incentives, remove barriers and allocate Medicaid resources to promote integrated care

through health homes based in community mental health centers and federally qualified health centers.

Increase the mental health workforce capacity. With millions of Americans gaining health insurance coverage in 2014, there is likely to be an acute shortage of mental health workers available. States should ensure active recruitment and training of mental health professionals skilled in effective, culturally competent interventions for children and adults. States should assess mental health workforce shortages and enhance existing capacity by increasing telehealth and appropriate use of peer specialists and allied professions. Training should be required to enable primary care clinicians to recognize mental health conditions and provide routine mental health care.

Identify mental illness and intervene early. Early identification of mental illness and early intervention are essential to ensure that children, youth and adults living with mental illness have the opportunity to thrive and reach their full potential. Mental health screening should be routine in primary care. Those who screen positive should be promptly linked with more comprehensive evaluation and an **array** of effective services for children, youth and young adults as indicated. States should fully comply with Medicaid requirements for Early Periodic Screening Diagnosis and Treatment (EPSDT).

Build the bridge from Medicaid to private health coverage. For the first time in 2014, Medicaid beneficiaries with mental illness will have the opportunity to return to the workforce, leaving Medicaid rolls for guaranteed private health insurance, including mental health benefits. State policy and resources should promote successful transition to private coverage by offering services such as case management, supported employment and peer support.

Increase access to supported employment services. The improving economy combined with guaranteed health coverage creates a pivotal opportunity for adults recovering from mental illness to return to work and for transitional youth to launch into education and employment. Evidence-based supported employment programs help people with psychiatric disabilities prepare for and obtain employment and perform successfully in the classroom or workplace. States should enact policies and allocate resources to increase access to supported education and employment.

Increase housing with supportive services. Lack of safe, decent and affordable housing is a significant barrier to recovery from mental illness. Supportive housing and rapid rehousing are cost-effective models that combine housing with support services to increase housing stability and independence and markedly reduce shelter use, hospitalizations and criminal justice system involvement.[17] States should enact policies and leverage federal and private sector

[17] Pearson, C; et al; Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology*, June, 2009

resources to provide the supportive housing necessary to end homelessness and promote successful independent living for people with mental illness.

Increase justice system diversion strategies. Too many people with mental illness are involved in criminal justice systems,[18] often as a result of untreated or undertreated illness. States should increase justice system diversion programs to divert offenders with mental illness from unnecessary arrest and incarceration to more appropriate and cost-effective community-based treatment and supervision. However, diversion programs will only succeed to the degree that an **array** of timely, effective services is available.

Conclusion

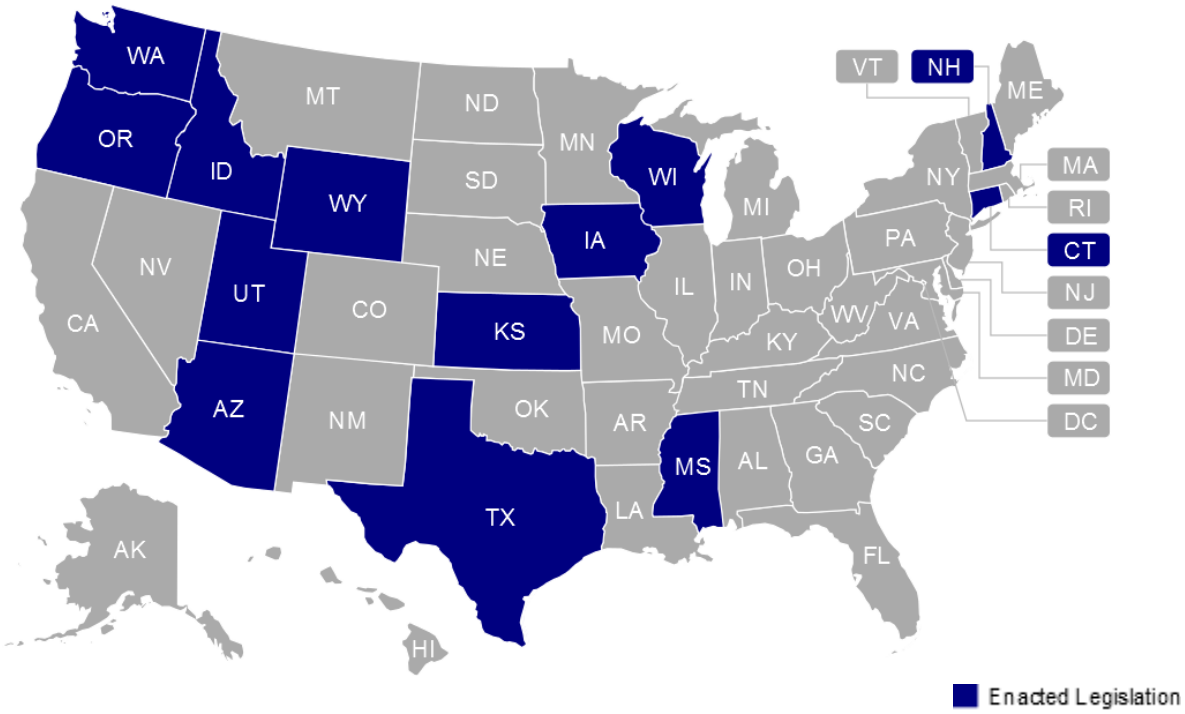
Dramatic changes in American health care finance and delivery systems combine with an improving economy and a growing array of best practices to provide a window of opportunity in the next few years to transform the mental health system and integrate care across systems. Advocates and policy makers should continue the work of building the mental health system of the future, one in which mental illness is identified as it emerges and an array of proven, cost-effective services are available as needed to provide **children, youth** and **adults** with the mental health care they need to stabilize, recover and live healthy lives.

Note: Appendices are arranged by issue with U.S. maps to indicate states enacting related legislation. Appendix tables provide brief bill summaries with links to actual legislation by bill and chapter number.

Gold stars denote bills considered to be best practices while bills posing potential threats to the interests of individuals and families living with mental illness are marked with red flags.

[18] James, Doris J., and Glaze, Lauren E., Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates,* Sept. 2006, NCJ 213600.

Appendix 1: Mental Health System Monitoring and Improvement

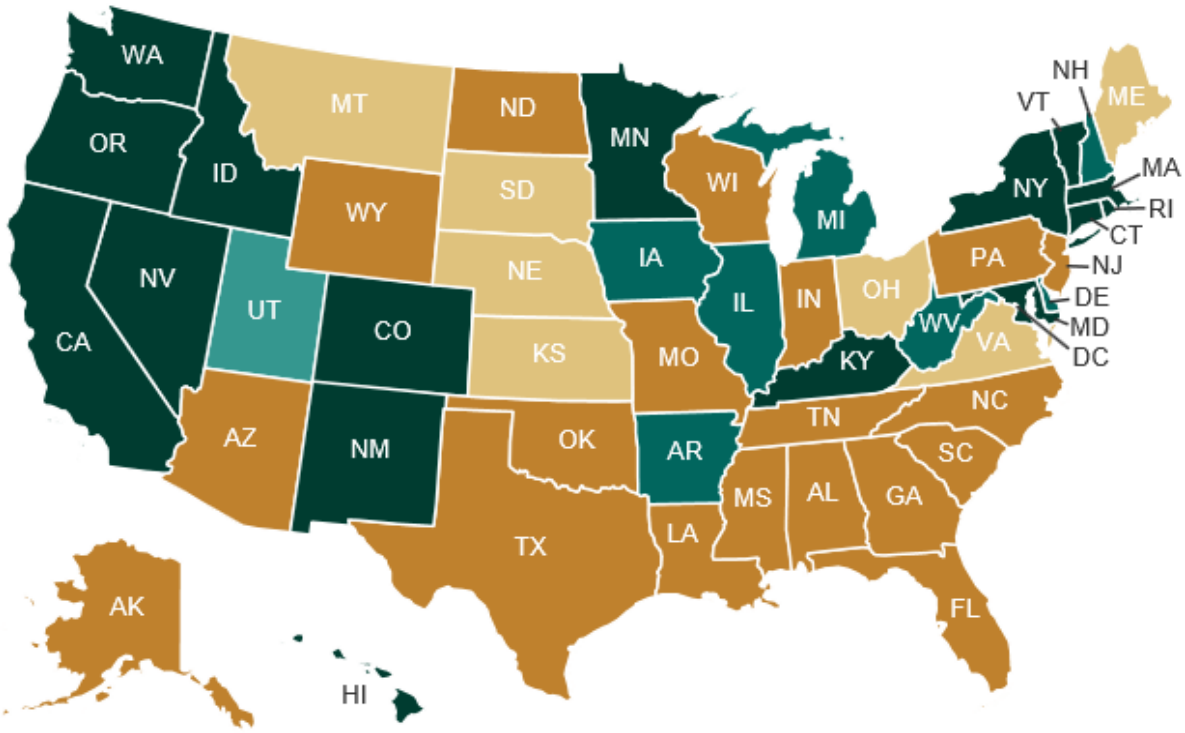


State	Bill	Chapter	Description
AZ	SB 1375	220	Requires Dept. of Economic Security, Dept. of Health Services and the AHCCC (Medicaid) to determine and report: 1. The most efficient, effective way to provide comprehensive behavioral health services, including diagnostic, evaluation and treatment services for children who are provided care. 2. Determine the number of placement disruptions in foster care by age of child due to behavioral health management issues and the extent each child is receiving behavioral health services. 3. Determine the number of adopted children who have entered foster care due to the adoptive parents' inability to receive behavioral health services to adequately meet the needs of the child and parents.
CT	SB 972	178	Requires the Department of Children and Families (DCF), Office of Early Childhood (OEC) to address Connecticut children's mental, emotional and behavioral health needs. DCF is required to develop a comprehensive plan to (1) Meet these needs and (2) Prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children. OEC is required to: (1) Provide recommendations on coordinating home visitation programs that offer services to vulnerable families with young children and (2) Design and implement a public information and education campaign on children's mental, emotional and behavioral health issues.
CT	HB 6392	26	Combines the Department of Mental Health and Addiction Services reporting requirements into one report submitted every three years.

State	Bill	Chapter	Description
ID	SB 1010	25	Realigns Medicaid behavioral health benefits to allow for a managed care delivery system that includes independent, standardized, statewide assessment and evidence-based benefits. Currently, Medicaid behavioral health benefits are restricted by specific service limitations outlined in statute and benchmark benefit package in which the participant is enrolled.
IA	SF 446		Requires the DHS and IDPH to collaboratively maintain the level of mental health and substance-related disorder treatment services provided by the managed care contractor through the Iowa plan for behavioral health.
IA	CCS 452		Continues the mental health and disability services redesign fiscal viability study committee.
KS	HB 2368		Replaces references to reflect a name change to the Governor's Behavioral Health Services Planning Council (Council) to replace the term "mental health" with "behavioral health."
MS	SB 2670	549	Prescribes the powers and duties of the Mental Health Strategic Planning and Best Practices Committee.
NH	HB 375	41	Requires the vendors contracting with the department of health and human services for Medicaid managed care to make quarterly reports to the commissioner of health and human services regarding their efforts to implement the state 10-year mental health plan of 2008.
OR	HB 2020	362	Requires the Oregon Health Authority to convene a committee to advise the authority in adopting rules governing on-site quality assessments of organizations that provide mental health or chemical dependency treatment. Requires coordinated care organizations to accept credentials of mental health treatment providers and chemical dependency treatment providers found by another coordinated care organization to meet credentialing requirements.
TX	SB 126		Requires establishment and maintenance of a public reporting system of performance and outcome measures relating to mental health and substance abuse services. To the extent possible, outcome measures shall be included that capture inpatient psychiatric care diversion, avoidance of emergency room use, criminal justice diversion and the numbers of people receiving homeless services.
TX	HB 1023		Creates task force to study and improve mental health workforce shortages.
UT	HB 57	17	Requires the Division of Substance Abuse and Mental Health to promote integrated programs that address substance abuse, mental health and physical health care needs. Requires the Division to evaluate the effectiveness of integrated health programs.
WA	SB 5732	338	Improves behavioral health services provided to adults in Washington state. Creates a task force to examine reform for behavioral health services.
WI	AB 40	20	Creates an Office of Children's Mental Health in the Department of Health Services. Requires the Office to study, recommend and coordinate initiatives, improve integration across state agencies of mental health services provided to children and monitor the performance of programs that provide those services Provides funding for mental health treatment programs. Allows Department to administer medical home initiative to serve individuals exiting mental health or correctional facilities; or individuals diagnosed with serious mental illness or substance abuse disorder.

State	Bill	Chapter	Description
WY	SF 60	117	Requires the department of health to proceed with a reform and redesign of the Wyoming Medicaid program to include expanding available behavioral health services with particular attention to persons with serious and persistent mental illness or serious psychological distress.

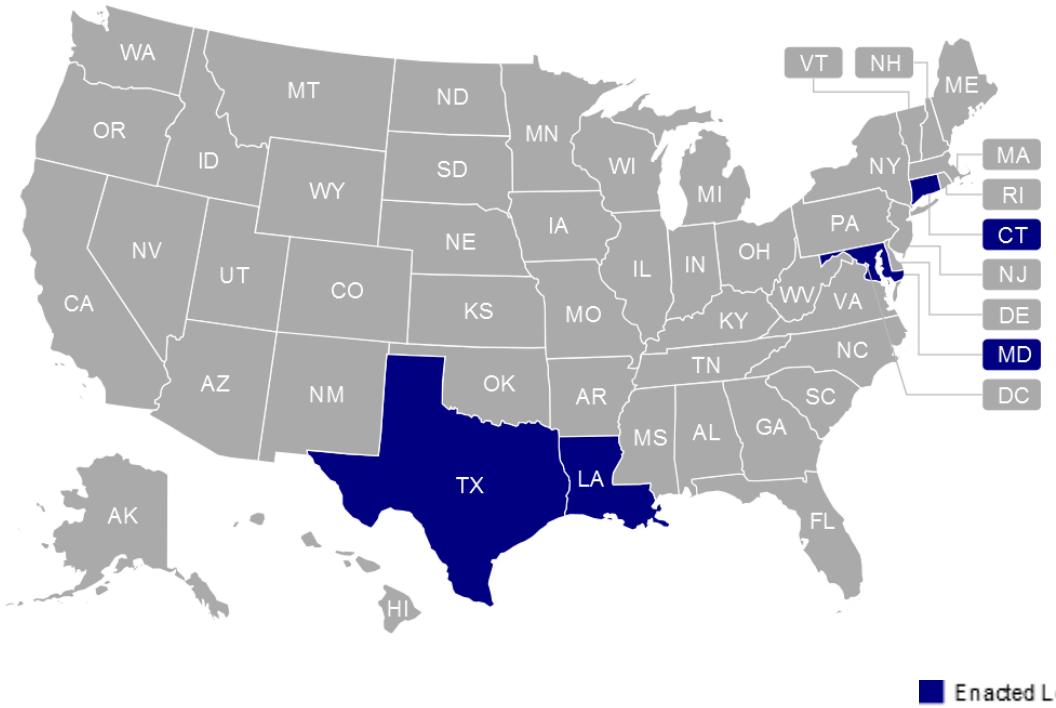
Appendix 2: Health Insurance Marketplaces, Affordable Care Act



State Health Benefit Marketplaces	
	State Run Marketplace
	Federal/State Partnership; state conducting plan management and consumer assistance
	State Running Small-Business marketplace; federal government running individual marketplace
	Federally facilitated marketplace; state conducting plan management
	Federally facilitated marketplace

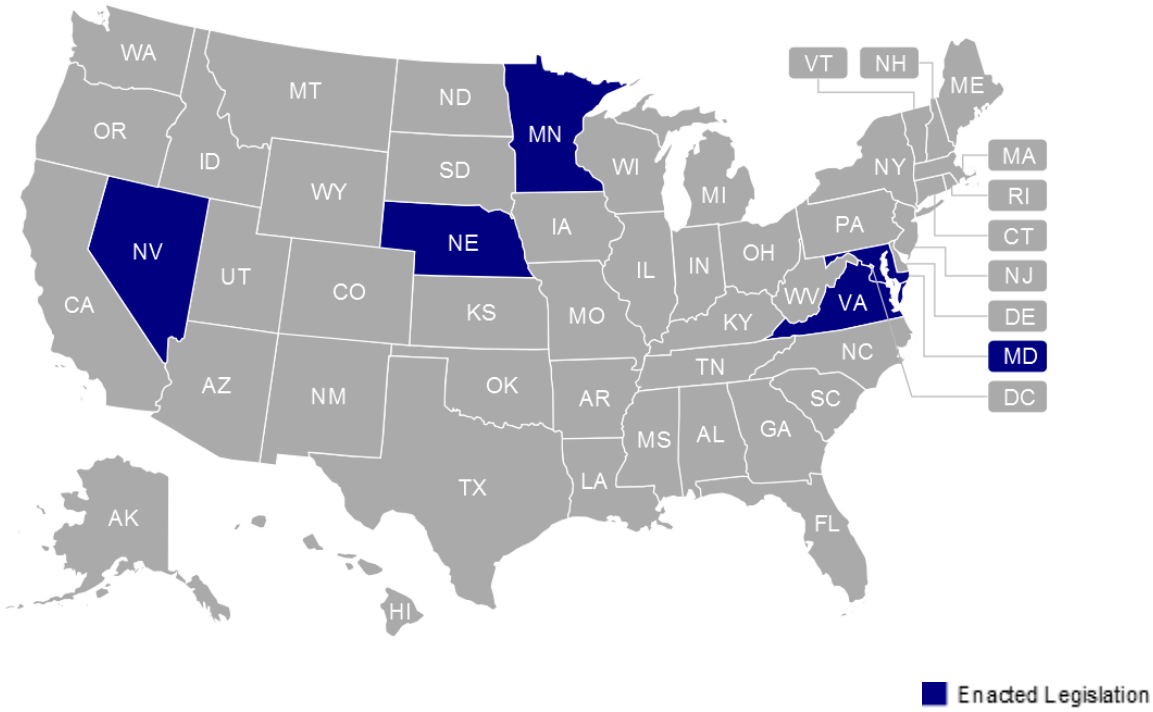
Source: Commonwealth Fund http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx

Appendix 3: Health Insurance, Mental Health Parity



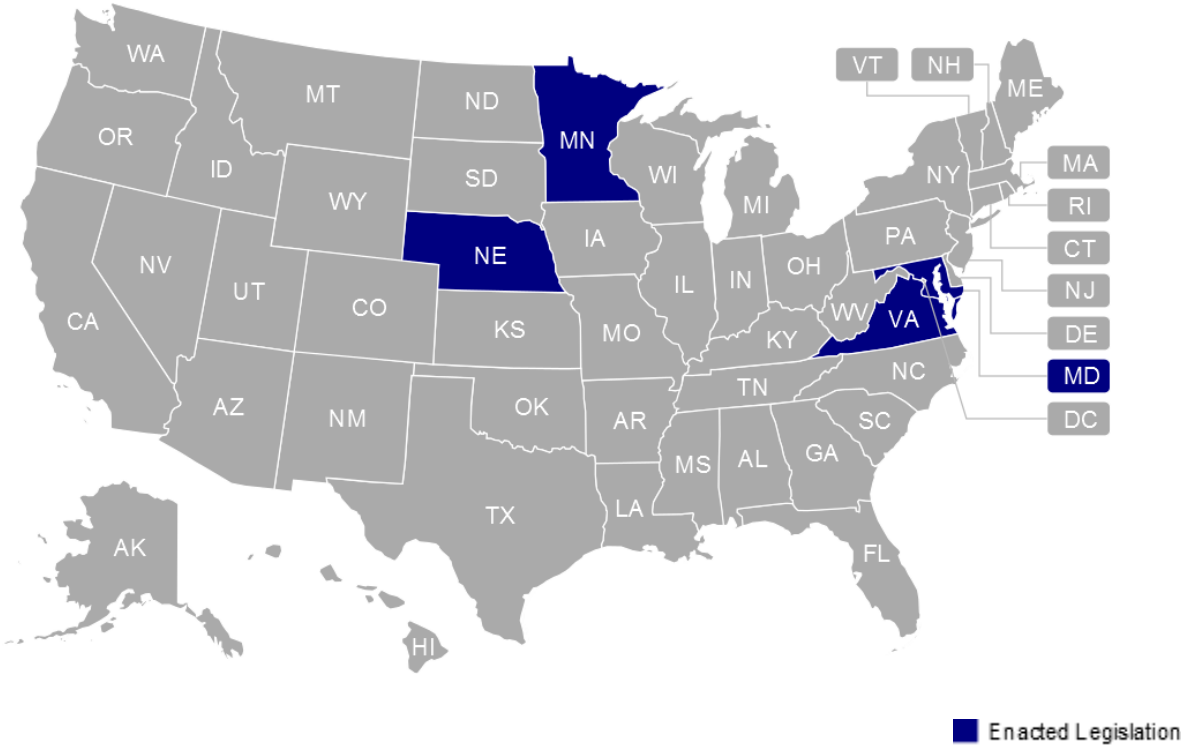
State	Bill	Chapter	Description
CT	SB 1160	3	Reduces time health insurers have to: (1) make initial determinations on requests for treatments for mental health or substance abuse disorders and (2) review claim denials and other adverse determinations of such requests. Expands the role of, and qualifications required for, health care professionals who evaluate the appropriateness of adverse determinations. Requires the insurance commissioner to monitor compliance with state and federal mental health coverage parity laws and report on these issues to the Insurance and Public Health committees.
LA	HB 592	205	Requires a health insurance issuer providing a health benefit plan to maintain a network of providers that includes providers that specialize in mental health and substance abuse services.
MD	HB 1216 / SB 581	289	Requires health maintenance organizations and entities that issue or deliver specified health insurance policies or contracts to provide, on their web sites and in print, notice about specified benefits for mental illness, emotional disorders, drug abuse, or alcohol abuse required under State law and under the federal Mental Health Parity and Addiction Equity Act.
MD	HB 1252/ SB 582	291	Requires entities that propose to issue or deliver specified insurance policies or contracts in the State to ensure that, when conducting utilization review for mental health and substance abuse benefits, the criteria and standards used are in compliance with the federal Mental Health Parity and Addiction Equity Act.
TX	SB 1057		Outlines regulation of private health care insurance coverage and the health insurance exchange for individuals applying for certain Department of State Health Services health or mental health benefits, services and assistance.

Appendix 4A: Early Identification and Mental Health Screening



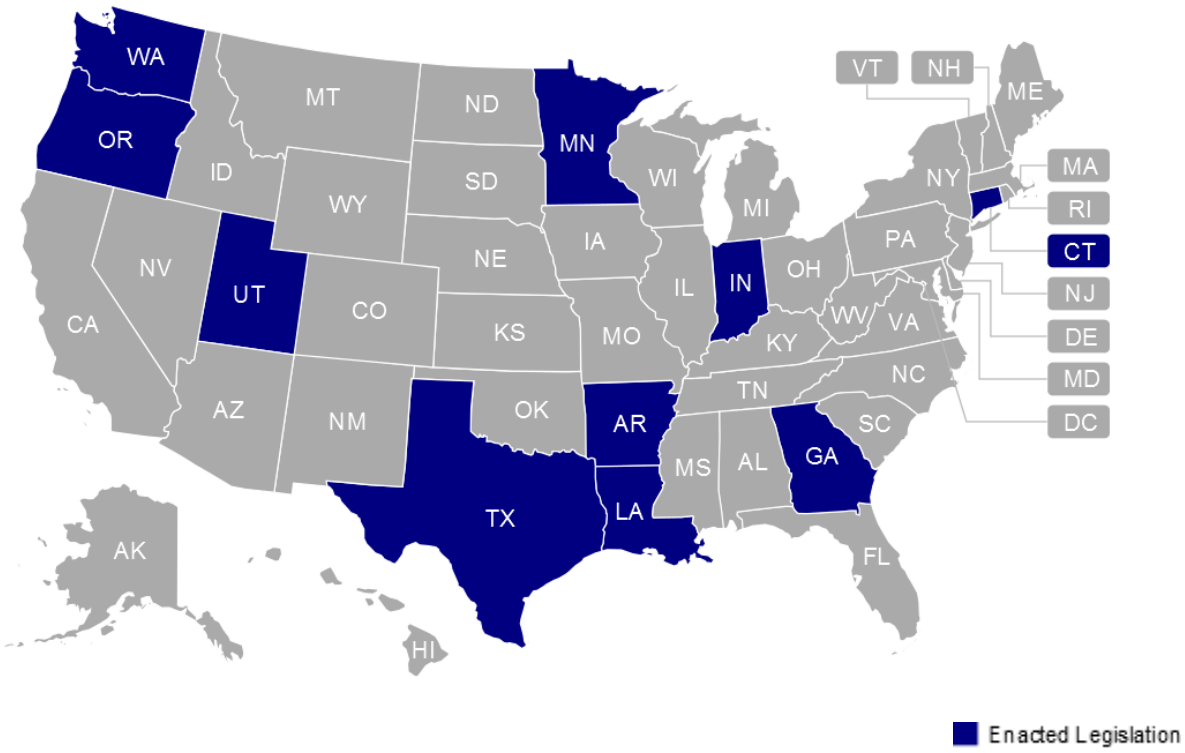
State	Bill	Chapter	Description
MN	HF 1233	108	Requires the commissioner, to fund the family home visiting program to target families with serious mental health disorders including maternal depression.
NE	LB 556		Establishes the Behavioral Health Screening and Referral Pilot Program to demonstrate a method of addressing the unmet emotional or behavioral health needs of children.
NV	AB 386	361	Established a pilot program for the administration of mental health screenings to pupils enrolled in selected secondary schools.
VA	HB 2322/ SB 1078	606	Requires the State Board for Community Colleges to develop a policy directing community colleges to establish one designee at each college to serve as a point of contact with an emergency services system clinician to facilitate screening and referral of students who may have emergency or urgent mental health needs. Colleges may establish relationships with community services boards or other mental health providers for referral and treatment of persons with less serious mental health needs.

Appendix 4B: Services for Transitional Youth



State	Bill	Chapter	Description
MD	SB 764/ HB 823		Establishes a task force to identify and study the mental health needs of homeless youth, evaluate resources and make recommendations.
MN	HF 359	108	Continued case management services must be offered to youth receiving children's case management who turn 18. Before discontinuing case management for youth between the ages of 17 and 21, the county must develop a transition plan that includes health insurance, housing, education, employment and treatment.
NE	LB 216		Helps state wards transition into young adulthood and provides them with community services including access to mental health services.
VA	SB 1342/ HB 1609	735	Requires the governing board of each public four-year institution of higher education to establish a written memorandum of understanding with the local behavioral health authority and with inpatient facilities in order to expand the scope of services available to students seeking treatment.

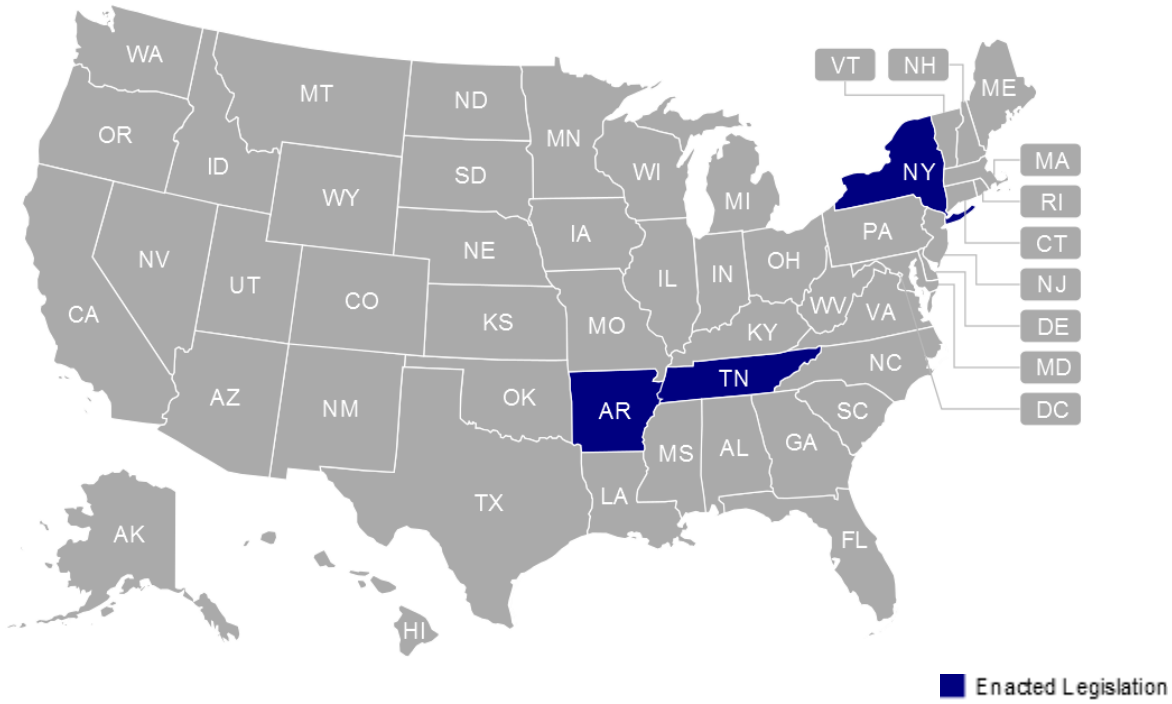
Appendix 5: School Mental Health Training and Services



State	Bill	Chapter	Description
AR	SB 588	647	Provides grants for mental health training and other initiatives for addressing mental health challenges of adolescent students.
CT	SB 972	178	Requires training for school resource officers, mental health care providers, pediatricians and child care providers. Requires the (1) state to seek existing public and private reimbursement for mental, emotional and behavioral health services and (2) Birth-to-Three program for mental health services to children eligible for early intervention services under federal law.
CT	SB 1160	3	Includes mental health first aid training in schools.
CT	HB 6292	133	Ensures teachers receive training in social and emotional development and learning of children. Training shall include instruction on comprehensive, coordinated social and emotional assessment and early intervention for children displaying behaviors associated with social or emotional problems, the availability of treatment services for such children and referring children for assessment, intervention or treatment services.
GA	HR 502	314	Creates a Joint Study Committee on Mental Health and School Violence.
IN	SB 345	122	Establishes a commission on seclusion and restraint in schools to adopt rules concerning the use of restraint and seclusion in schools and develop a model restraint and seclusion plan.

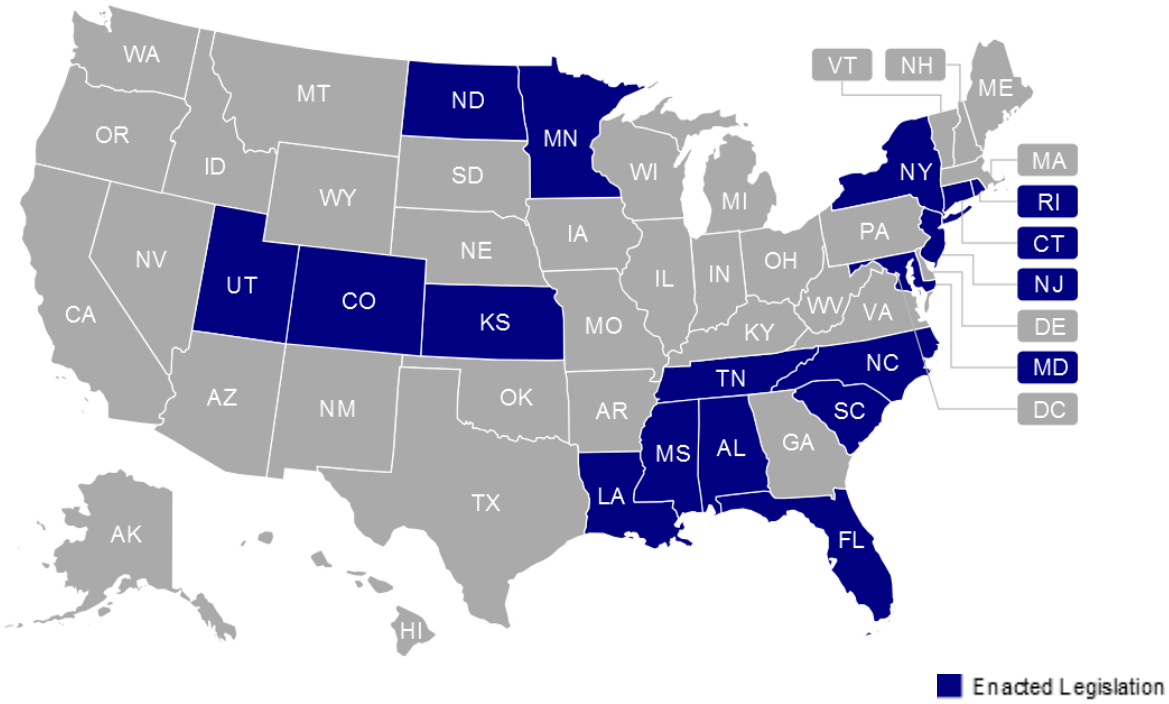
State	Bill	Chapter	Description
IN	HB 1423	285	Provides training and education requirements as well as procedures for mental health support services.
LA	HB 718	50	Outlines school crisis management and response plans, provides rules and regulations for plans, requires schools to report plans and provides mental health services in the event of a crisis.
MN	HF 358		Provides for school linked services with funding increased by $7.4 million the first biennium and $9.8 in the second biennium.
MN	HF 1233	108	Provides appropriations for children's mental health crisis services, mental health first aid training, respite care and community health worker training.
MN	HF 630/ SF 453	116	Requires schools to provide mental health instruction for students in grades six through 12.
OR	HB 2756		Calls for removal of all seclusion cells from public schools.
TX	SB 460		Provides training for public school teachers in detection and education of students at risk for suicide or with other mental or emotional disorders and inclusion of mental health concerns in coordinated school health efforts.
UT	HB 298	139	Requires school districts to offer an annual seminar to parents with information on mental health, depression and suicide awareness.
WA	HB 1336 SB 5365	197	Requires school clinicians training on youth suicide screening and referral. School districts must adopt plans to recognize, screen and respond to student emotional/ behavioral distress. Establishes task force to identify successful strategies to partner school districts with health, mental health and social services to improve support for youth in need. The task force shall explore use of online youth emotional health and crisis response systems developed in other countries. Requires the department to provide funds for mental health first-aid training for teachers and educational staff.

Appendix 6: Clinician Duty to Warn



State	Bill	Chapter	Description
AR	HB 1746	1212	Requires a mental health services provider to warn a law enforcement officer of a credible threat by a patient.
NY	S2230/ A2388	1	Creates the N.Y. Secure Ammunitions and Firearms Enforcement Act of 2013. Requires mental health professionals, in the exercise of reasonable professional judgment, to report if an individual they are treating is likely to engage in conduct that will cause serious harm to him- or herself or others. The report will be used to crosscheck the individual's name against a comprehensive gun registration database. If the individual possesses a gun, the license will be suspended and law enforcement will be authorized to remove the person's firearm or the individual may be prevented from obtaining one in the future.
TN	SB 789/ HB 645	300	Requires mental health professionals to report any patient who makes an actual threat of bodily harm against a reasonably identifiable victim patient to NICS.

Appendix 7: Gun Ownership – Mental Health Record Reporting

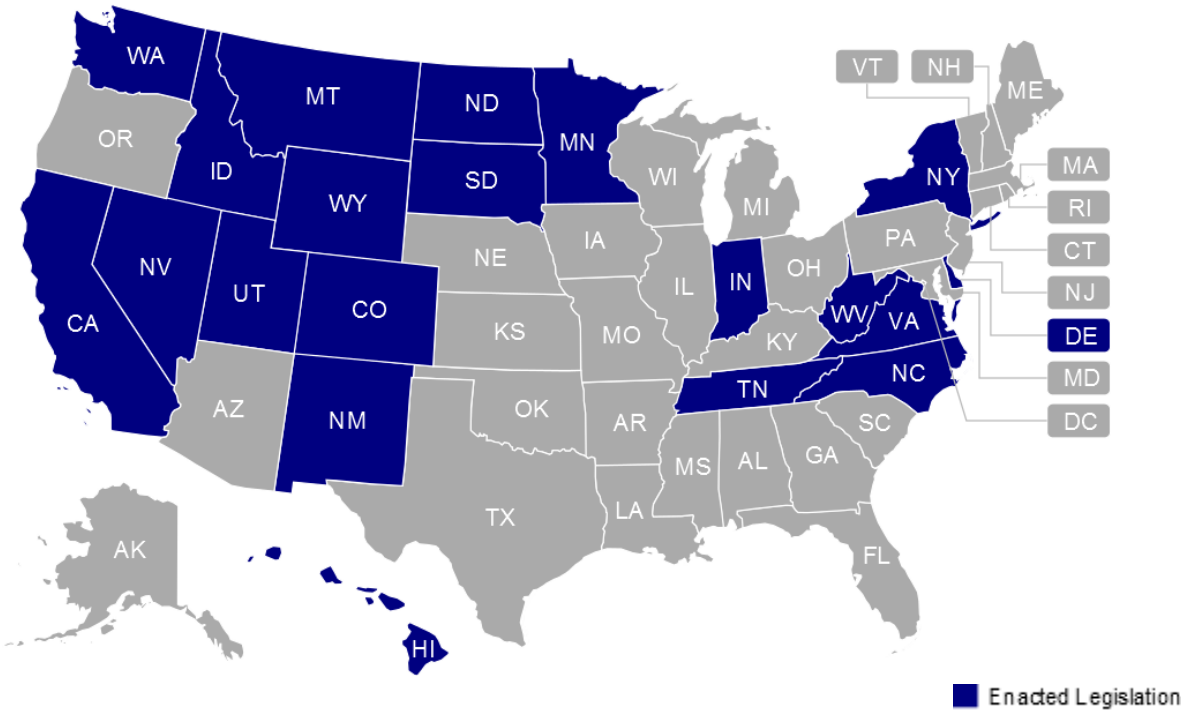


State	Bill	Chapter	Description
AL	SB 286	283	Allows sheriff to determine if a license to own a pistol may be denied or revoked based on suspicion that the person will use a weapon unlawfully or to endanger the person's self or others. The sheriff may consider whether the applicant or current licensee: 1. Was found guilty but mentally ill in a criminal case. 2. Was found not guilty in a criminal case by reason of insanity or mental disease or defect. 3. Was declared incompetent to stand trial in a criminal case. 4. Was found not guilty only by reason of lack of mental responsibility under the Uniform Code of Military Justice. 5. Required involuntary inpatient treatment in a psychiatric hospital. 6. Required involuntary outpatient treatment based on imminent danger to self or others. 7. Required involuntary commitment to a psychiatric hospital for any reason, including drug use.
AL	SB 133	290	Provides for petition for the review of a person's mental capacity to purchase a firearm to be filed in circuit court.
CT	SB 1094	220	Amends SB 1160 by expanding the ban on assault weapons and amending who is prohibited from owning guns based on mental health history.
CT	SB 1160	3	Requires reporting of mental health information for gun permits. Makes any person who voluntarily admitted himself or herself to a psychiatric hospital during the preceding six months ineligible for a gun permit or handgun eligibility certificate.

State	Bill	Chapter	Description
CO	HB 1229	47	Requires reporting the mental health status of applications for a license to purchase and carry a firearm, including court ordered short-term psychiatric treatment. Also makes provision for persons to petition for relief.
FL	SB 1000 / HB 1355	249	Provides conditions under which persons voluntarily admitted to a mental institution for treatment and has undergone an involuntary examination under the Baker Act may be prohibited from purchasing a firearm.
KS	SB 21		Amends law regarding the prohibition of those found to be mentally incompetent from owning a gun. Requires use of the National Instant Criminal Background Check system before obtaining a firearm permit.
LA	HB 717	403	District court shall report to the state Supreme Court who shall report to the NICS: (1) Court determined lack of mental capacity to proceed with a criminal trial; (2) Court ordered involuntarily committed to an inpatient mental health treatment facility. Allows a person prohibited from or ineligible to possess a firearm or concealed handgun permit because of adjudication or commitment to, upon release from involuntary commitment, file a petition seeking removal of that prohibition. The court shall grant requested relief if it finds that the petitioner's record and reputation are such that he will not be likely to act in a manner dangerous to public safety and that the granting of the relief requested would not be contrary to the public interest.
MD	SB 281/ HB 294	427	Requires that a person may not possess a firearm if the person: suffers from a mental disorder and has a history of violent behavior against the person or another; has been found incompetent to stand trial; has been voluntarily admitted for more than 30 consecutive days; has been involuntarily committed; or is under the protection of a court-appointed guardian of the property or guardian of the person, except for cases in which the appointment of a guardian is solely a result of a physical disability. Requires that a hearing officer who enters an order for involuntary commitment and determines that the individual cannot safely possess a firearm due to dangerousness to others, must order the individual to surrender firearms. Requires a mental health care facility to report to NICS the name and identifying information of a person admitted or committed to the facility if the person has been admitted to a facility for 30 consecutive days or more or was involuntarily committed. Authorizes person seeking relief from firearms disqualification to file with the Department of Health and Mental Hygiene if the application is signed by a board certified psychiatrist or psychologist stating: 1. Length of time the applicant has not had symptoms that cause danger to self or others; 2. Length of time that the applicant has been compliant with the treatment plan for mental illness; and 3. Opinion as to whether the applicant, because of mental illness, would be a danger to self or others if allowed to possess a firearm.
MN	SF 671	86	Requires a court to electronically enter into the National Instant Criminal Background Check System information on all persons civilly committed during the period from Jan. 1, 1994, to Sept. 28, 2010, not already entered.

State	Bill	Chapter	Description
MS	SB 2647	384	Creates the National Instant Criminal Background Check System Improvement Act, defines the responsibility of court clerks to enter information of those adjudicated mentally incompetent into the system and provides for rehabilitation from disability of being able to purchase a firearm.
NJ	A 3717/ S2492		Requires submission of certain mental health records to National Instant Criminal Background Check System.
NY	**S2230/ A2388**	1	Creates the NY Secure Ammunitions and Firearms Enforcement Act of 2013. Applies clinician duty to warn and mental health reporting laws for the purpose of limiting firearms purchases.
NC	**HB 937**	369	Requires superior court to report to the NICS in the following instances: (1) Involuntarily commitment to inpatient mental health treatment upon a finding that the individual is mentally ill and a danger to self or others. (2) Involuntarily commitment for outpatient mental health treatment upon a finding that the individual is mentally ill and in need of treatment in order to prevent further disability or deterioration that would predictably result in a danger to self or others. (3) Involuntarily commitment to a facility for substance abuse treatment upon finding that the individual is a substance abuser and a danger to self or others. (4) Not guilty by reason of insanity. (5) Mentally incompetent to proceed to criminal trial. (6) Lacks the capacity to manage the individual's own affairs due to marked subnormal intelligence or mental illness, incompetency, condition, or disease. (7) Petition granted to an individual for the removal of disabilities.
ND	HB 1327	491	Prevents those adjudicated as mentally incompetent from obtaining a license to carry a concealed firearm and requires disclosure of mental health information when applying for license to carry.
RI	SR 862	397	Creates behavioral health and firearms safety task force to review and make recommendations for statutes on firearms and behavioral health issues.
SC	S413/ H3560	22	Establishes a confidential process for compiling and transmitting information to the South Carolina Law Enforcement Division (SLED), which then transmits the information to NICS, about persons who have been adjudicated mentally incapacitated or committed to a mental institution. Also provides ways to obtain removal of certain disqualifications.
TN	SB 789/ HB 645	300	Requires mental health professionals to report any patient who makes an actual threat of bodily harm against a reasonably identifiable victim to NICS for purposes of prohibiting the purchase of a firearm when a background check is conducted. Provides that if a service recipient is involuntarily committed to an inpatient treatment facility, the facility must report to local law enforcement, who must report the service recipient to the FBI-NICS Index and the Department of Safety.
UT	HB 121	188	Allows an owner cohabitant to voluntarily commit a firearm to a law enforcement agency for safekeeping if the owner cohabitant believes that another cohabitant is an immediate threat to: (1) himself or herself; (2) the owner cohabitant; or (3) any other person .

Appendix 8: Civil Commitment, Inpatient and Outpatient Treatment



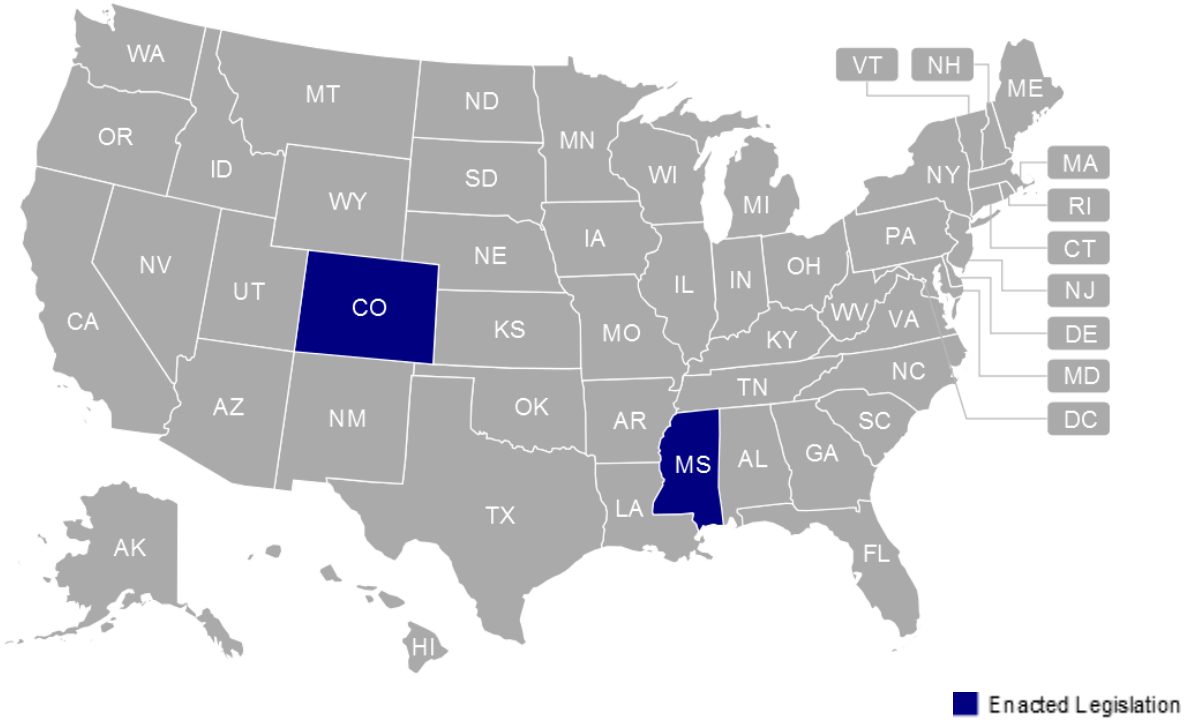
State	Bill	Chapter	Description
CA	SB 82	34	Invests in Mental Health Wellness Act of 2013, a negotiated rider to the governor's budget, which provides $365 million for mental health & substance use services, primarily crisis services such as residential crisis beds, crisis teams and triage services.
CO	HB 1296	232	Creates the civil commitment review task force. The task force will study and prepare recommendations concerning the implementation of the consolidation of the mental health, alcohol and substance use disorder statutes related to civil commitments.
DE	HB 9	07	Clarifies immunity as regards the process to detain or not detain a person for an involuntary mental health evaluation. Immunity is limited to the mental health assessment, resulting clinical decision and involuntary hold necessary until the person is presented to a designated psychiatric treatment facility that is able to provide such psychiatric healthcare services for the 24 hour detention. After the person presents to the designated psychiatric treatment facility and during the 24 hour involuntary detention period no medical doctor or designated psychiatric treatment facility shall be subject to civil damages or criminal penalties for harm to the person with a mental condition resulting from the performance of functions unless such harm resulted from negligent, reckless, willful, wanton and/or intentional misconduct.

State	Bill	Chapter	Description
HI	SB 310 / HB 991	221	Establishes an assisted community treatment program in lieu of the involuntary outpatient treatment program for severely mentally ill individuals who meet specified criteria, such as not being deemed dangerous. Amends procedures for determination of order to and discharge from a treatment program. Requires an entity designated by the department of health to submit an annual report to the legislature about hospitalization of persons who are under an order for assisted community treatment.
ID	HB 291	293	Provides that a minor who is suffering from a serious emotional disturbance and poses a danger to him or others may be temporarily detained by a health care professional without a hearing; and that they may temporarily detain a mentally ill patient in an emergency without a hearing. "Health care professional" means a physician, physician's assistant or advanced practice registered nurse, any one of whom is practicing in a hospital.
IN	HB 1130	4	Provides that an individual who is gravely disabled, in addition to having a mental illness, may be detained by a law enforcement officer and transported to the nearest appropriate facility.
MT	HB 16	308	Updates the emergency detention standard in the civil commitment process to make it clear it is an emergency situation when a person is symptomatic from mental illness when they are substantially unable to provide for their own basic needs.
MN	HF947	49	Creates two distinct chapters of civil commitment law. Laws regarding people committed as *sexually dangerous persons* or *people with sexual psychopathic personalities* have been separated from laws regarding people committed as *mentally ill, mentally ill and dangerous, a chemically dependent person or person who is developmentally disabled*.
NM	SB 271	39	Allows independently licensed mental health professionals to provide emergency evaluation for the purpose of transport to an evaluation facility; eliminating the limitation that certain emergency mental health evaluation and care services be provided by a certified psychologist or psychiatrist.
NY	S2230 A2388	1	Creates the New York Secure Ammunitions and Firearms Enforcement (SAFE) Act of 2013. Amends Kendra's law to increase maximum initial Assisted Outpatient Commitment (AOT) from six months to a year and requires county mental health officials to evaluate the need for renewal.
NV	AB 287	537	Authorizes involuntary court-ordered admission of certain persons with mental illness to programs of community-based or outpatient services under certain circumstances; requiring a peace officer to take into custody and deliver a person to the appropriate location for evaluation by an evaluation team from the Division of Mental Health and Developmental Services of the Department of Health and Human Services in certain circumstances; providing a penalty; and providing other matters properly relating thereto.

State	Bill	Chapter	Description
NC	HB 635 SB 687	308	Requires a physician or psychologist at a 24 hour facility who recommends inpatient commitment; when the respondent is physically present and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the clerk or magistrate may issue an order to take the respondent into custody. Upon receipt of the custody order, the physician, psychologist or designee, shall: (1) notify the respondent that the respondent is not under arrest and has not committed a crime but is being taken into custody to receive treatment and for the respondent's own safety and the safety of others; (2) take the respondent into custody; and (3) complete and sign the appropriate portion of the custody order.
ND	SB 2157	223	Allows physicians to direct an emergency medical services professional (rather than do it themselves solely in-person) when they reasonably believe that the respondent is not complying with an order for alternative treatment, that the alternative treatment is not sufficient to prevent harm or injuries to the respondent or others and that considerations of time and safety do not allow intervention by a court, the designated professional may cause the respondent to be taken into custody and detained at a treatment facility.
SD	HB 1020	122	Adds licensed physician assistants with a certain level of clinical experience to definition of qualified mental health professionals. Allows direct referral to a mobile crisis team, crisis intervention team or certified law enforcement officer. Allows certain facility officials to countermand the wishes of the parent to have an immediate discharge of their minor upon written notice of intention to terminate inpatient treatment if the official believes the minor requires emergency intervention and initiate a mental illness hold. Removes convulsive or shock therapy and electric shock from types of interventions that minors are not allowed to receive. Allows that a minor sixteen years of age or older, whether involuntarily committed or admitted by a parent, has the right to refuse convulsive or shock therapy or electric shock.
TN	HB 1073 SB 884	238	Authorizes surrogates under the Tennessee Health Care Decisions Act to seek voluntary admission to inpatient mental health treatment for certain patients. "Surrogate" means an individual, other than a patient's agent or guardian, authorized to make a health care decision for the patient.
UT	SB 135	29	Requires an applicant for an involuntary commitment order to consult with the appropriate local mental health authority before the court may issue a judicial order, if the local mental health authority appears at the commitment hearing.
UT	SB 285	312	Adds a requirement that an application for an individual to be involuntarily civilly committed, if reasonably available, contain the individual's name, date of birth and Social Security number.
VA	SB 920	371	Requires magistrates to consider a request to authorize alternative transportation, if available, for persons subject to an emergency custody or involuntary temporary detention order if the order is based upon a finding that the person who is the subject of the order has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs but

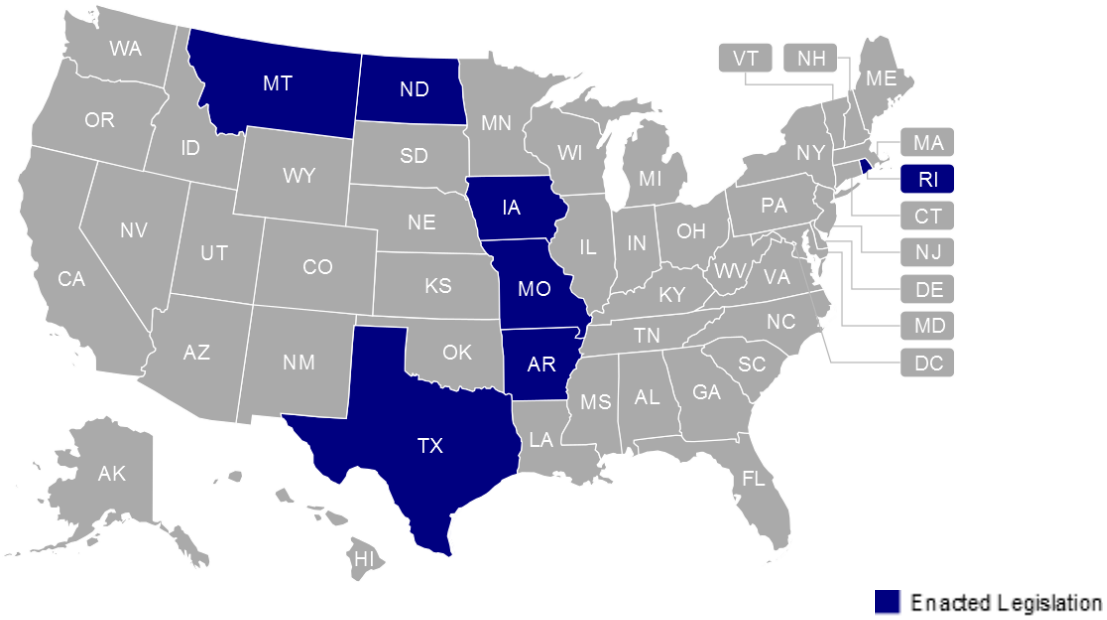
State	Bill	Chapter	Description
			there is no substantial likelihood that the person will cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information.
VA	HB 1423	179	Following a period of voluntary or involuntary treatment, allows community services board serving the county or city where such person receives treatment to petition for an order of mandatory outpatient treatment.
WA	HB 1114 SB 5176	289	For criminal defendants whose felony charges were dismissed due to incompetency, evaluation for the purposes of filing a civil commitment petition under the ITA must occur at a state hospital. Eliminates court discretion to release a defendant who has had felony charges dismissed. The court must make a finding as to whether the acts the person committed constitute a violent offense. On petitions for continued commitment of a person who has had a violent felony charge dismissed, when the court has made an affirmative additional finding at the initial petition, the person will be committed for up to an additional 180 days upon presentation of prima facie evidence that the person continues to suffer from a mental disorder or developmental disability that results in a substantial likelihood that the person will commit acts similar to the criminal behavior. The committed person may challenge the renewed commitment with an admissible expert opinion indicating that the person's condition has changed such that his or her mental disorder or developmental disability no longer presents a substantial likelihood that he or she will commit acts similar to the charged criminal behavior.
WA	SB 5221	214	Requires a facility conducting a civil commitment evaluation that makes a determination to release a person instead of filing a civil commitment petition, to provide written notice to the prosecutor and defense attorney at least twenty-four hours before the release.
WA	SB 5480 SB 5732	335	Accelerates changes to mental health involuntary commitment laws.
WA	SB 5732	338	Requires when a person has been involuntarily committed for treatment to a hospital for a period of 90 or 180 days and the superintendent or professional person in charge of the hospital determines that the person no longer requires active psychiatric inpatient treatment, the regional support network responsible must work with the hospital to develop an individualized discharge plan and arrange for transition to the community in accordance with the person's individualized discharge plan within 21 days.
WV	SB 481	128	Permits acceptance of a notarized application, in lieu of in-person application, for certain voluntary hospitalization; allows use of article five, chapter twenty-seven of said code for juveniles in certain situations; and requires parents or guardians to transport minors for voluntary hospitalization.
WY	HB 102	115	Provides that the Department of Health, in proceedings for the involuntary hospitalization of a person who is a minor, shall consult with the minor's parents or guardian to the extent feasible.

Appendix 9: Mental Health Crisis Care



State	Bill	Chapter	Description
CO	SB 266	231	Establishes a Coordinated Behavioral Health Crisis Response System for communities throughout the state. Requires a continuum of care from crisis response through stabilization and safe return to the community. Components include: (1) 24 hour telephone crisis service to perform assessment and referrals for children, youth and adults; (2) Walk-in crisis services and crisis stabilization units with the capacity for immediate evidence-based clinical intervention, triage and stabilization. (3) Mobile crisis services and units that are linked to the walk-in crisis services and crisis respite services; (4) Residential and respite crisis services that include a range of short-term crisis residential services, including but not limited to community living arrangements; and (5) A public information campaign.
MS	HB 1049	567	Appropriates bond money for the purpose of constructing several crisis intervention facilities.

Appendix 10: Mental Health Facilities, Deinstitutionalization



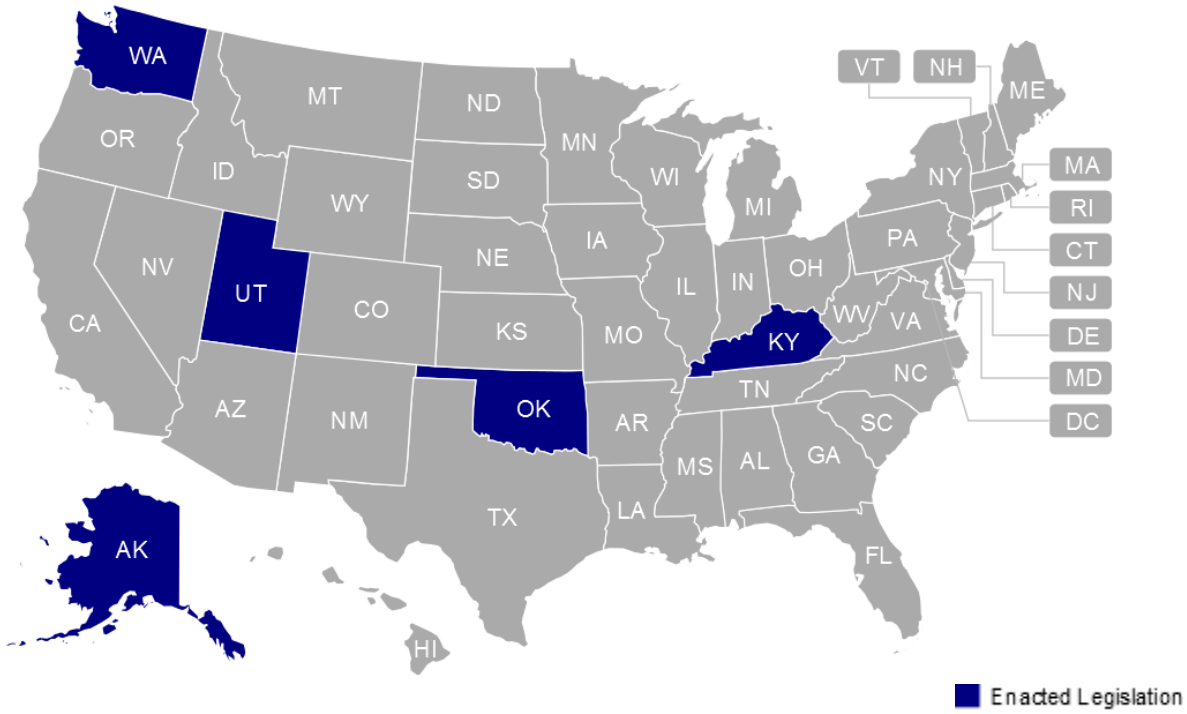
State	Bill	Chapter	Description
AR	SB 801	1251	Authorizes the department of Human services to donate property to community mental health clinics and centers.
IA	SF 406		Expands the allowable providers upon admittance to a facility or hospital from solely an examining physician to include an examining physician assistant, or examining psychiatric advanced registered nurse practitioner.
MO	HB 351		Requires the department of health and senior services to post on its website information regarding investigations of complaints against hospitals including peer group comparisons of psychiatric hospitals or psychiatric units within hospitals.
MT	HJ 16		Requests an interim study of state-operated public institutions serving individuals with mental illness.
ND	HB 1089	382	Allows that if geropsychiatric services are insufficient to meet the needs of the state the department may choose other nursing facility to set up another geropsychiatric unit.
RI	S680B	158	Expands parent deinstitutionalization subsidy aid program in the Dept. of BH/DD and Hospitals to include appropriate relatives. Allows relative to care for a child or adult if the parent is unable. Allows an appropriate relative who is providing care to receive subsidy through the aid program.
TX	SB 1842		Authorizes a registered nurse, other than the nurse who initiated the use of restraint or seclusion, to conduct a face-to-face evaluation of a patient within one hour the time restraint or seclusion is initiated. Requires a physician to conduct a face-to-face evaluation of the patient and document clinical justification for continuing the restraint or seclusion before issuing or renewing an order. Requires facilities to file a quarterly report regarding the inpatient psychiatric services measures of restraint and seclusion required by the federal CMS.

Appendix 11: State Psychiatric Hospitals, Total Clients Served

State	2007	2012	Change:
Alabama	3,550	2,880	-670
Alaska	1,291	1157	-134
Arizona	537	307	-230
Arkansas	1,085	621	-464
California	8,050	8,866	816
Colorado	3,401	1,956	-1,445
Connecticut	1,490	1,282	-208
Delaware	555	397	-158
DC	827	620	-207
Florida	4,291	4,756	465
Georgia	14,033	6,709	-7,324
Hawaii	414	413	-1
Idaho	758	960	202
Illinois	8,126	10,027	1,901
Indiana	1,519	1,263	-256
Iowa	1,793	1,063	-730
Kansas	3,595	3,109	-486
Kentucky	6,945	6,989	44
Louisiana	1,938	2,407	469
Maine	555	595	40
Maryland	2,890	1,835	-1,055
Massachusetts	1,551	1,343	-208
Michigan	1,483	1,501	18
Minnesota	2,451	1,923	-528
Mississippi	4,273	3,850	-423
Missouri	7,393	1,578	-5,815
Montana	681	750	69
Nebraska	1,946	460	-1,486
Nevada	2,997	3,071	74
New Hampshire	1,625	1,778	153
New Jersey	3,420	4,281	861
New Mexico	1,063	943	-120
New York	10,814	10,642	-172
North Carolina	11,963	3,547	-8,416
North Dakota	644	614	-30
Ohio	5,525	6,326	801
Oklahoma	2,574	1,847	-727
Oregon	1,601	1,358	-243
Pennsylvania	3221	2,617	-604
Rhode Island	1,020	1,134	114
South Carolina	3,199	2,205	-994
South Dakota	2238	2,137	-101
Tennessee	7,075	7,962	887
Texas	15,242	14,395	-847
Utah	664	629	-35
Vermont	231	87	-144
Virginia	5,697	4,736	-961
Washington	3374	2,904	-470
West Virginia	1,411	1,194	-217
Wisconsin	5,307	4,289	-1,018
Wyoming	349	283	-66
Totals	**178,675**	**148,596**	**-30,079**

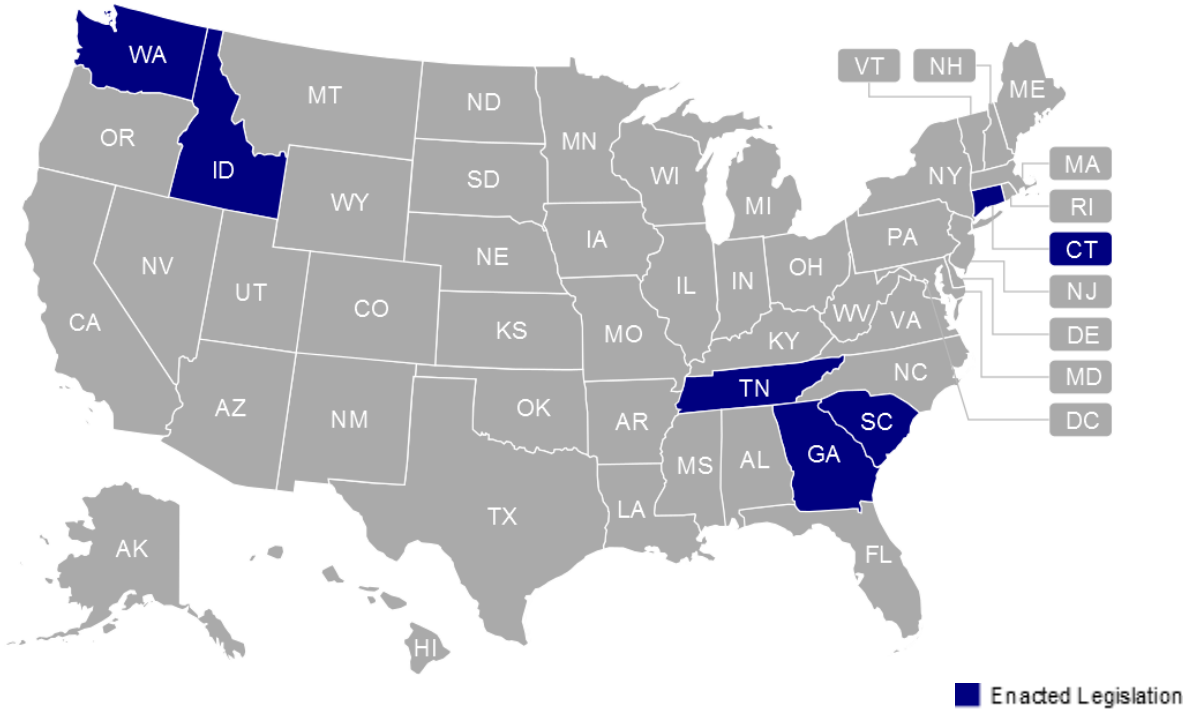
Source: Substance Abuse and Mental Health Services Administration (SAMHSA). Uniform Reporting System (URS) Output Tables. http://www.samhsa.gov/dataoutcomes/urs/

Appendix 12: Suicide Prevention



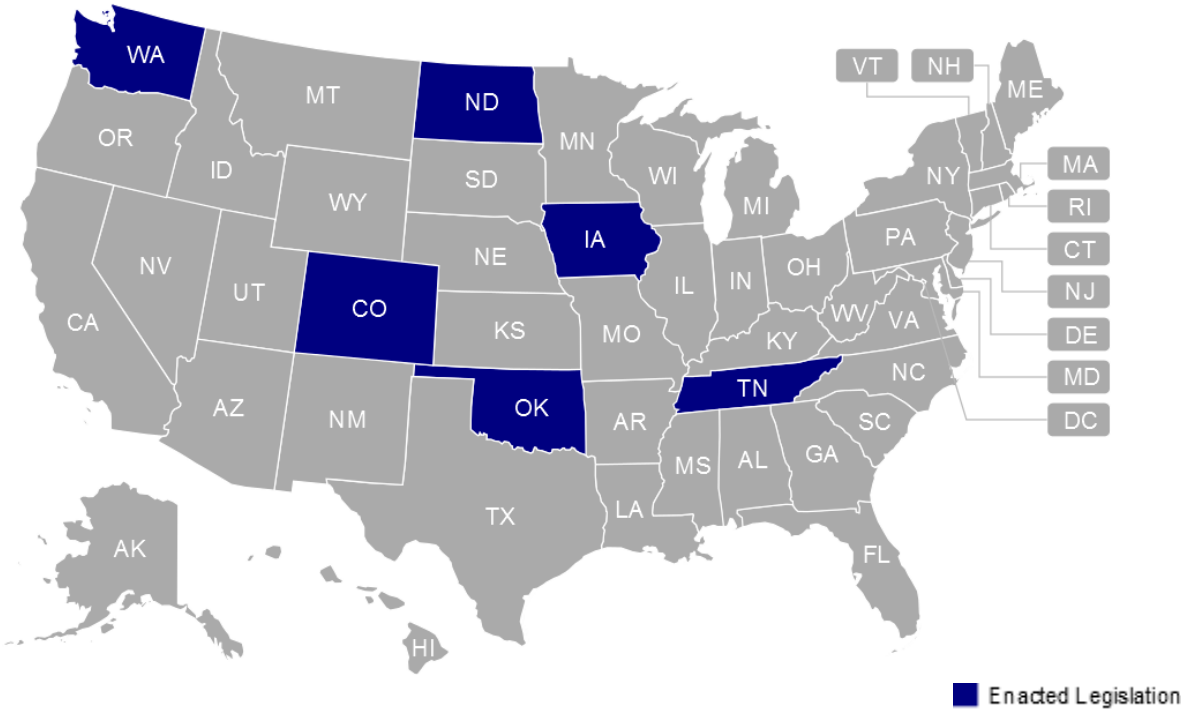
State	Bill	Chapter	Description
AK	SB 37	37	Extends the statewide suicide prevention council.
KY	SB 72	17	Establishes mandatory training requirements for social workers, marriage and family therapists, professional counselors, fee-based pastoral counselors, alcohol and drug counselors, psychologists and occupational therapists in suicide assessment, treatment and management.
OK	SB 181		Extends the Oklahoma Suicide Prevention Council until 2020 and adds an additional six members to the council including representatives from the military, Native American/Tribal and the medical community.
UT	HB 154	194	Requires the State Board of Education to designate a State Office of Education suicide prevention coordinator to oversee school district and charter school youth suicide prevention programs; establishes model youth suicide prevention programs for school districts and charter schools that include certain requirements.
WA	HB 1376	78	Clarifies the requirement that certain health professionals complete training in suicide assessment, treatment and management.

Appendix 13: Family Involvement in Care



State	Bill	Chapter	Description
CT	HB 5727	130	Changes the time for a hospital to notify a parent when a child is admitted to the hospital for diagnosis or treatment of a mental disorder from within five days of the child's admission to not later than one day after the child's admission.
GA	SB 1	171	Provides that both parents shall have equal access to the child's health insurance information and records.
ID	HB 125	262	Revises provisions relating to criminal history and background checks on certain persons and revises provisions relating to guardianship proceedings.
SC	SB 117/ HB 3366	39	Requires a health care provider to give a patient an opportunity to authorize disclosure of certain information to designated family members or representatives and the involvement of these family members or representatives in treatment.
TN	SB 442/ HB 880	32	Allows family members and friends to transport individuals in mental health crisis to regional mental health institutes for civil commitment.
WA	SB 5153	230	Permits the transfer of clients between regional support networks so they can be closer to relatives or other strong personal supports.

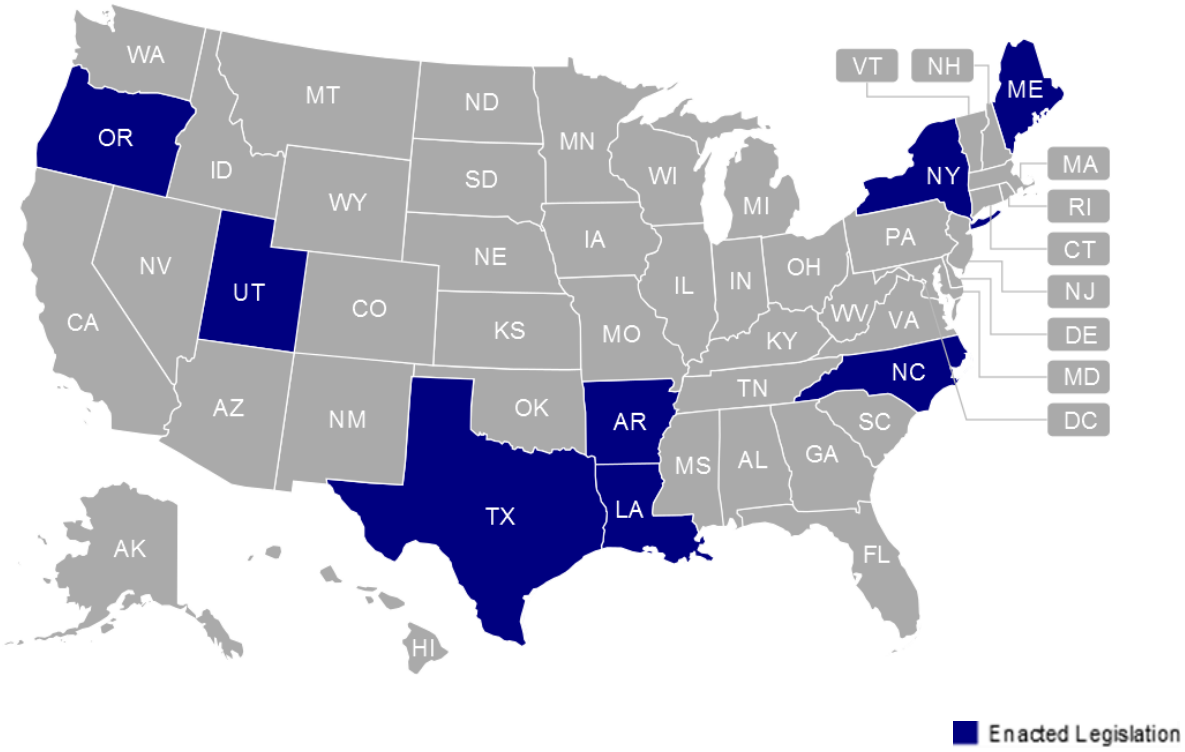
Appendix 14: Health Information Privacy



State	Bill	Chapter	Description
CO	HB 1015	38	Repeals the prohibition against disclosure of mental health claims information by small group health plans.
IA	SF 203		Allows in sub-acute facility for a mental health professional within the scope of their practice to supervise treatment plans rather than solely requiring a psychiatrist to do so. Repeals the Interagency Information Service on Persons with Mental Disabilities which permitted information concerning persons who are believed to have mental disabilities to be efficiently used by and exchanged among the state and local governments, their departments and agencies and with other public or private agencies, where the use or exchange of the information is for the purpose of assisting any of the agencies in providing care, evaluation, services, assistance, education, or habilitation to such persons.
ND	SB 2113	337	Provides for the confidentiality of emergency responder peer or group counseling session records relating to critical incident stress management.
OK	SB 581		Increases parties allowed to access court records related to treatment to include: (1) a person having a valid power of attorney with health care decision-making authority, (2) a person having valid guardianship with health care decision-making authority, (3) a person having an advance health care directive, (4) a person having an attorney-in-fact as designated in a valid mental health advance directive.
TN	SB 28 / HB 68	220	Authorizes the court, when it deems appropriate, to order the disclosure of confidential mental health information of a party.

State	Bill	Chapter	Description
WA	HB 1679	200	Brings standards for release of patient information into compliance with the Uniform Health Care Information Act (UHCIA). Disclosure for management or financial audits allows disclosure to a person for health care education; planning; quality assurance; peer review; administrative, legal, financial, or actuarial purposes; or for assisting a health care provider or facility in the delivery of health care. Standards concern release of information to researchers, penal institutions, Department of Health for licensing standards, county coroners and medical examiners for death investigations, organ procurement organizations to determine medical suitability of a body part, Food and Drug Administration related to quality, safety, or effectiveness of a regulated product.

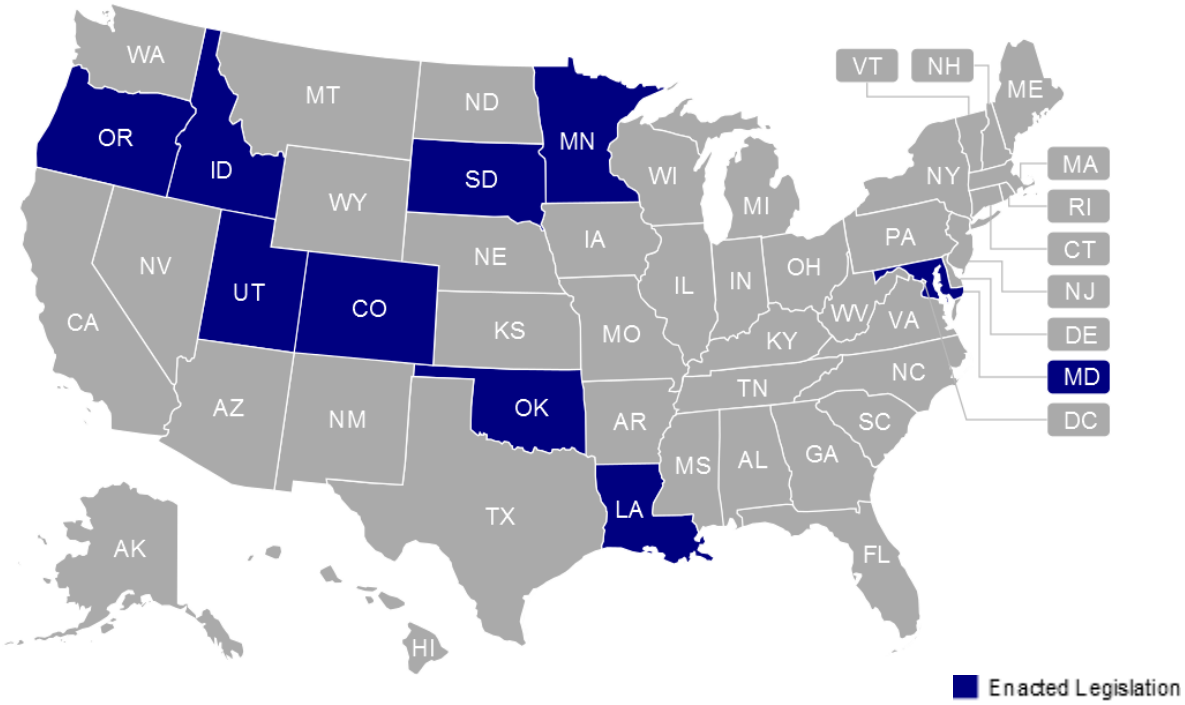
Appendix 15: Prescription Medications



State	Bill	Chapter	Description
AR	HB 1185	274	Authorizes a pharmacist to substitute a therapeutically equivalent drug that is at a lower cost to the patient and communicate that authorization by any generally accepted means of communication of a prescription from a prescriber to a pharmacist and shall inform the patient that the patient has a right to refuse the substitution.
AR	SB 965	536	Requires the substitution of a therapeutically equivalent drug to occur only after the prescriber grants authorization for each prescription. Does not apply to specific acts of drug therapy management or disease management.
LA	HB 393	312	Provides for creation of drug formulary and preferred drug list for the prepaid coordinated care network. When medications are restricted by a managed care organization by a step therapy or fail first protocol, the prescribing physician shall be able to expeditiously request an override.
ME	LD 716	68	Requires the Commissioner of Health and Human Services to convene a work group to review and recommend appropriate prescribing of certain medications for children with attention deficit hyperactivity disorder.
NY	A 3006 / S 2606	56	Maintains "prescriber prevails" clause for atypical antipsychotics and antidepressants in current Medicaid plans as state moves to managed care. Requires managed care providers to cover medically necessary prescription drugs including upon demonstration by the prescriber, after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary.

State	Bill	Chapter	Description
NC	SB 402	360	In order to achieve cost-savings and improve health outcomes the Dept. of Medical Assistance may impose prior authorization requirements and other restrictions on medications prescribed to Medicaid and Health Choice recipients for treatment of mental illness, including, but not limited to, prior authorization requirements and restrictions on (1) medications on the Preferred Drug List (PDL) that are prescribed for the treatment of mental illness and (2) medications for attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD) prescribed to juveniles for off-label uses.
OR	HB 2090	569	Renews the preferred drug list for medical conditions covered under the Oregon health plan.
TX	HB 915		Changes the requirements for prescribing a psychotropic medication to a foster child. Modifies legal and medical oversight of a foster child's medical care. The person authorized to consent to medical treatment for a foster child prescribed a psychotropic medication is required to ensure that the child has been seen at least once every 90 days by the prescribing physician, physician assistant, or advanced practice nurse to: (1) appropriately monitor side effects of medication; and (2) determine whether medication is helping the child achieve the treatment goals, if continued use of the medication is appropriate.
UT	HB 270	130	Requires identities of prescribers, patients and pharmacies in the database to be de-identified in accordance with HIPAA rules, kept confidential and not disclosed to a designee or individuals not associated with scientific studies.

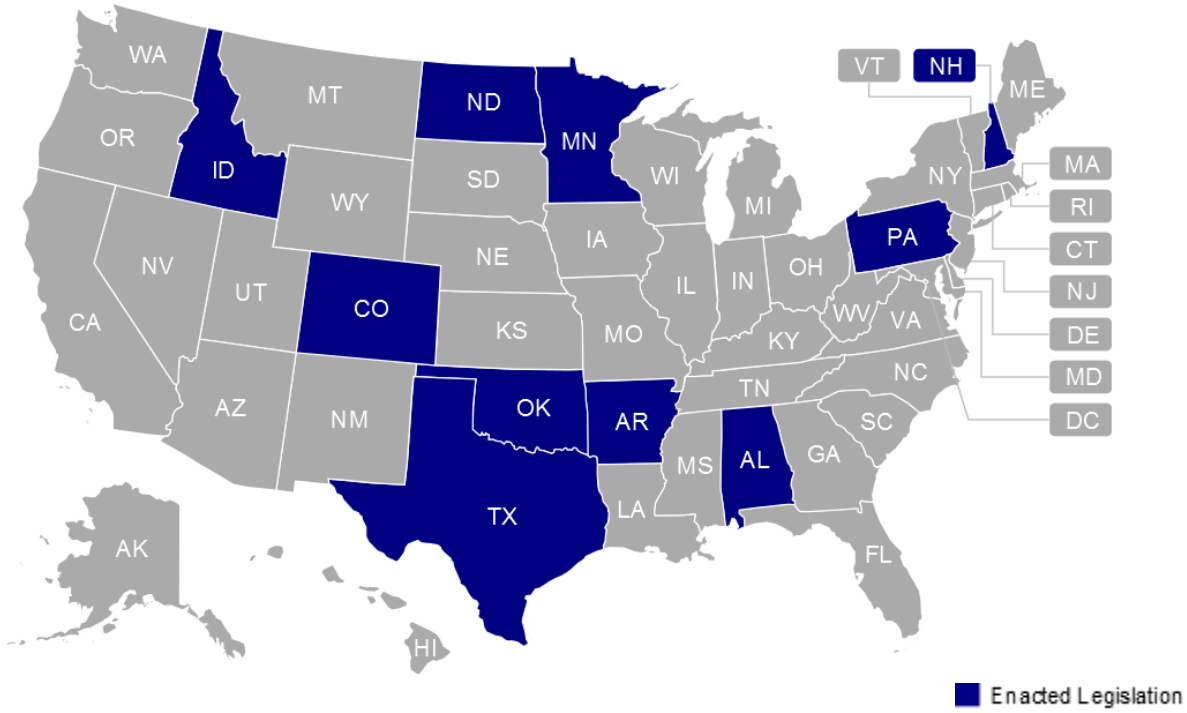
Appendix 16: Provider Credentials



State	Bill	Chapter	Description
CO	SB 116	115	Expands the authority of forensic psychologists to conduct mental health evaluations.
CO	HB 1065	42	Allows persons licensed as physicians or psychologists in another state to treat persons with a mental illness at Colorado treatment facilities that are operated by the Armed Forces of the United States, the United States Public Health Service, or the United States Department of Veterans Affairs.
ID	HO 189		Allows psychiatric nurse practitioners to place temporary health hold on adults and children.
LA	SF 203		In sub-acute facilities expands the types of mental health professionals allowed to supervise treatment plans. Order for seclusion remains solely under the supervision of a psychiatrist.
LA	SB 86	173	Amends the Louisiana Mental Health Counselor Licensing Act to increase licensing fees and outline rules and regulations for obtaining a license.
LA	HB 281	308	Authorizes the Department of Health and Hospitals to promulgate and publish rules and regulations to provide for integrated behavioral health services under one license; to provide for the health, safety and welfare of persons receiving behavioral health services; and to provide for the safe operation and maintenance of providers and facilities providing such care.
MN	HF 358		Adds family peer specialists (FPS) to mental health practitioners covered by Medicaid for children's mental health services. FPS must be parents of a child mental illness and must undergo specialized training. FPS on treatment teams support families and promote family-driven planning.

State	Bill	Chapter	Description
MD	HB 56	348	Requires applicants for a license or certificate from the State Board of Professional Counselors and Therapists to submit to a criminal history records check.
OK	HB 1109		The Board of Mental Health and Substance Abuse Services shall promulgate rules for certification of peer recovery support specialists who are employed by a behavioral services provider certified by the Department of Mental Health and Substance Abuse Services. Provided, however, that certification as a peer recovery support specialist shall be limited to providing services within the employer's area of certification.
OR	HB 2737	581	Requires Oregon Health Authority to adopt standards and procedures to certify specified mental health providers to qualify for insurance reimbursement.
SD	SB 69	171	Revises provisions of the health professionals' diversion program and updates licensing requirements of health care professionals.
UT	HB 244	123	Amends the definition of the term "Mental Health Therapist" under the Mental Health Professional Practice Act and the Psychologist Licensing Act and clarifies the educational requirements of an applicant for a license as a substance use disorder counselor.

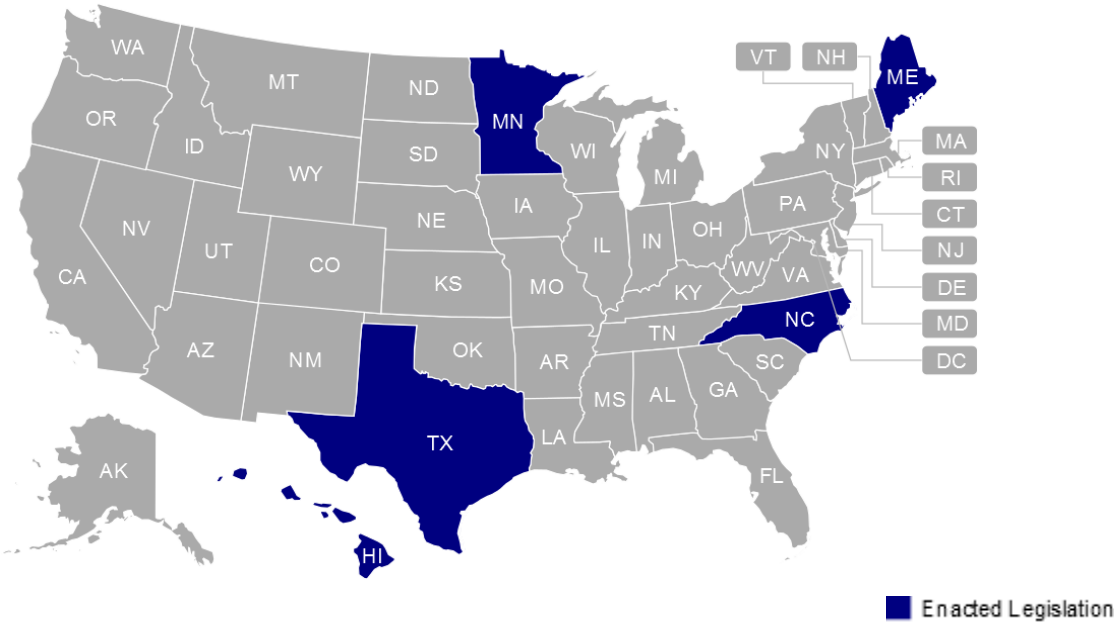
Appendix 17: Standards of Care



State	Bill	Chapter	Description
AL	HB 301	201	Defines physical therapists and employees of public and private institutions of postsecondary and higher education as persons required to report child abuse or neglect; clarifies that both public and private school teachers and officials are required to report.
AR	HB 1029	1200	Promotes mental health treatment for alleged child sex offenders who are under the age of 18 and the victims of sexual abuse.
CO	HB 1104	77	Repeals the requirement that mental health professionals provide required disclosures verbally and modifies the mental health professional peer health assistance program.
ID	HO 125		Revises guardianship and conservatorship provisions for criminal history and background checks. Revises provisions for guardianship proceedings.
MN	HF 1359 / SF 1234	70	Adds posttraumatic stress disorder (PTSD) to the list of eligible injuries under the state's worker's compensation law.
ND	HB 1424	418	Provides for legislative management study of feasibility and desirability of participating in the provision of nontraditional healing therapies for posttraumatic stress disorder (PTSD), traumatic brain injury and other neurological conditions for North Dakota veterans and their families.
NH	HB 636	140	Extends the prospective repeal relative to the waitlist for community mental health services.
OK	SB 755		Specifies certain persons to be deemed treatment advocates and authorizes the disclosure of information. Includes as a 'treatment advocate' a person holding the powers vested in guardianship of the person, a grant of general health care decision-making authority or designation of health care proxy contained in an advance directive for health care, or a durable power of attorney with health care decision-making authority.

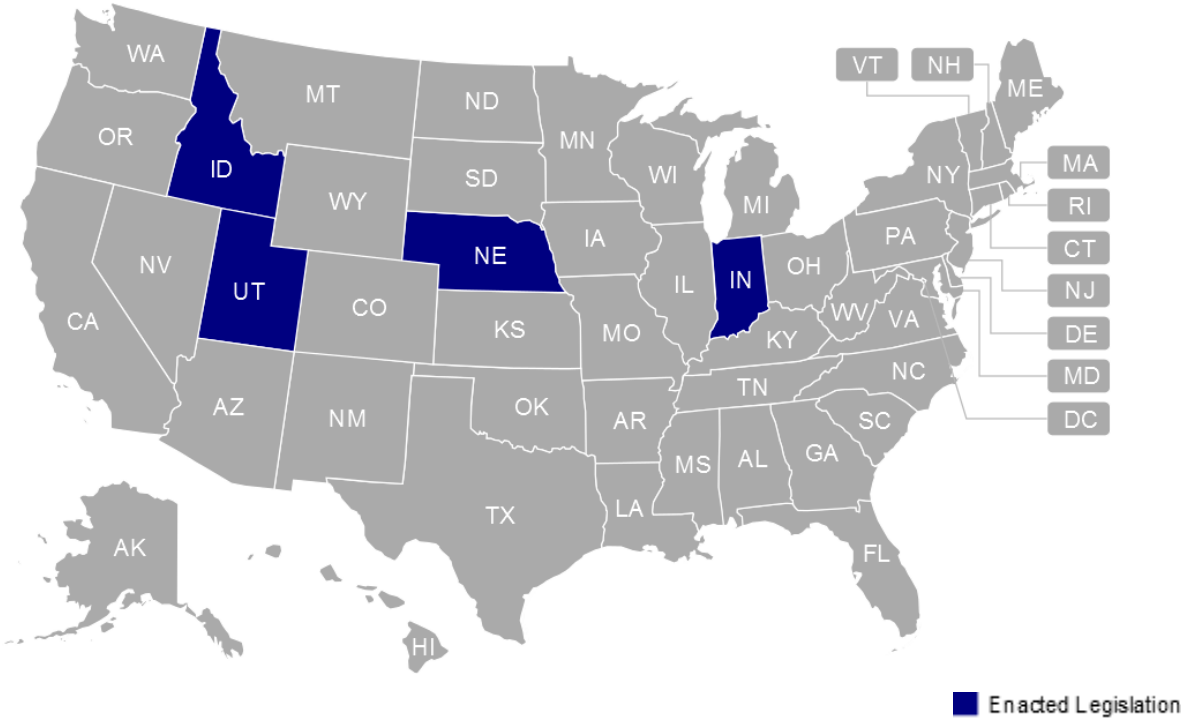
State	Bill	Chapter	Description
PA	SB 5	10	Requires establishment of the Community-Based Health Care Program in the Department of Health which expands and improves health care access and services such as preventive care, chronic care/disease management, behavioral health and pharmacy services. Requires that not more than 50 percent of the expansion of an existing or the development of a new community-based health care clinic should use criteria to include addition of ancillary health care services, such as behavioral health and pharmacy.
TX	SB 7		Allows a local mental health authority to ensure the provision of assessment services, crisis services and intensive and comprehensive services using disease management practices for children with serious emotional, behavioral, or mental disturbance and adults with severe mental illness who are experiencing significant functional impairment due to a mental health disorder. Requires the local mental health authority to ensure that individuals with mental illness are engaged with treatment services in a clinically appropriate manner. Requires each local mental health authority to incorporate jail diversion strategies into the authority's disease management practices to reduce the involvement of the criminal justice system in managing adults with posttraumatic stress disorder; schizoaffective disorder, including bipolar and depressive types; anxiety disorder; or delusional disorder.

Appendix 18: Supports, Employment and Housing



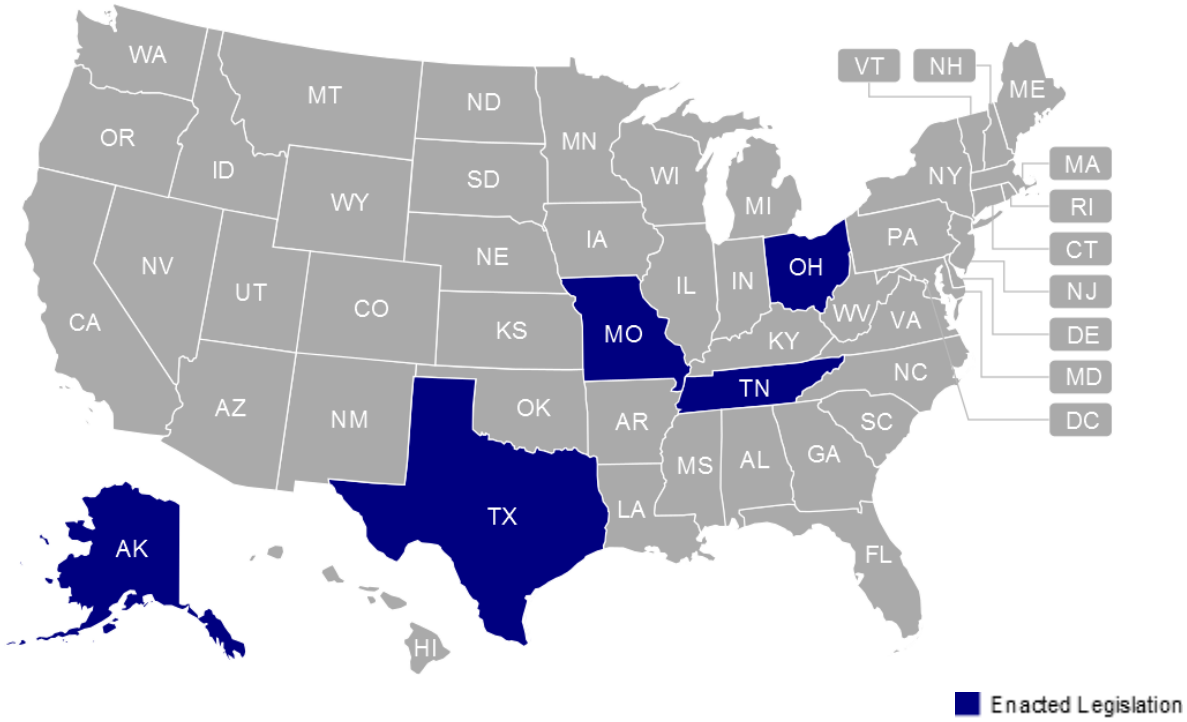
State	Bill	Chapter	Description
HI	SB 515/ HB 1345	222	Funds substance abuse treatment, mental health support services and clean and sober housing services. Funds the Public Housing Authority to administer housing first programs for chronically homeless individuals and reestablish homeless prevention and rapid re-housing program.
ME	LD 1352, SP 471	335	Provides integrated community-based employment and customized employment for persons with disabilities.
MN	HF 1233/ SF 1034		Increases funding for the Extended Employment Program for People with Serious Mental Illnesses (EE-SMI) by $1 million.
MN	SF 1607		Encourages the use of evidenced-based practices, such as the Individual Placement and Support (IPS) model, in the EE-SMI program.
NC	SB 402	360	Allocates $4.6 million to group homes to replace loss of Personal Care Medicaid Funding. Requires a pilot program to implement a tiered rate structure within the State County Special Assistance program for individuals residing in group homes, in home living arrangements and assisted living residences.
NC	HB 5	4	Requires temporary, short-term financial assistance to (1) group homes serving residents determined not to be eligible for Medicaid personal care services as a result of changes to eligibility criteria; (2) special care units serving residents who qualify for Medicaid-covered personal care services.
TX	HB 1191		Provides for information on housing options for individuals with mental illness through public and private entities on the Texas Information and Referral Network website. The site must contain a searchable listing of available housing options for persons with mental illness by type, with a definition for each type of housing and an explanation of the populations of persons with mental illness generally served by that type of housing. The list must contain a specified array of housing options for persons with mental illness.

Appendix 19: Telehealth, Technology



State	Bill	Chapter	Description
ID	HB 32	13	Allows the Board of Psychologist Examiners to establish, by rule, the standards and requirements for the use of communication technology in the practice of psychology, including supervision.
IN	SB 554	204	Requires the office of Medicaid Policy and Planning to reimburse community mental health centers, home health agencies, FQHC, rural health clinics and critical access hospitals for telemedicine services under the Medicaid program.
NE	LB 556		Requires the Department of Health and Human Services to promulgate rules and regulations for the use of telehealth in children's behavioral healthcare.
UT	HB 56	016	Amends the Mental Health Professional Practice Act and Psychologist Licensing Act to allow mental health therapists and substance use disorder counselors to engage in mental health therapy or substance use disorder counseling via Internet, telephone, or other electronic means.

Appendix 20: Law Enforcement



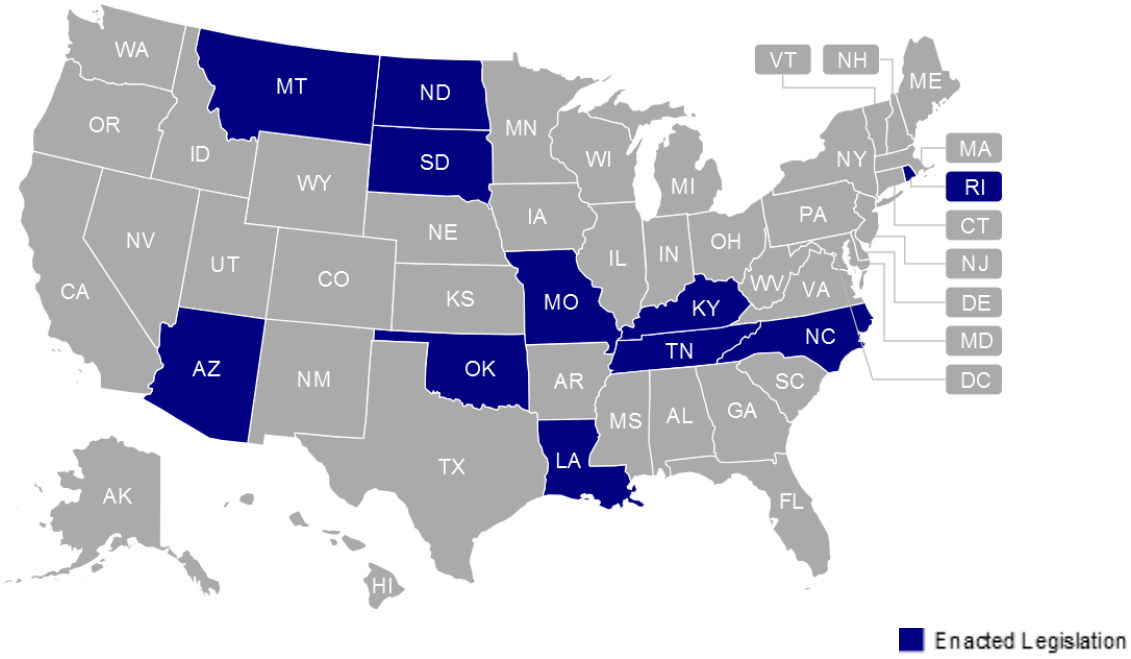
Law Enforcement and Mental Health

State	Bill	Chapter	Description
AK	HB 59	71	Requires coordination of a missing vulnerable adult response plan with statewide media coverage and law enforcement.
OH	SB 7		Requires, if a court orders a person convicted of a violent offense to receive a mental health evaluation or treatment for mental illness, the court shall report the conviction and evaluation or treatment to the local law enforcement agency which shall enter report to the national crime information center supervised release file. Information entered into the file shall remain until further order of the court.
TX	HB 1738		Authorizes a peace officer who takes a person into custody without a warrant to immediately inform the person orally of the reason for detention and that a staff member of the facility will inform the person his/her rights within 24 hours after admission. Grants the right to reasonable opportunity to communicate with a relative or other responsible person who has a proper interest in the person's welfare. Requires the Commissioner to, by rule, prescribe the manner in which person is informed of rights.

Law Enforcement Personnel Standards

State	Bill	Chapter	Description
MO	HB 404		Specifies that, for workers' compensation purposes, psychological stress may be recognized as an occupational disease for paid peace officers who are certified under Chapter 590, RSMo, if direct causal relationship is established.
TN	SB 175 HB 169	137	Revises the qualifications to be a sheriff, youth service officer or police officer. Orders that applicants be certified by a psychiatrist or psychologist as free from any psychiatric impairment per the DSM that would affect the applicant's ability to perform an essential function of the job, with or without a reasonable accommodation.

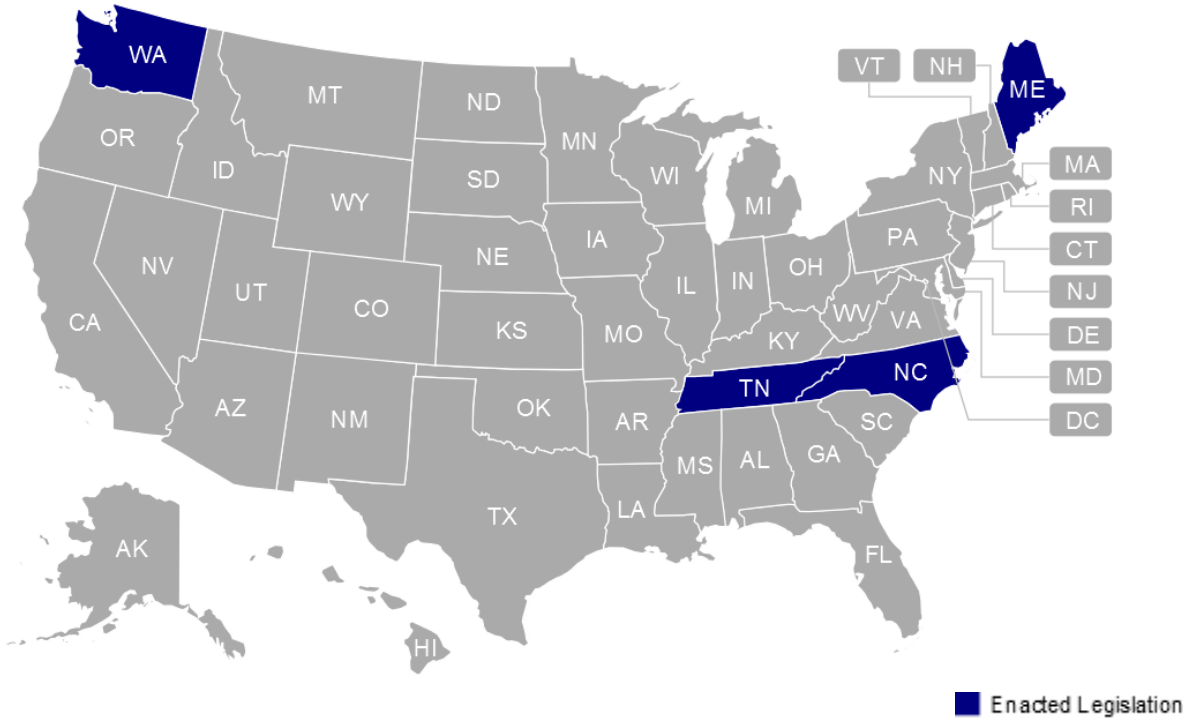
Appendix 21: Criminal Justice, Courts



State	Bill	Chapter	Description
AZ	HB 2310	140	Develops standards for the design, training in and procedures to establish and implement efficient, effective and accountable mental health courts in this state.
KY	SB 67	16	Requires a revocation or denial of a license or the withdrawal of the privilege of operating a motor vehicle due to a person being found incompetent to stand trial shall extend until the person is found competent to stand trial or the criminal case is dismissed.
LA	SB 71	346	Authorizes mental health court treatment programs in Louisiana.
MO	SB 118		Authorizes circuit courts to create a veterans treatment court. The court will handle cases involving substance abuse or mental illness of current or former military personnel.
MT	HB 92	9	Removes public defenders from drug and mental health courts' treatment team.
NC	SB 45/ HB 88	18	When a defendant who is incarcerated or involuntarily committed lacks capacity to proceed, the court shall dismiss the charges when the defendant has served the maximum term of imprisonment. The defendant shall not be discharged from custody of the hospital, institution or outpatient commitment until examined for capacity to proceed and a report is filed with the clerk of court.
ND	HB 1116	102	Requires that when evaluating a defendant's fitness to proceed a human service center may not be considered a suitable facility and may not be considered suitable personnel unless the court is aware that an inquiry has been made prior to the court ordering the evaluation to ensure that appropriate resources exist at the human service center being ordered to conduct the evaluation.

State	Bill	Chapter	Description
OK	HB 1109		Stipulating that after an initial appearance a person accused of a felony offense may be required to submit to an approved risk, mental health and substance abuse assessment.
RI	HB 5851	279	Grants jurisdiction to the district court to order an examination of a person who requires specialized mental healthcare services and would allow for additional procedural due process rights for those individuals who have sufficiently recovered their mental health and who are to be returned to their original place of confinement.
SD	SB 70	101	Would require magistrate and circuit judges to be trained on evidence-based principles, including the use of behavioral health assessments.
TN	SB 180/ HB 174	100	If a defendant is found to be incompetent to stand trial, any misdemeanor charges pending at the time of the incompetency determination shall be retired no later than 11 months and 29 days after the date of arrest.

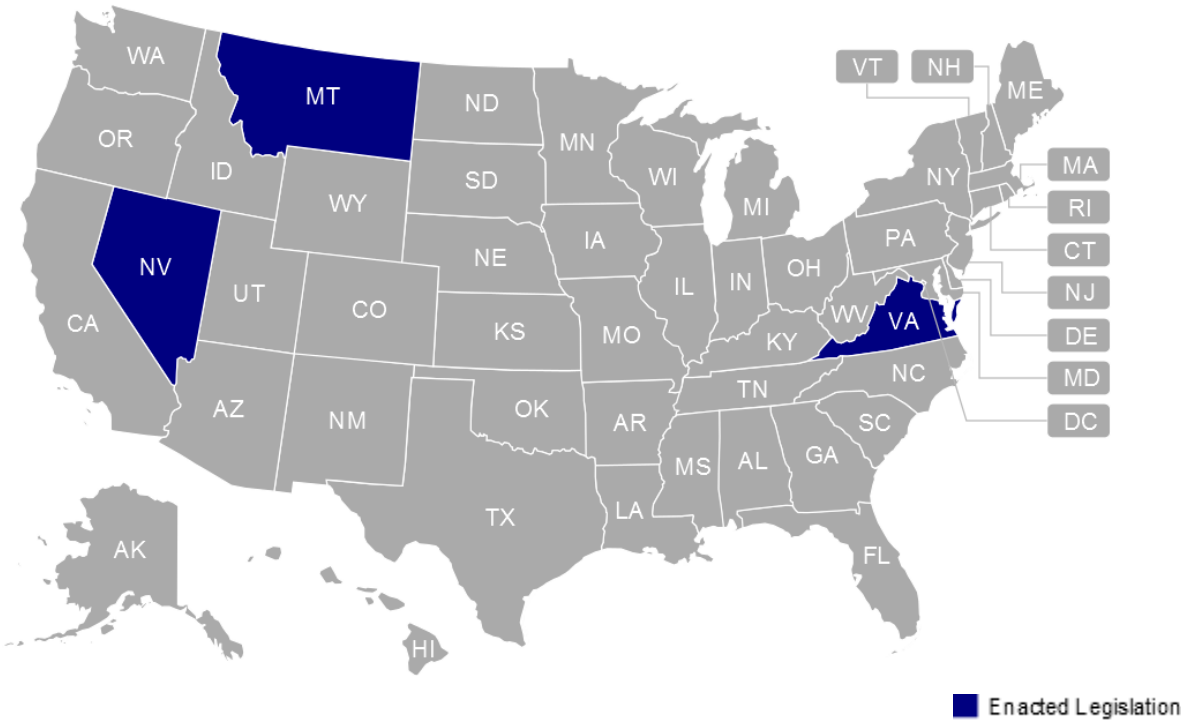
Appendix 22: Criminal Justice, Incarceration



State	Bill	Chapter	Description
ME	LD 1433, HP 1022	265	Provides that a person who is in prison and is found not criminally responsible by reason of insanity for another offense must finish the first prison term before beginning the commitment ordered by the court for the second offense. An individual who is in state custody on the basis of being not criminally responsible by reason of insanity may petition the court to be off institutional grounds if the individual is monitored.
NC	SB 45/ HB 88	18	A presiding district or superior court judge who orders an examination shall order the release of relevant confidential information to the examiner, including mental health records of the defendant. When a defendant lacks capacity to proceed, the court shall dismiss the charges upon the earliest when as a result of incarceration, involuntary commitment to an inpatient facility, or other court-ordered confinement, the defendant has been substantially deprived of his liberty for a period of time equal to or in excess of the maximum term of imprisonment permissible for prior record Level VI for felonies or prior conviction Level III for misdemeanors for the most serious offense charged.
TN	SB 1376/ HB 1339	173	Prohibits the Board from granting waivers for any person hired as a jail administrator, workhouse administrator, jailer, corrections officer, or guard in any county jail or workhouse who has been found not to be free from any disorder as described in the current edition of the DSM that would impair the subject's ability to perform any essential function of the job or would cause the subject to pose a direct threat to public safety.

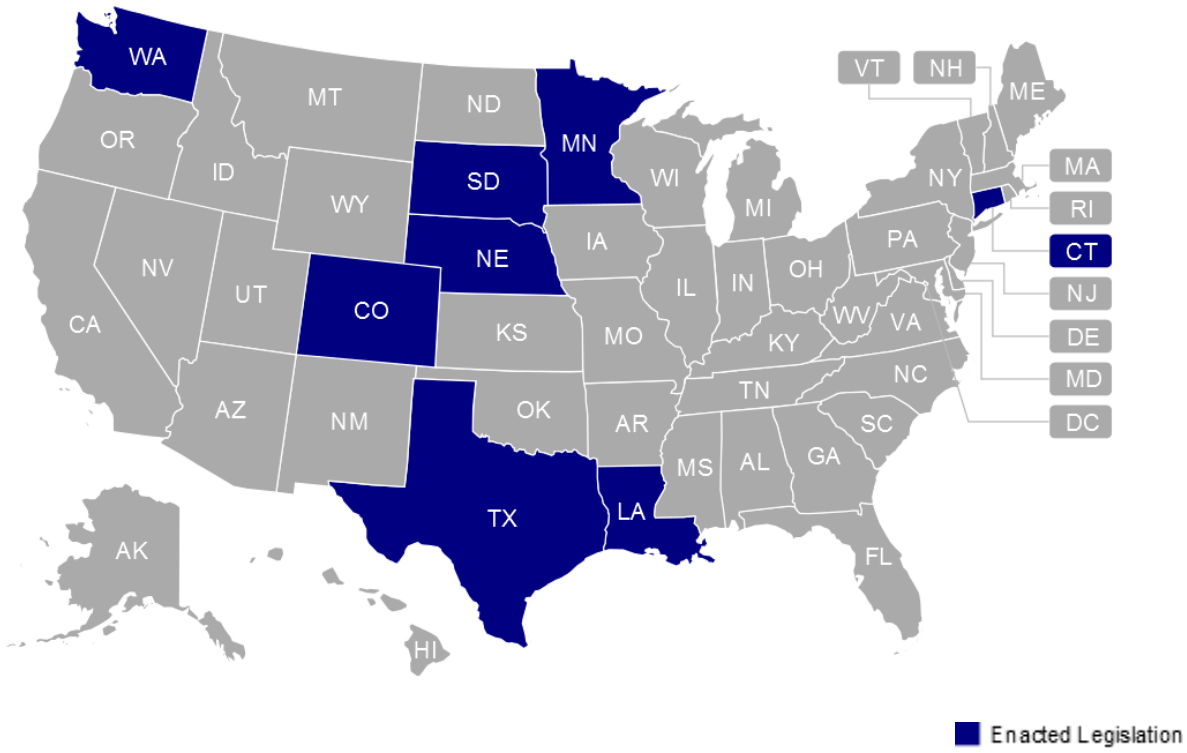
State	Bill	Chapter	Description
WA	SB 5551 / HB 1627	284	The Department of Social and Health Services (DSHS) must reimburse a county for the cost of appointing an expert to complete a competency evaluation for a defendant in jail if DSHS does not meet its seven-day performance target for the timeliness of competency evaluations for at least 50 percent of defendants in the county during the most recent quarter.

Appendix 23: Criminal Justice, Release, Probation, Parole



State	Bill	Chapter	Description
MT	SB 11	209	Revises the parole and probation system to work more effectively for offenders that have a serious mental illness.
MT	HB 68	176	Law and Justice Interim Committee bill to create a re-entry task force pilot project to reduce recidivism. Requires the department, in consultation with the reentry task force to develop partnerships with and contract with community-based organizations that provide needed services to released inmates in areas such as mental health, chemical dependency, employment, housing, health care, faith-based services, parenting, relationship services and victim impact panels.
NV	SB 519	501	Authorizes the Director of the Department of Corrections to apply on behalf of a prisoner for a determination of Medicaid eligibility.
VA	HB 2148/ SB 1217	164	Authorizes the Department of Corrections to exchange medical and mental health information and records of any person committed to the Department with the Department for Aging and Rehabilitative Services, the Department of Social Services and any local department of social services in the Commonwealth for the purposes of reentry planning and post-incarceration placement and services.

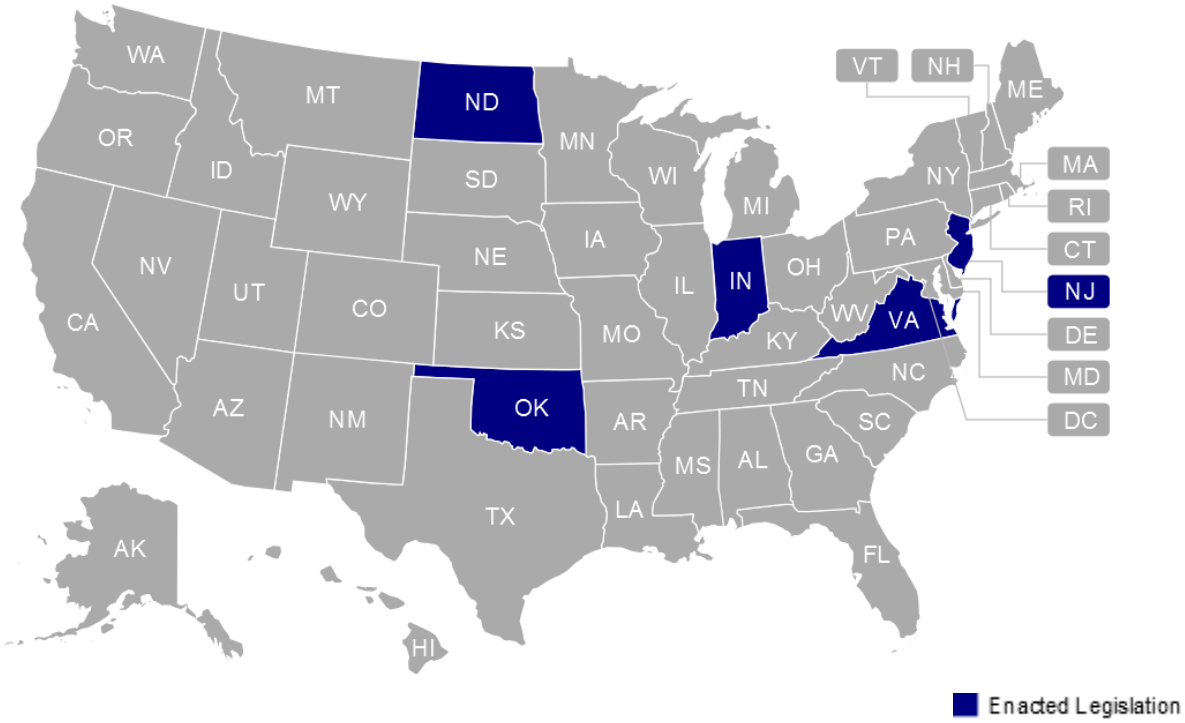
Appendix 24: Juvenile Justice



State	Bill	Chapter	Description
CO	SB 177	88	Reduces the number of available juvenile detention beds statewide from 422 to 382.
CT	SB 972	178	Develops an integrated case management system to provide a complete continuum of care for at-risk youths to reduce the number who enter into the juvenile and criminal justice systems, improve access to treatment and rehabilitative services for youths currently involved in the system and reduce recidivism.
LA	SB 107	214	Develops an integrated case management system to provide complete continuum of care for at-risk youths to reduce the number of youths who enter into the juvenile and criminal justice systems, improve access to treatment and rehabilitative services for youths currently involved in the system and reduce recidivism.
MN	SF 671/ HF 724		Creates a working group to discuss juvenile justice and mental health. The group is composed of NAMI Minnesota, commissioners of human services, corrections and education; a district court judge designated by the Supreme Court; the MN County Attorneys Association; the state public defender; the Indian Affairs Council; the MN County Probation Officers Association; and the MN Association of Community Corrections Act Counties. Issues to be discussed: • Strategies for early identification and response.

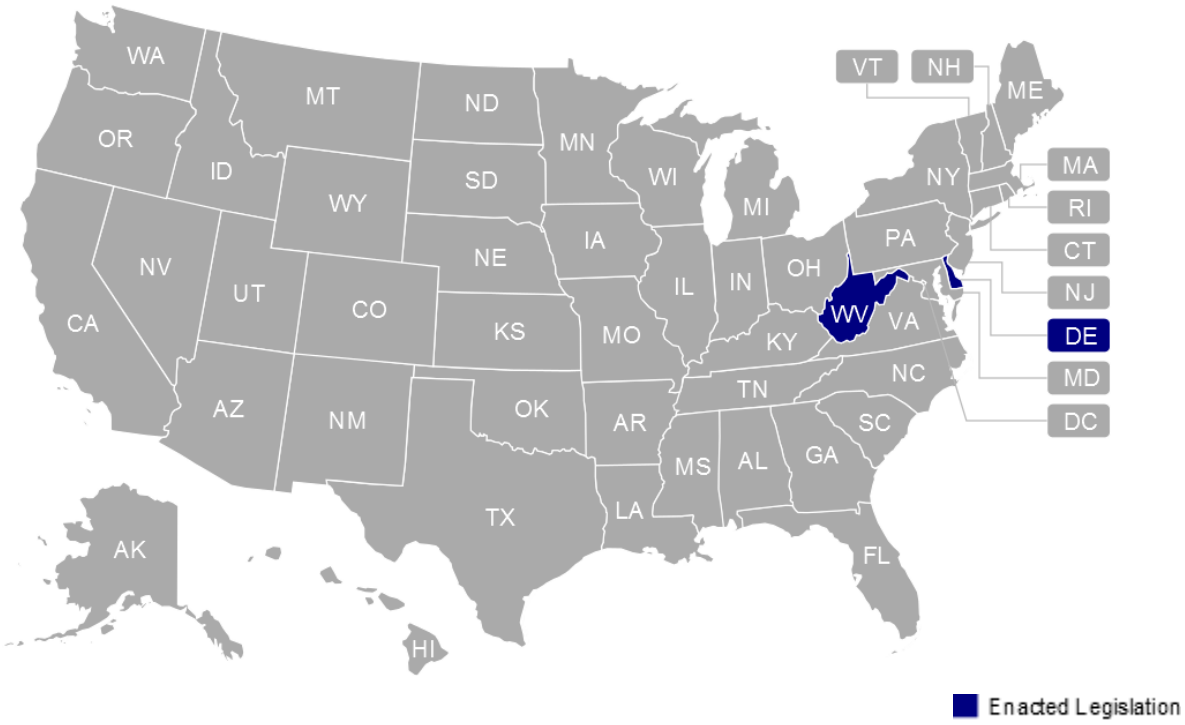
State	Bill	Chapter	Description
			• Changes needed to ensure coordinated delivery of quality services: information-sharing, service shortages and cost pressures. • Changes needed to ensure coordination between delinquency and other child serving systems. • Changes to rules and statutes that create barriers to achieving outcomes agreed upon by the work group. • Implementation plan to achieve integrated service delivery across systems and across the public, private and nonprofit sectors. • Financing mechanisms that include all possible revenue sources. Requires NAMI Minnesota to report to the legislature on results.
NE	LB 44		Limits the penalty of a Class IA felony committed by a minor to no more than life imprisonment and includes provisions to provide mental health screenings for juvenile defendants.
NE	LB 561		Allows for mental health evaluations to judge the competency of the juvenile to proceed in a court hearing and when considering sentencing. Also creates mental health treatment programs for juvenile offenders.
SD	HB 1073	121	Requires that if the court determines that a competency determination is necessary, the court shall order the juvenile be examined by a licensed professional familiar with clinical evaluation of juveniles. If the examiner determines that the juvenile suffers from a mental illness, the examiner shall provide the following information: (1) The prognosis for recovery from the mental illness; and (2) Whether the juvenile is taking any medication and, if so, what medication. If the court finds that the juvenile is not competent to proceed, but there is substantial probability that the juvenile will be competent in the foreseeable future, the court shall continue the suspension of the proceedings and may refer the juvenile to a facility for evaluation and treatment.
TX	HB 144		Clarifies a juvenile court's authority to order a physical and mental examination for a child who is referred to the court or who is alleged to have engaged in delinquent conduct or conduct indicating a need for supervision when the child is initially detained in a pre-adjudication secure detention facility or a post-adjudication secure correctional facility.
WA	HB 1524	179	Provides for juvenile mental health diversion and disposition strategies.

Appendix 25: Civil Rights, Protection from Discrimination



State	Bill	Chapter	Description
IN	SB 203	45	Provides that an individual with mental illness is eligible for services from the protection and advocacy services commission if the individual lives in a community setting, including the individual's own home.
NJ	S1456/ A 2390	80	Prohibits discrimination against potential organ transplant recipient on basis of mental or physical disability.
ND	SB 2323	384	Requires the reporting of abuse or neglect of a vulnerable adult.
OK	SB 755		Specifies certain persons who are to be deemed treatment advocates and authorizes the disclosure of information to the treatment advocate. Includes as a 'treatment advocate' a person holding the powers vested in a guardianship of the person, a grant of general health care decision-making authority or designation of health care proxy contained in an advance directive for health care, or a durable power of attorney with health care decision-making authority shall be the treatment advocate for the patient by operation of law.
VA	HB 1682/ SB706	419	Creates a penalty for the financial exploitation of mentally incapacitated persons.

Appendix 26: Stigma Reduction



State	Bill	Chapter	Description
DE	HB 90	35	Removes the provision that allows districts to reject applications of students with special needs.
WV	SB 193 / HB 2463	28	Repeals the article of the West Virginia Code that permits the sterilization of persons deemed to be mentally incompetent.