NAMI

National Alliance on Mental Illness

December 2015

State Mental Health Legislation 2015

Trends, Themes & Effective Practices

State Mental Health Legislation, 2015: Trends, Themes and Effective Practices

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

Acknowledgements and Gratitude
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Executive Summary

Good news and bad news emerged from state legislative sessions and some regulatory actions in 2015. The bad news is that state investment in mental health services is slowing. The good news is that some states nonetheless enacted measures that can serve as models for mental health care reform.

This is NAMI's third annual report on state legislation enacted during the course of the year. The reports (2013-2015) have coincided with recovery from a devastating economic recession in which states cut $4.35 billion from the overall mental health care system. At the same time, public awareness of mental illness increased dramatically as a result of high profile events such as the Newtown, Connecticut tragedy in 2012[a] and the death of Robin Williams in 2014.

From 2013-2014, states led the cause of mental health care reform while Congress was largely absent. In 2015, two federal bills, S 1945 and HR 2646, have begun to move forward in Congress. At the time of this report, a House subcommittee has passed HR 2646, while action on S 1945 is expected in early 2016. Together, these bills represent a comprehensive framework that supports state innovations. States, however, must also continue moving forward to meet growing public expectations for comprehensive mental health reform.

Unfortunately, state mental health budget trends are currently cause for alarm (see Appendix 1). In the wake of the Newtown tragedy, 36 states and the District of Columbia increased mental health spending in 2013. In 2014, the number dropped to 29, including D.C. This year, only 23 states increased their mental health budgets. At the time this report was written, budgets were still pending in Illinois and Pennsylvania.

Of even greater concern:

- While other states have worked to regain lost ground from the recession, three have been in steady decline over three years: Alaska, North Carolina and Wyoming.
- Two states increased mental health spending in 2013, but have now cut for two years in a row: Kentucky and Arkansas.
- Warning bells are sounding in four states where, after two years of increases, cuts in mental health services occurred in 2015: Arizona, Iowa, Kansas and Ohio. D.C. is hearing the warning bells as well.

Only 11 states have steadily increased investment from 2013 to 2015: Colorado, Connecticut, Delaware, Idaho, Minnesota, New Hampshire, New Jersey, South Carolina, South Dakota, Virginia and Washington.

Despite budget concerns, the good news is that some states have been able to pursue innovations in certain areas of mental health policy.

This report organizes legislation and regulatory action in 2015 into 11 topical areas. While not exhaustive, measures listed in Appendices 1 through 23 represent much of the meaningful action on mental health issues at the state level during 2015.

[a] The Newtown tragedy and others have helped fueled public demand for mental health reform. At the same time, studies consistently show that the vast majority of individuals living with mental illness are not violent.

The topical areas are:

- State Mental Health Budgets
- Medicaid and Medicaid Expansion
- Insurance Parity
- Workforce
- Children and Youth
- First Episode Psychosis: Early Intervention
- Inpatient and Crisis Care
- Civil Commitment and Court-Ordered Treatment
- Criminal Justice
- Suicide Prevention
- Housing and Employment

Under each topic, NAMI has marked measures that it considers innovative or exceptional with a gold star.  We encourage other states to consider them as potential models. Gold stars are not a rating of any state's overall mental health care system; they only reflect special praise for a specific measure. They also do not imply criticism of other measures that did not earn gold stars. Measures considered ill-informed or discriminatory and to be avoided by other states are marked by a red flag. 

Thirty-six states adopted one or more measures in 2015 that received gold stars. Minnesota, New York and Virginia stand out as showing some of the strongest leadership. Minnesota and Virginia have earned the distinction for the second year in a row.

NAMI was pleased to see a volume of legislation in 2015 that addressed broad systemic issues such as Medicaid, insurance parity, workforce capacity, school-based mental health, criminal justice and suicide prevention.

What we did not see is disturbing. Scant attention was paid to early identification and early intervention, school-linked mental health services or housing and employment, even though such programs are critical in supporting individual well-being and are a long-term, cost-effective use of taxpayer dollars.

This report is intended to serve as a source of ideas for state leaders and a tool for advocates who share a desire to strengthen mental health care systems that for too long have been fragmented and existing in perpetual crisis. NAMI seeks a coordinated, cost-effective system that will support recovery. Our common goal must be to improve the lives of individuals and families affected by mental illness. We hope not only that people will read the report, but also act on it—to provide greater help and hope to millions of Americans.

Methodology

This report is based on information obtained from a survey of state NAMI leaders regarding policy priorities in the 2015 state legislative sessions. The survey gathered information on the status of the state mental health authority budget, changes to Medicaid and legislation supported or opposed by NAMI State Organizations and NAMI Affiliates. Further information for this report was gleaned from state legislature websites and media coverage of mental health issues. The report narrative discusses trends and notable examples of state legislation enacted in 2015. The appendices include more categories of legislation than are covered in the narrative.

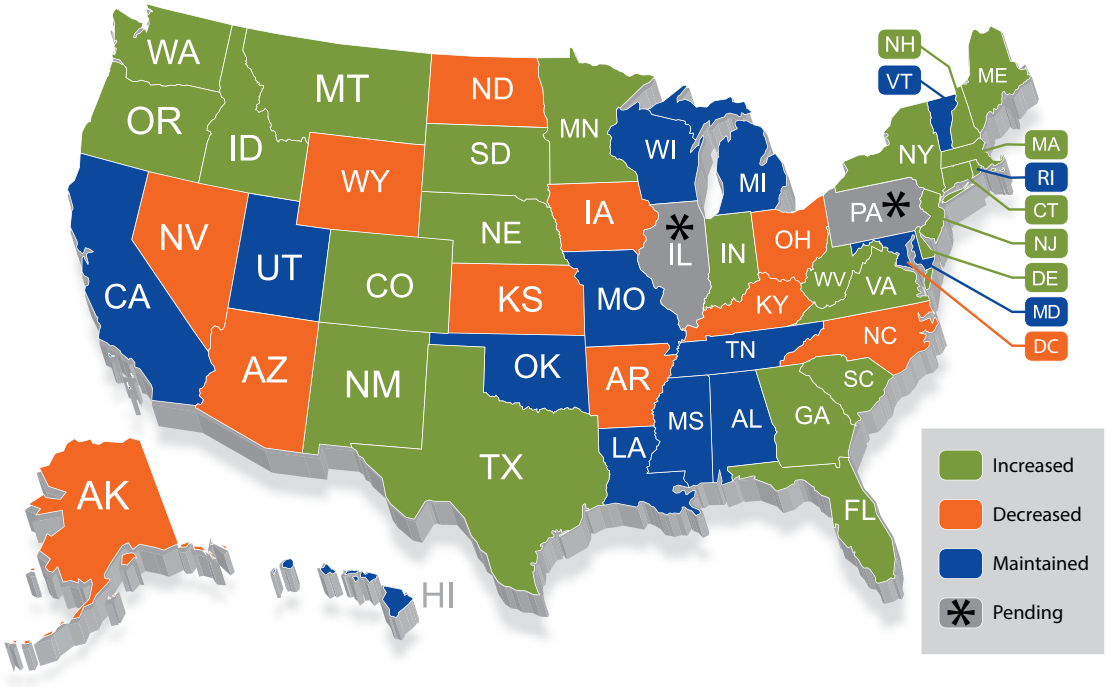
Disclaimer

This report is a summary rather than an exhaustive compendium of state mental health bills enacted during 2015 legislative sessions. With a few exceptions, only enacted legislation was included versus pending or vetoed legislation.

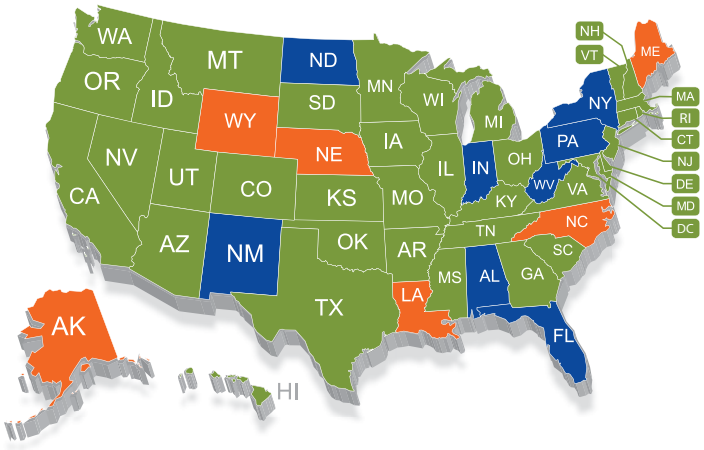
State Mental Health Budgets

NAMI tracks state mental health agency (SMHA) budgets as a measure of public commitment to the well-being of children and adults with mental illness.[b] With a few notable exceptions, the outlook is troubling. Between 2013 and 2014, states began the process of rebuilding from the sweeping cuts that devastated state mental health budgets during the recession. Yet, this year state mental health funding once again took a hit as governors and state legislators tangled over taxes and spending priorities. In 2015 only 23 state mental health budgets increased—down from 29 in 2014 and 36 in 2013. Twelve states decreased general funds for mental health, while 14 states maintained their budgets from the previous year.

State Mental Health Budgets Fiscal Year (FY) 2015-2016



State Mental Health Budgets FY 2013-2014



[b] State Mental Health Agencies are subject matter experts within state government charged with planning, delivery and evaluation of inpatient and community mental health services. The continuum of services offered through the public mental health system is vital to promote innovation and fill gaps in health coverage from other sources.

Prolonged budget debates left Pennsylvania and Illinois at an impasse. As this report went to press, both states' budgets were still pending. This has left social service agencies and community mental health centers in turmoil, borrowing money to keep doors open, laying off staff, delaying payment to vendors and placing clients on ever-increasing wait lists.

Particularly troubling, states like Wyoming, North Carolina and Alaska have decreased state mental health budgets for the last three years running. In North Carolina, after two years of cuts, the governor had proposed a modest 4% increase to the state mental health budget. After a difficult political fight, the end result was that the budget took a startling $84 million (14%) cut. However, the state did fund a psychiatric bed registry and 150 additional psychiatric beds in rural areas.

In a few states, ugly political wrangling ended with mixed results. In Florida, which is ranked 49th in state funding for mental health, the governor had proposed a nearly $22 million increase to the state mental health budget. Infighting in the legislature left the state with a modest increase for community mental health services, hardly enough to offset the massive cuts that have taken place in previous years. In Alabama, by contrast, devastating budget cuts were originally proposed. After public outcry followed by debate in two special sessions, the legislature managed to enact a budget that at least preserved spending levels compared to 2014.

Also of concern are states like Kansas, Ohio, Arizona and Iowa that—after two years of budget increases—have reversed the trend by making cuts. For example, Kansas saw a four percent cut to their state mental health budget. Both Ohio and Michigan, who expanded Medicaid by executive order, largely folded mental health services into Medicaid funding. With cuts to the state mental health budget, however, advocates in both states are concerned that neither Medicaid nor the mental health system will meet the needs of individuals who remain uninsured and hard to reach.

Yet, there is cause for hope. A few states made important investments in mental health. New York enacted a budget that represents the state's strongest investment in mental health services in many years. New Hampshire, which was one of the states with a long budget battle, ended the session with a substantial increase in the state mental health budget, partially to fulfill the state's obligation under a U.S. Department of Justice consent decree. Washington has invested $700 million[1] since the low point in 2012. This has been driven, in part, by three court cases about emergency rooms, jails and youth in juvenile justice. Minnesota, which has increased its mental health budget for three years running, also allocated $46 million new dollars to build on what works, expand access to existing services and fund several new initiatives.

Medicaid and Medicaid Expansion

Millions of Americans rely on Medicaid for access to mental health care. In fact, Medicaid is the single largest payer of mental health services across the country. In most states, Medicaid covers a broad array of community mental health services and supports, including some not covered by Medicare or private insurance.

Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) gave states the option of expanding Medicaid eligibility to individuals and families living at or below 138% of the federal poverty level. At present, 30 states plus the District of Columbia have expanded Medicaid. Six of these states (Arkansas, Iowa, Michigan, Montana, New Hampshire and Indiana) have expanded Medicaid through an 1115 demonstration waiver—a tool used by the U.S. Department of Health and Human Services to approve experimental programs that benefit low-income individuals who would not otherwise have access to Medicaid. These states have taken a nontraditional approach to Medicaid expansion—often imposing cost-sharing responsibilities on plan participants or limiting access to services such as non-emergency medical transportation (NEMT).

During the 2015 session, legislators in Montana passed SB 405, allowing the state to expand Medicaid through an 1115 demonstration waiver. The expansion will cover 45,000 –70,000 residents, including 7,500 – 13,000 with mental health conditions.[2] As approved by the federal Centers for Medicare and Medicaid Services (CMS), Montana's Healthy Economic Livelihood Partnership (HELP) plan will require Medicaid beneficiaries to pay premiums amounting to 2% of their income in addition to other cost-sharing obligations.

Utah[3] and Tennessee[4] governors proposed alternative plans for Medicaid expansion that failed to gain legislative support. Pennsylvania originally obtained CMS approval for an alternative plan. Instead, with a newly elected democratic governor, the state is moving toward expanding the state's traditional Medicaid program.

Virginia remains one of the states yet to expand Medicaid. However, the legislature allocated nearly $104 million GF dollars to implement the Governor's Action Plan (GAP), which serves uninsured individuals living with mental illness.

Health Insurance Parity

Mental health parity refers to coverage of mental health and substance use services on the same terms and conditions as other types of medical care. Despite the existence of two federal laws that strengthen parity provisions for people with mental illness, enforcement challenges remain.[c]

California and New York are leading the nation in parity enforcement through legislation and litigation. Not far behind:

- Connecticut enacted SB 1085 clarifying that individual health plans must cover 'nervous conditions'. The state also requires that behavioral health be included in the health plan compliance survey and Consumer Report Card.

Rhode Island, Wyoming and Virginia recently enacted laws to bring state parity regulations into alignment with federal parity laws. Notably:

- Virginia's law (HB 1747) mandates the state Bureau of Insurance to require annual reports from insurers on denied claims, complaints and appeals involving mental health coverage.

States often find themselves footing the bill for psychiatric crisis services even for people with private insurance. To help remedy this:

- Louisiana enacted HB 307 prohibiting an insurer from issuing medical necessity denials for inpatient behavioral health services provided to a person admitted under an emergency certificate.

Health insurers resist additional coverage mandates, yet a few states enacted laws to ensure that parity provisions are applied to specific conditions. For example:

- Colorado (SB 15-015) and North Carolina (SB 676) enacted laws requiring autism services to be included in state mental health parity provisions.

- Missouri enacted SB 145 mandating coverage for eating disorders.

[c] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that was enacted requiring certain group health plans, if they provide mental health benefits, to do so on par with, or equivalent to, other medical-surgical benefits. The Patient Protection and Affordable Care Act of 2010, extended the reach of MHPAEA, applying it to most individual and small group plans, and some types of Medicaid plans. To learn more, please visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

Workforce

A critical nationwide shortage of mental health professionals[5] prevents children and adults from getting the mental health care they need, particularly in diverse and sparsely populated communities.[6] The acute nature of this shortage is giving rise to solutions such as telehealth, use of peer support specialists, integrated care and educational loan forgiveness.

Telehealth

Telehealth is a rapidly advancing technology that can deliver mental health expertise to underserved communities. Medicaid now reimburses for telehealth—in some form—in nearly all states.[7] Several states enacted laws to promote the use of telehealth.

- Washington (SB 5175) established criteria for health plans to reimburse for telehealth and telemedicine expenses.

- Tennessee enacted HB 699 to establish requirements and protections for healthcare providers delivering care through telehealth.

A lingering challenge is that telehealth providers may not be located in the same state as the patients they serve. Unfortunately, only 13 states and D.C. currently allows telehealth to be practiced across state lines.[8]

Peer and Family Support

The use of peer support specialists is an evidence-based, cost-effective way to enhance the mental health work force. Peer support specialists have lived experience with a mental health condition and are trained to provide support, guidance, and assistance navigating the mental health system. A few states enacted legislation supporting the development of peer specialists. For example:

- Minnesota passed HF 1535 allowing peer specialists to serve as case-manager associates. The law also requires the Commissioner of Human Services to study the role of peers in the mental health system and to make recommendations on how best to utilize peer specialists.

- Oklahoma enacted SB 713 that requires the Department of Mental Health and Substance Abuse Services to develop peer-supported drop-in centers for veterans in the state.

The use of family support specialists, also known as family navigators, is another promising practice that many states are beginning to utilize. Family navigators are family members of individuals with mental health conditions trained to provide support, education and care coordination. Most states provide Medicaid reimbursement for peer support services, but only a handful reimburses for family navigators.[9]

Integrated Mental Health and Primary Care

There is significant overlap between physical and mental health conditions. Studies show that up to 70% of all primary care visits involve a mental health concern[10] and nearly 68% of people with mental illness have chronic health conditions such as diabetes, hypertension or heart disease.[11] Yet, primary care providers often lack the training to diagnose and treat mental health conditions. Integrated care models that provide coordination between mental and physical health care improve quality of care, reduce costs and provide opportunities for training and collaboration among professionals.

A few states enacted laws to support integrated care models. For instance:

- Oregon enacted SB 832 to develop standards for integrating behavioral health and physical health services for patient-centered primary care homes and behavioral health homes.

- Arizona passed SB 1283 that develops standards for co-location of health care, behavioral health care or counseling service facilities.

Loan Repayment

Educational loan repayment is a long-standing, effective strategy to boost the mental health workforce in rural or minority communities. Emerging professionals benefit from student loan repayment in return for a post-graduate period of practice with an underserved population.[12]

- Nebraska passed LB 196 establishing a loan repayment program for medical residents who agree to serve Medicaid enrollees for one year in a designated health profession shortage area.

- Texas enacted SB 239 establishing student loan repayment for mental health professionals who agree to work in underserved communities.

- With passage of HB 71, Wyoming authorized loans for doctoral nursing degrees, the repayment obligation forgiven if the recipient teaches nursing at a Wyoming community college.

Children and Youth

Mental Illness often strikes early in life. Half of all mental illness emerges by the age of 14 and three quarters by age 24. Research shows that early identification and intervention can prevent mental health crises and prepare children to thrive. Despite this, in the United States, there is an average lag of 8 to 10 years between the onset of a mental health condition and the start of treatment. While nearly 1 in 5 American youth live with a mental health condition, less than half receive any services. During the 2015 legislative session, some states turned their attention to these critical issues.

In an effort to grasp the scope of the challenge, a number of state legislatures established study committees this year to assess the public children's mental health system. For instance:

- With passage of HB 422 Montana authorized an interim study committee on evidence-based practices for children's mental health and a pilot project to improve outcomes for youth in the children's mental health system.

Early Identification and Intervention

Mental health screening is a simple, effective strategy that can detect mental health conditions early and prevent them from engulfing children and their families. Yet, too few children receive this screening and early warning signs of mental health conditions often go undetected. Federal Medicaid law requires mental health screening as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, yet many states have struggled to comply with this mandate. In an effort to address these issues:

- Nebraska passed LB 240 which extended an initiative to require mental health screening for children as a routine part of primary care.

School personnel can also play an important role in identifying the early warning signs of a mental health condition. With training, educators can effectively communicate with families and help students get connected with services. Several states took steps to enhance early identification through schools. For example:

- Connecticut enacted SB 1053 which requires school-based health programs to include screening for behavioral or disciplinary problems.

- Illinois passed HR 478 that encourages schools to conduct mental health screening and to post information about mental health on their websites.

- With passage of SB 2048, North Dakota requires teachers to have mental health training as a component of licensure.

School Disciplinary Procedures

Students with mental or emotional conditions are more often subject to harsh discipline in school, including restraint and seclusion measures that have resulted in injuries and even death. Federal legislation on this issue has failed to gain any traction over the past 8 years. Several states have stepped into the breach with measures to address excessive disciplinary practices.

- Connecticut passed SB 927 that prevents the use of restraint or seclusion for non-emergency situations and requires teacher in-service training on restraint, seclusion and alternative de-escalation techniques.

- Kansas (HB 2170) and Virginia (HB 1443) also enacted bills regulating the use of seclusion and restraint in schools.

- Florida enacted SB 954 requiring school health services plans to include notification requirements when a student is removed from school, school transportation, or a school-sponsored activity for involuntary examination.

Intensive Services and State Custody

Many families struggle to find appropriate care and support for children with mental health conditions. Access to effective home and community-based services, including supportive wraparound services, can help ensure that children receive comprehensive care and treatment.[14] In a desperate search for services, some families have made the devastating decision to relinquish custody of their child to the state. Tragically, that is the only way a child can receive adequate treatment sometimes. In an effort to address this:

- Virginia enacted HB 2083 to create a process by which parents can refer at-risk children to multidisciplinary family assessment teams.

- Illinois passed HB 4096 allowing residential placement funds to pay for intensive in-home or community mental health services when clinically appropriate.

College Student Mental Health

Colleges across the country are reporting significant increases in the number of students with mental health conditions. Many college campuses are currently struggling to provide students with adequate supports and services.[15] In response to this, several states enacted bills to improve mental health services for students:

- Illinois enacted (HB 3599) requiring institutions of higher learning to give all students the opportunity to pre-authorize disclosure of certain private mental health information to a designated person.

- In Texas, HB 197 requires colleges to post mental health information on their websites, and SB 1624 requires post-secondary institutions to furnish students with information on early warning signs of suicide as well as available mental health and suicide prevention services.

- Virginia passed SB 1122 requiring college personnel to notify student health when a student demonstrates risk of suicide.

First Episode Psychosis: Early Intervention

Approximately 3 in every 100 people will experience psychosis during their lifetime. Psychosis is a symptom associated with several types of mental illness including schizophrenia, bipolar disorder, and certain types of major depressive disorder. Promising new studies, including Recovery After Initial Schizophrenia Episode (RAISE),[d] have shown that early intervention—particularly after a first episode of psychosis (FEP)—can dramatically improve outcomes for individuals living with these conditions.[16] FEP programs, like RAISE, emphasize community-based treatment, educational and vocational rehabilitation, family and peer support and individualized treatment protocols. Given the success of such programs, it is no surprise that programs throughout the country are replicating and investing in this model. For example:

- Minnesota (SF 1458) appropriated $260,000 to establish a program to provide evidence-based services for youth experiencing first episode psychosis.

Congress has also required states to use 5% of the 2015 and 2016 Mental Health Block grant to encourage the adoption of FEP programs.

[d] RAISE is a multi-site study sponsored by the National Institute of Mental Health (NIMH). For more information http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml

Inpatient and Crisis Care

Crisis response and acute inpatient psychiatric services are essential to the continuum of mental health care. State investment in a well-coordinated, comprehensive mental health system that includes appropriate crisis response services helps to ensure that people with mental health conditions have access to the services and supports they need.

Psychiatric Bed Tracking

In recent years, the number of beds available in state psychiatric hospitals has significantly decreased. During the recession, many states made drastic cuts to SMHA budgets, including funding to state psychiatric hospitals. In most states, psychiatric inpatient beds are available in a combination of private and public hospital settings. This multi-tiered system can make it difficult to track the availability of inpatient psychiatric beds. In some states, inpatient capacity is inadequate to meet the demand. These factors lead to long wait times, emergency room boarding or unnecessary justice system involvement for people experiencing acute psychiatric crises. In an attempt to address these difficult issues:

- Virginia passed HB 2118, which strengthens the state's inpatient psychiatric bed tracking system. It requires all public and private inpatient and crisis stabilization facilities to report on bed availability at least once daily.

Even state officials acknowledge that the tracking system is only a partial solution to the need for inpatient capacity. However, the practice of matching bed demand to supply in real-time will hopefully pinpoint the gaps.

Crisis Response System

Coordinated crisis response systems are necessary to intervene effectively and make appropriate use of inpatient services. Recognizing this:

- Minnesota (SF 1458) budgeted $8 million to create a statewide crisis line, establish a statewide pool of experts, expand mobile crisis services, develop state standards and fund crisis beds. The provision also requires private health plans to cover mental health crisis services under the emergency services category.

Outcome data is critical to monitoring system effectiveness. In an effort to improve data collection:

- Maryland passed HB 367 requiring the state crisis response system to evaluate service outcomes on an annual basis. Reported data must include: behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations, hospital diversions, arrests, detentions, and diversion of arrests and detentions of individuals with behavioral health diagnoses.

Civil Commitment and Court-Ordered Treatment

The majority of Americans living with mental health conditions do not have access to adequate treatment. In fact, only about 41% of adults and just over half of children with mental health conditions received any mental health care over the past year. Many states and communities lack a comprehensive array of effective services and supports leading to people with mental illness experiencing crises that land them in hospitals, jails, prisons and on the streets. In response, many state legislatures enact civil commitment legislation.

Inpatient Commitment

Reflecting the country's mental health workforce shortage, a number of states passed legislation this year permitting psychiatric advanced nurse practitioners or physician's assistants to play a role in the civil commitment process. For example:

- North Dakota enacted HB 1040 that authorizes advanced practice nurse practitioners and physician's assistants to participate in involuntary commitment proceedings and continuing treatment petitions.

In a response to long wait times:

- Virginia enacted HB 2368 which directs the Commissioner of Behavioral Health and Developmental Services to review the state's current practices for conducting emergency evaluations for involuntary admissions and, where appropriate, to develop a system for expending such reviews.

Outpatient Commitment[e]

A few states enacted legislation that clarified procedures to be followed for outpatient commitment. For example:

- Hawaii passed SB 961 to modify hearing procedures for assisted community treatment.

- Washington enacted HB 1450 to refine the state's involuntary assisted outpatient treatment provisions.

Transportation to Civil Commitment

In many states, law enforcement is responsible for transportation to civil commitment. Fortunately, at least a few states have recognized that such an arrangement is not appropriate and have moved to provide alternatives. For example:

- Virginia enacted HB 1693 to permit a magistrate to authorize alternative transportation for an individual subject to an emergency custody order or temporary detention order.

[e] Outpatient commitment or assisted outpatient treatment (AOT) refers to mental health law that allows an individual to be court ordered to participate in a specified community-based mental health treatment plan for a designated period as a condition of remaining in the community.

Criminal Justice

Each year, people slip through the cracks of our disjointed mental health system. Without access to appropriate care, many end up trapped in the revolving door of the criminal justice system. Nearly 2 million people with mental illness are detained in jails across the United States.[18] Over half of inmates in the nation's jails and prisons[19] and at least 65% of youth[20] involved in the criminal justice system have a mental health condition.

Despite these grim facts, there is some cause for hope. With jail and prison populations at a historic high, there is recognition that the current approach is not working. Lawmakers and criminal justice experts are joining together to develop alternatives to incarceration and to improve mental health services for individuals involved in the justice system. The nationwide *Stepping Up Initiative*[21] was launched this year to reduce the number of people with mental health conditions in county jails. County and state governments across the county are working together with various stakeholders to improve outcomes.

Law Enforcement

In the absence of adequate crisis response systems, law enforcement officers have increasingly become default first responders to mental health crises. Crisis Intervention Teams (CIT) are programs designed to improve emergency responses to people in mental health crisis and ensure people in crisis get transferred to mental health services, not jail. CIT programs bring together law enforcement, mental health professionals and individuals and families affected by mental illness to coordinate services, problem-solve and provide comprehensive training to law enforcement. Recognizing the challenges facing law enforcement officers, many states have begun to invest in training and programs like CIT. For example:

- Indiana enacted SB 380 that directs the Indiana Criminal Justice Institute to establish a CIT Technical Assistance Center (TAC). The TAC will be responsible for creating a statewide CIT advisory committee, providing technical assistance to local CIT coalitions, and identifying grants and other sources of funding for CIT training. In addition, SEA 380 directs the Indiana Law Enforcement Academy to provide an overview of CIT in Indiana to all trainees.

- With passage of HB 4112, Illinois mandates a standard certified training program in crisis intervention addressing specialized policing responses to people living with mental illness.

- Maryland passed SB 321 requiring Baltimore city and county police officers to create behavioral health units consisting of a minimum of six officers trained to understand mental health conditions, substance use disorders and co-occurring conditions.

Judiciary

Mental health courts are nontraditional programs designed to meet the specific needs of people with mental health conditions. Given the large numbers of people with mental illness involved in the criminal justice system, more states are establishing such programs. For example:

- South Carolina passed S 426 that created a mental health court designed to divert people with mental health conditions to appropriate treatment programs, rather than incarceration.

- Arizona enacted HB 2310 that permits superior court judges in certain counties to establish mental health treatment courts and to refer cases to those courts.

Alternative sentencing—which can include practices such as fines, restitution and alternatives to incarceration—is gaining momentum across the nation as states seek a way to reduce incarceration. For a number of years, New Jersey, New York, and California have led the nation in alternative sentencing, driving down prison populations by about 25% while simultaneously reducing crime rates.[22] This year a few states applied alternative sentencing specifically to inmates with mental health or substance use disorders.

- With enactment of SB 219, California specifies that female inmates in state prison cannot be excluded from voluntary alternative custody solely on the basis of a psychiatric condition.

- With passage of SB 578, Texas provides for alternatives to incarceration for non-violent offenders with a mental health condition and/or substance use disorders.

- Utah passed HB 348 requiring the state mental health agency to evaluate the benefits and costs of treatment as an alternative to incarceration.

Incarceration and Re-Entry

Jails and prisons are ill-equipped to provide mental health services. The vast majority of inmates in prison and jails do not receive mental health services and those who do rarely receive comprehensive services necessary for recovery.[23] Several states enacted legislation to improve mental health services during incarceration and upon release. For instance:

- New Jersey passed S 2380 that requires the Commissioner of Human Services and Corrections to provide prison-based mental health and substance use disorder programs.

- Indiana enacted HB 1269 that designates the Department of Corrections or the Sheriff as an inmate's personal representative in applying for Medicaid and securing necessary treatment at the time of discharge.

Juvenile Justice

Several states have begun investing in early intervention programs and diversion programs for justice-involved youth with mental health conditions. For example:

- Louisiana passed HB 292 that requires juvenile justice diversion programs to follow a model that facilitates coordination between homes, schools, social service agencies and the legal system to identify youth who may be exhibiting mental health issues and to help provide early intervention.

Finally, states have also enacted laws that limit the shackling and restraining of juveniles during court proceedings. For example:

- Utah enacted SB 167 that prohibits the use of shackles when youth are appearing in court unless so ordered by the court.

Suicide Prevention

Each year over 40,000 Americans lose their lives to suicide.[24] The statistics are alarming. Suicide is the tenth leading cause of death in the United States and the second leading cause of death among young adults ages 15-24. Each day between 18 and 22 veterans die by suicide.

Research tells us that with appropriate training, education and outreach, suicide is often preventable. Nearly 90% of people who die by suicide have an underlying mental health condition, yet the American Association of Suicidology reports that many mental health professionals do not have appropriate training in suicide intervention.[25] In response to this, several states enacted legislation mandating training for mental health professionals. For example:

- New Hampshire passed SB 33 requiring mental health practitioners to receive at least three hours of continuing education training in suicide prevention, intervention, or postvention as part of the biennial license renewal procedure.
- Utah enacted HB 209 that requires certain behavioral health providers to receive at least two hours of suicide prevention training in order to obtain or renew a license.

For children who spend nearly seven hours each day in a school setting, training school staff in suicide prevention and awareness can lead to recognition, awareness, and intervention that saves lives. In response to this, several states also passed legislation that supports suicide prevention training for school staff. For example:

- In North Dakota, SB 2209 requires school districts to provide annual suicide prevention training to all middle school and high school instructional staff, teachers, and administrators.
- In Pennsylvania, HB 1559 encourages public schools to require faculty to complete at least 4 hours of professional development in suicide awareness every 5 years.

Housing and Employment

Stable housing and meaningful employment are central components of recovery for millions of Americans living with mental illness. Research has repeatedly shown that investment in supportive housing and employment services not only enhances recovery, it saves states money that is otherwise spent on crisis services, homeless services, and criminal justice systems.

Hundreds of thousands of people with mental health conditions in the United States remain trapped in a cycle of homelessness and poverty.[26] Hundreds of thousands more remain isolated in large group residential settings.[27] To address these issues:

- Arizona passed HB 2488 that created a housing trust fund to provide rental assistance for individuals with mental illness.

- Washington State enacted HB 2263 which included a local option sales and use tax that could be used to fund housing and related services.

People with mental illness are unemployed and underemployed at rates far higher than their counterparts.[28] Though supported employment programs have shown tremendous promise in helping people with mental illness find and retain employment,[29] less than 2% of people served by the SMHAs have access to these services.[30] In response to this need:

- Minnesota passed HF 3 which included additional funding for supported employment programs that were established in 2014.

- Minnesota also enacted SF 1458 that would permit accredited Clubhouse programs—which include employment services—to be reimbursed with Medical Assistance dollars.

Conclusion

There has been a great deal of rhetoric in recent years about the broken mental health system in America and the need to invest in services that work in helping people living with mental illness to recover and reach their full potentials. Unfortunately, the response of states, as illustrated in this report, has been uneven at best. Some states have increased funding for mental health services and passed legislation to ensure that these funds are invested in the most effective services. Other states are treading water or are even taking backwards steps by cutting mental health funding. It is particularly distressing that more states cut funding for mental health services in 2015 than in the previous two years. When mental health services are cut, the inevitable consequences are more spending on homelessness, criminal justice and crisis services. It is time for all states to invest in recovery.

Recommendations

Medicaid and Medicaid Expansion

Recommendations:

- States should expand Medicaid and include all mental health care benefits that are available in traditional Medicaid. Recipients with mental illness should be exempt from cost-sharing requirements.
- States should ensure Medicaid reimbursement for electronic, video and telephonic consultation of primary care with mental health and substance use treatment providers and mental health and substance use care with primary care providers.
- States should recognize and accept licensure across state lines for mental health professionals.

Health Insurance Parity

Recommendations:

- States should require health plan transparency regarding mental health benefits, medical necessity criteria for mental health, substance use and primary care, out-of-pocket costs, provider networks for mental health and substance use and consumer protections.
- States should regularly audit insurers for parity compliance rather than relying on a complaint-driven process.

Early Intervention

Recommendations:

- States should promote early identification and intervention for children's mental health conditions through primary care and schools.
- States should provide wraparound services for children with serious mental health conditions.
- States should invest in the First Episode Psychosis program (FEP) coordinated specialty service array to empower young people experiencing psychosis to achieve their potential.

Inpatient and Crisis Care

Recommendations:

- States should ensure 24/7 psychiatric response services with mobile crisis response teams or crisis response specialists, crisis stabilization units and respite services.
- States should require real-time tracking of psychiatric bed and crisis stabilization availability and require collection and reporting on emergency department wait times for people experiencing psychiatric crises and response times for psychiatric crisis response services.

Criminal Justice

Recommendations:

- States should ensure that all local enforcement agencies have a well-trained Crisis Intervention Team (CIT) program.
- States should ensure statewide availability of mental health and substance use treatment courts and veteran treatment courts that provide effective alternatives to sentencing.
- States and counties should collaborate with community stakeholders to reduce the number of people with mental illness in jail.

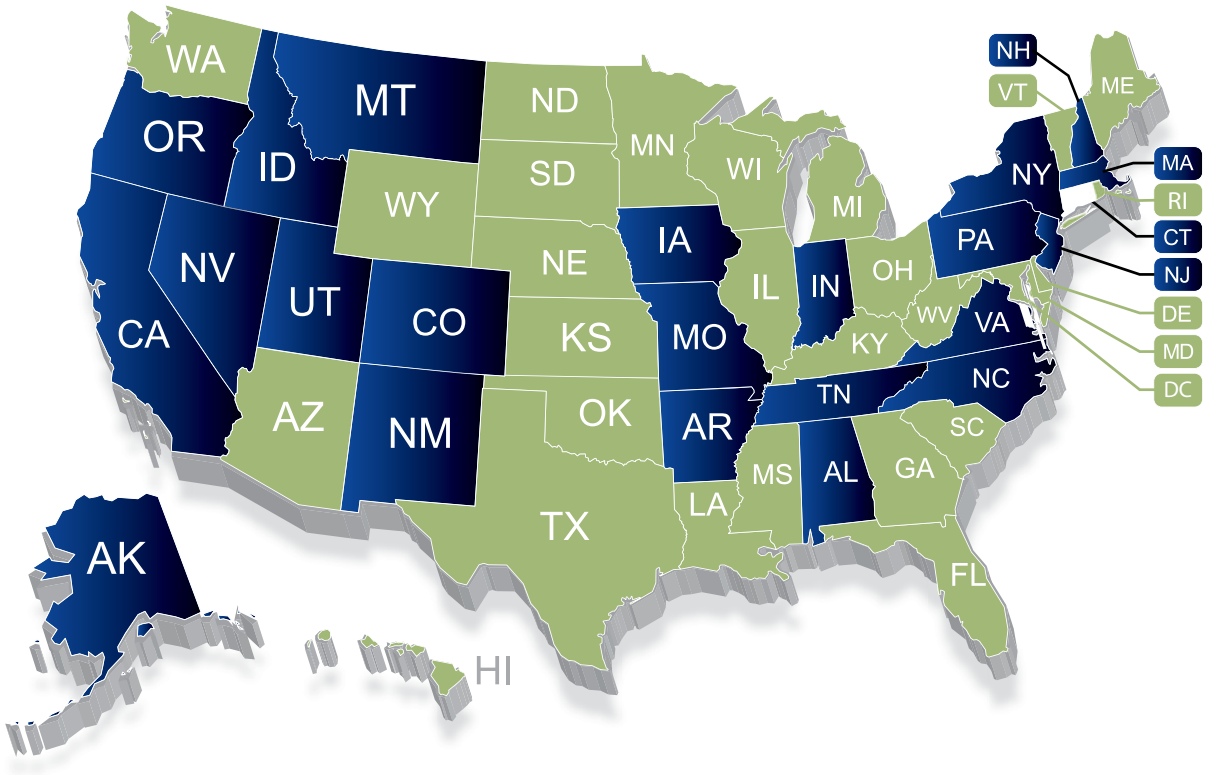
[1] Mental health funding turns corner. (2015, April 16) The Olympian http://www.theolympian.com/opinion/editorials/article26121673.html
[2] SAMHSA (2013) Enrollment under Medicaid Expansion and Insurance Exchanges, a focus on those with behavioral health conditions in Montana. https://store.samhsa.gov/shin/content/PEP13-BHPREV-ACA/NSDUH_state_profile_Montana_508_final_extra.pdf
[3] Lisa Riley Roche (2015, Oct. 13) Latest version of Medicaid expansion fails to win House, Senate support. Deseret News. http://www.deseretnews.com/article/865638979/Latest-version-of-Medicaid-expansion-fails-to-win-House-Senate-support.html?pg=all
[4] Andy Sher (2015, June 30) Insure Tennessee supporters renew push for Medicaid expansion. Chattanooga Times Free Press http://www.timesfreepress.com/news/local/story/2015/jun/30/insure-tennessee-supporters-renew-push-medica/312173/
[5] U.S. Department of Health & Human Services, Health Resources and Services Administration (HRSA), (2011, Sept. 2) Designated Health Professional Shortage Areas (HPSA) Statistics http://bhpr.hrsa.gov/shortage/hpsas/updates/09012011mentalhpsas.html
[6] SAMHSA (2013) Report to Congress on the nation's substance use and mental health workforce issues. https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf
[7] Thomas, L; Capistrant, G; (May, 2015) State Telemedicine Gaps Analysis. American Telemedicine Association P.66 http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis--physician-practice-standards-licensure.pdf?sfvrsn=14
[8] Ibid.
[9] Center for Health Care Strategies, Inc. (May, 2012) Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs http://www.chcs.org/media/FYPS_Matrix.pdf
[10] Collins, C; Levis Hewson, D; Munger, Wade, T; (2010) Evolving models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund. P.1 http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf
[11] Substance Abuse and Mental Health Services Administration, Can We Live Longer? (Infographic), http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf (Accessed Nov. 13, 2015).
[12] Rural Iowa Primary Loan Repayment Program https://www.iowacollegeaid.gov/content/rural-iowa-primary-loan-repayment-program (Accessed Nov. 8, 2015)
[13] Turner, W., National Health Law Program, Health Advocate, Early Periodic Screening and Diagnosis and Treatment, (2013), http://www.healthlaw.org/publications/health-advocate-epsdt#.VjxGt6QZ0bs
[14] Burchard, J. D., Bruns, E.J.,& Burchard, S.N. (2002). The Wraparound Process. In B. J. Burns, K. Hoagwood, & M. English. Community-based interventions for youth. New York: Oxford University Press. http://depts.washington.edu/wrapeval/wrapdef.html.
[15] NAMI, College Students Speak: A Survey Report on Mental Health (2014), https://www.nami.org/About-NAMI/Publications-Reports/Survey-Reports/College-Students-Speak_A-Survey-Report-on-Mental-H.pdf
[16] National Institutes of Mental Health, Raise Project Overview, http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml (Accessed Oct. 5, 2015)
[17] Leys, T. (2015, July 20) Registry aims to ease search for mental health care. The Des Moines Register. http://www.desmoinesregister.com/story/news/health/2015/07/19/iowa-launch-psychiatric-bed-tracking-system/30393113/
[18] Subramanian R., Delaney R. Roberts S., Fishman N., McGarry P. (2015). "Incarceration's Front Door: The Misuse of Jails in America" Vera Institute of Justice 4 http://www.vera.org/sites/default/files/resources/downloads/incarcerations-front-door-report.pdf
[19] James, D, and Glaze, L. (2006). "Mental health problems of prison and jail inmates. US Department of Justice, Bureau of Justice Statistics." Bureau of Justice Statistics Special Report.
[20] National Center for Mental Health and Juvenile Justice (2014) "Better Solutions for Youth With Mental Health Needs in the Juvenile Justice System" Mental Health and Juvenile Justice Collaborative for Change Technical Assistance and Training Paper. http://cfc.ncmhjj.com/wp-content/uploads/2014/01/Whitepaper-Mental-Health-FINAL.pdf
[21] The Stepping Up Initiative, https://stepuptogether.org/
[22] Mauer, M; Ghandnoosh, N. (2014) Fewer Prisoners, Less Crime: A Tale of Three States, The Sentencing Project. http://sentencingproject.org/doc/publications/inc_Fewer_Prisoners_Less_Crime.pdf
[23] James, D, and Glaze, L. (2006). "Mental health problems of prison and jail inmates. US Department of Justice, Bureau of Justice Statistics." Bureau of Justice Statistics Special Report.
[24] American Foundation for Suicide Prevention: https://www.afsp.org/understanding-suicide/facts-and-figures (Accessed Sept. 5, 2015)
[25] William M. Schmitz et al., Preventing Suicide Though Improved Training in Suicide Risk Assessment and Care: An American Academy of Suicidology Task Force Report Addressing Serious Gaps in Mental Health Training, http://www.intheforefront.org/sites/default/files/articles/AAStaskforcearticle.pdf. (Accessed Nov. 7, 2015)
[26] U.S. Department of Housing and Urban Development, HUD's 2014 Continuum of Care Homeless Assistance Population: Homeless Populations and Subpopulations, https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatlTerrDC_2014.pdf (Accessed Oct. 7, 2015)
[27] Judge David L. Bazelon Center for Mental Health Law (2014), A Place of My Own: How the ADA is creating Integrated Housing Opportunities for People with Mental Illness, http://www.bazelon.org/portals/0/Where%20We%20Stand/Community%20Integration/Olmstead/A%20Place%20of%20My%20Own.%20Bazelon%20Center%20for%20Mental%20Health%20Law.pdf.
[28] Stuart, H (2006) Mental Illness and Employment Discrimination. Curr Opin Psychiatry. 2006;19(5):522-526. http://www.medscape.com/viewarticle/542517_2
[29] Cook, J, et al (2008) Effectiveness of Supported Employment for Individuals with Schizophrenia: Results of a Multi-Site, Randomized Trial http://www.psych.uic.edu/eidp/EIDP.%20Clinical%20Schizophrenia%20article.pdf
[30] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Service, Administration, Center for Mental Health Services, 2012 CMHS Uniform Reporting System Output, Tables 1.

Appendix 1: State Mental Health Budgets

State Mental Health Authority Budgets 2013-2015

State	2013	2014	2015
Alabama	Maintain	Increase	Maintain
Alaska	Decrease	Decrease	Decrease
Arizona	Increase	Increase	Decrease
Arkansas	Increase	Decrease	Decrease
California	Increase	Increase	Maintain
Colorado	Increase	Increase	Increase
Connecticut	Increase	Increase	Increase
Delaware	Increase	Increase	Increase
District of Columbia	Increase	Increase	Decrease
Florida	Maintain	Increase	Increase
Georgia	Increase	Maintain	Increase
Hawaii	Increase	Decrease	Maintain
Idaho	Increase	Increase	Increase
Illinois	Increase	Maintain	Pending
Indiana	Maintain	Maintain	Increase
Iowa	Increase	Increase	Decrease
Kansas	Increase	Increase	Decrease
Kentucky	Increase	Decrease	Decrease
Louisiana	Decrease	Decrease	Maintain
Maine	Decrease	Increase	Increase
Maryland	Increase	Increase	Maintain
Massachusetts	Increase	Maintain	Increase
Michigan	Increase	Decrease	Maintain
Minnesota	Increase	Increase	Increase
Mississippi	Increase	Maintain	Maintain
Missouri	Increase	Increase	Maintain
Montana	Increase	Maintain	Increase
Nebraska	Decrease	Decrease	Increase
Nevada	Increase	Maintain	Decrease
New Hampshire	Increase	Increase	Increase
New Jersey	Increase	Increase	Increase
New Mexico	Maintain	Increase	Increase
New York	Maintain	Increase	Increase
North Carolina	Decrease	Decrease	Decrease
North Dakota	Maintain	Maintain	Decrease
Ohio	Increase	Increase	Decrease
Oklahoma	Increase	Increase	Maintain
Oregon	Increase	Maintain	Increase
Pennsylvania	Maintain	Increase	Pending
Rhode Island	Increase	Decrease	Maintain
South Carolina	Increase	Increase	Increase
South Dakota	Increase	Increase	Increase
Tennessee	Increase	Maintain	Maintain
Texas	Increase	Maintain	Increase
Utah	Increase	Increase	Maintain
Vermont	Increase	Increase	Maintain
Virginia	Increase	Increase	Increase
Washington	Increase	Increase	Increase
West Virginia	Maintain	Increase	Increase
Wisconsin	Increase	Increase	Maintain
Wyoming	Decrease	Decrease	Decrease

Appendix 2: Medicaid and Medicaid Expansion



	State	Medicaid Expansion
★	AK	Although Gov. Walker's bills (SB 78/ HB 148) in House and Senate failed in the legislature, he announced expansion by executive order on 7/16/2015. http://www.nytimes.com/2015/07/17/us/over-objections-of-legislature-alaska-governor-bill-walker-says-he-will-expand-medicaid.html?_r=0. Opposition expected from legislature.
⚑	AR	Gov. Hutchison is terminating coverage for 35,000 Medicaid recipients, most enrolled in the "Private Option" Medicaid expansion program. The termination process is suspended while DHS addresses a processing backlog. http://www.thv11.com/story/news/politics/2015/08/04/governon-hutchinson-suspends-medicaid-terminations/31123043/
	IN	Indiana expanded Medicaid in February 2015 through a 1115 demonstration waiver - known as the Healthy Indiana Plan (HIP). While HIP does require cost-sharing and limits some "non-essential" services, enrollees designated as "medically frail" will be exempt from any lockout of coverage and will have access to dental, vision and non-emergency medical transportation, regardless of whether POWER Account contributions are made. http://www.namiindiana.org/news-and-updates/hip20-whatyouneedtoknow
	MT	SB 405 creates the Montana Health and Economic Livelihood Partnership (HELP) program to expand health care coverage to additional individuals, improve access to mental health care services, improve the readiness of program participants to enter the workforce or obtain better-paying jobs, and control health care costs. Establishes a Health Care Coverage Program to provide certain low-income Montanans with access to health care services using Medicaid funds and arrangement with a third-party administrator.

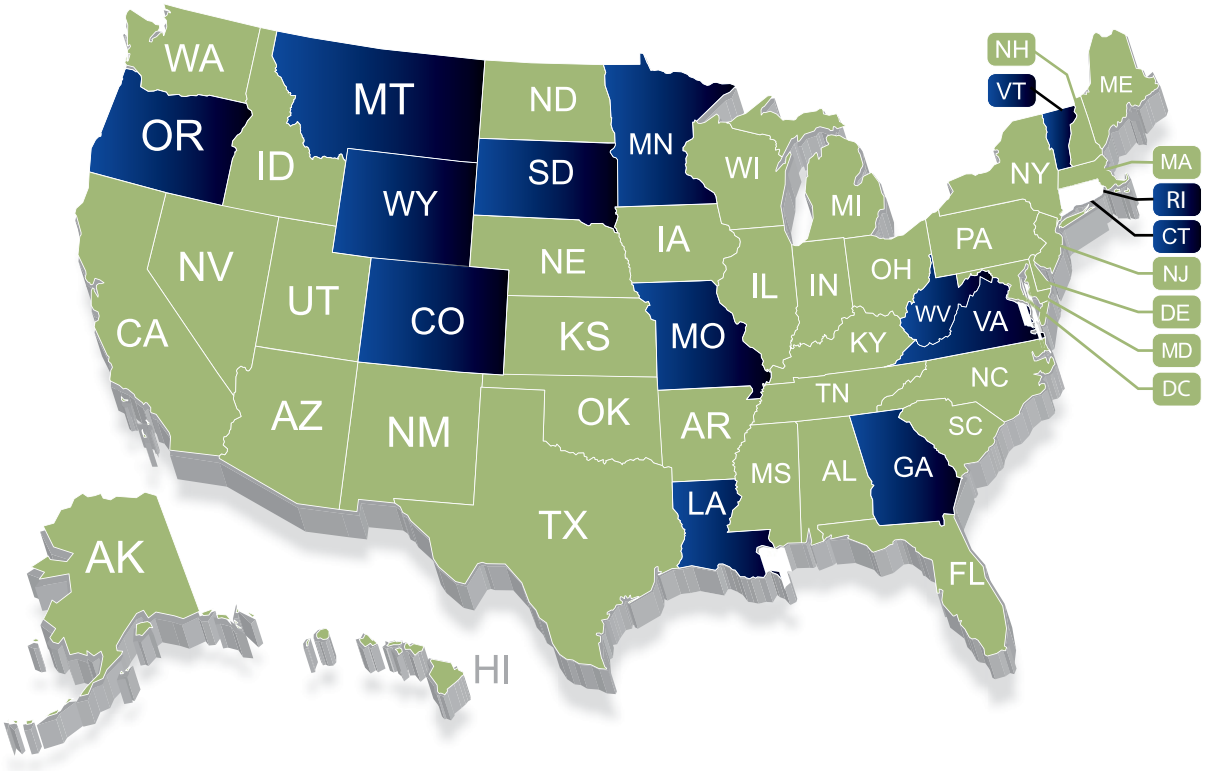
State	Medicaid Expansion
NH	**Defeated:** SB 185, intended to extend Medicaid expansion beyond the sunset date of 12/31/16, died in the Senate. The state is functioning on a 6-month temporary spending plan after the Governor Hassan and the legislature failed to agree on a budget.
PA	Per Governor Wolf, the alternative expansion program, Healthy PA, will be transitioned to a standard Medicaid expansion approach by 9/1/15.
TN	**Defeated:** The Legislature defeated Governor Haslam's Insure Tennessee proposal for Medicaid expansion during a special session. Several subsequent bills in the regular session also failed.
UT	**Defeated:** The legislature voted down a framework for an alternative Medicaid expansion strategy that would require hospitals, doctors and pharmaceutical companies to cover the state share of expansion costs. http://www.sltrib.com/home/2742096-155/breakthrough-utah-gop-leaders-reach
VA	For FY 2016, the legislature allocated $104 million in GF dollars to implement the Governor's Access Plan (GAP) that provides services for uninsured adults with mental illness under an 1115 waiver.

State	Medicaid Restructuring/Managed Care
AL	Medicaid enrollees are being moved from fee-for-service to capitated managed care.
CO	Proposed State Plan Amendment (CO-14-049) would remove the 45 day annual limit on adult psychiatric services in general hospitals.
CT	The state is implementing a State Innovation Model (SIM) process to produce an actionable plan of a health delivery and payment system reform (Medicaid and beyond) that coordinates care and shares savings with providers. The proposed model builds upon existing health reform efforts including medical home, accountable care organization (ACO) and primary care/behavioral health integration initiatives. Advocates are urging the establishment of safeguards for vulnerable populations to ensure that the risk of under-service and barriers to services will be minimized.
IA	A State Plan Amendment (IA-14-013) establishes reimbursement for services from non-state Psychiatric Medical Institutions for Children (PMICs) through the use of provider-specific per diem rates, consistent with the Iowa Plan for Behavioral Health.
ID	After hearing citizen testimony, the Idaho Joint Legislative Oversight Committee voted unanimously to have the Office of Performance Evaluation (OPE) conduct an extensive evaluation of the Medicaid Optum (MBHO) contract and mental health service provision. OPE must report to the Legislature prior to 2016 session.
IN	The presumptive eligibility (PE) process changed 4/1/2015. New provider types (including CMHCs) are now qualified to make PE determinations. This will be helpful for uninsured individuals who are trying to immediately access mental health or addictions services. While Medicaid Rehabilitation Option services are not included during the PE coverage period, individuals at least have access to basic Medicaid services.
NC	SB 423 Requires the Department of Health and Human Services, Division of Medical Assistance, to design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance in home and community-based settings. Allows the Department to submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly. Requires the Department to report the draft waiver, other findings and any other options or recommendations to best serve children with Serious Emotional Disturbance to the Joint Legislative Oversight Committee on Health and Human Services.
NC	HB 372/SB 574 enacts Medicaid reform with a blend of Managed Care Companies and locally owned Provider Led Entities (PLE).
NJ	Mental health and substance use services are carved out of Medicaid managed care. The payment mechanism is shifting from grant-based payments to fee for service. http://www.njspotlight.com/stories/15/04/30/state-shifts-way-it-pays-for-medicaid-mental-health-addiction-treatments/

State	Medicaid Restructuring/Managed Care
NM	Controversy continues stemming from a CMS audit performed in 2012 which found that 15 CMHCs overbilled Medicaid by a total of $36 million. In June 2013, State Medicaid payments to 15 CMHCs were frozen. An Arizona provider was contracted to provide services to the CMHC Medicaid population. http://www.santafenewmexican.com/news/health_and_science/records-show-feds-accused-state-firms-of-overbilling-medicaid-m/article_0c025962-dc90-5c13-8c0b-c4453971780d.html
NV	Nevada expanded Medicaid in January 2014. Patients awaiting SSI determinations became immediately eligible for and enrolled in Medicaid managed care. This shifted the cost and care from state funded mental health services to Medicaid-funded support. At this point, it is unclear whether adequate access to Medicaid mental health services is being provided through managed care. Medicaid was allowed by CMS to pay IMDs for adult inpatient services through Medicaid managed care based on the "in lieu of" provision.
NY	An 1115 waiver transitions the mental health and substance abuse population to Medicaid managed care. An allocation of $115 million is earmarked for the transition. Individuals with serious mental illness will be enrolled in Health and Recovery Plans (HARP) to provide integrated care through health homes.

State	Bill	Chapter	Description
CA	SB 36	Ch. 759	Existing law provides for a demonstration of better care coordination for seniors and persons with disabilities and maximizes opportunities to reduce the number of uninsured individuals. This bill would require a CMS waiver application that, among other things, continues the state's momentum and successes in innovation. The bill requires the department to consult with stakeholders and the legislature.
ID	HB 298	Ch. 301	Creates reimbursement methodology for adolescent inpatient services provided by a private, freestanding mental health facility. Allows these facilities to provide services to more adolescents with mental health issues. By revising the reimbursement, a greater number of authorized adolescents can be treated in an environment that is more conducive and safer, thus promoting quality mental health services.
MA	S. 578		**Pending:** Would require MassHealth (Medicaid) to cover mental health certified peers specialists services who have completed training as certified by the Department of Mental Health.
MO	SB 210		Extends the sunset on Missouri Medicaid healthcare provider reimbursement allowance taxes. The MO HealthNet division will not recover disproportionate share hospital audit recoupments from any tier 1 safety net hospital, excluding Department of Mental Health state operated psychiatric hospitals.
MT	SB 216		Establishes fraud prevention training, education and fiscal accountability requirements for certain Medicaid in-home care services that include people with development disabilities, chronic mental illness, emotional disturbance and in those in need of mental health supportive services, brain injuries, chemical dependency and lists services.

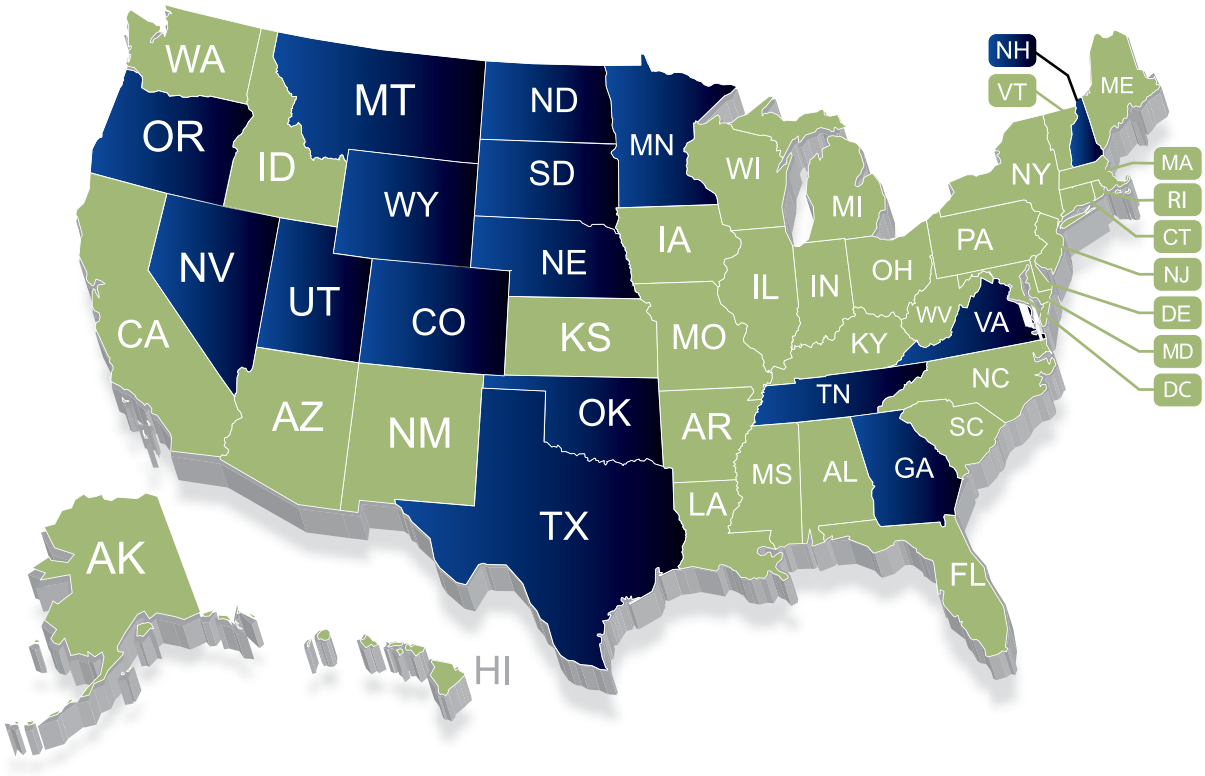
Appendix 3: Health Insurance Parity



	State	Bill	Chapter	Description
★	CO	SB 15-015		Includes autism spectrum disorders (ASD) in the state's mental health parity law. Repeals a provision specifying that autism is not to be treated as a mental illness for purposes of health care coverage. Clarifies that health benefit plans must include health care benefits for ASD that are no less restrictive than benefits available for physical illness.
★	CT	SB 1085	Ch. 15-266	Clarifies that health policies are required to cover mental or nervous conditions including (1) general inpatient hospitalization and outpatient hospital services; (2) psychiatric inpatient hospitalization and outpatient hospital services; (3) intensive outpatient services; and (4) partial hospitalization.
	GA	HB 429	Act 31	Provides that no health benefit plan shall restrict coverage for prescribed treatment based upon the insured's diagnosis including terminal conditions and pediatric autism; provides for definitions, penalties and repeals conflicting laws.
★	LA	HB 307	Ch. 390	Prohibits an insurer from denying payment for inpatient behavioral health services provided to a person admitted under an emergency certificate on the basis of medical necessity.
★	MN	SF 1458	Ch. 71	Requires health plans to cover mobile mental health crisis services under the emergency services category. Appropriates $8 million over FYs 2016 and 2017 to fund mental health crisis services. Requires the Department of Human Services to create one phone number for crises, establish a statewide pool of experts, expand crisis services across the state, establish and implement state standards, and fund crisis beds.
★	MO	SB 145		On or after 1/1/2017, requires health benefit plans to provide coverage of eating disorders, including a broad array of specialist services based on medical necessity. Medical necessity determinations and care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with the eating disorder and shall not be based solely on weight.

State	Bill	Chapter	Description
OR		Rule	A state Insurance Division parity rule was updated to provide consumers with an improved process to appeal insurance coverage denials for mental health care on par with other medical conditions. Also requires insurers to provide explicit disclosures and documentation to enable consumers to understand the reason for a denial.
RI	SB 2801 2014	Ch. 108	Conforms Rhode Island law to the Mental Health Parity and Addition Equity Act (MHPAEA). Enacted in 2014.
SD	SB 1088		Permits procurement of certain disability insurance from a non-admitted insurer.
VA	HB 1747	Ch. 649	Conforms coverage for mental health and substance use disorders to MHPAEA. Requires group and individual health insurance coverage to provide mental health and substance use disorder benefits. Benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the Act, even where those requirements would not otherwise apply directly. Requires the Bureau of Insurance to develop reporting requirements regarding denied claims, complaints and appeals involving such coverage and to report the information annually.
VT	SB 139	Act 54	Requires the Agency of Human Services to evaluate the services offered by each entity licensed, administered or funded by the State to provide services to individuals who have mental health needs or substance use disorder and determine areas in which there are gaps in services. The Director of Health Care Reform in collaboration with the Green Mountain Care Board and Department of Financial Regulation shall evaluate the necessity of maintaining provisions requiring health insurance companies to submit materials related to mental health quality assurance.
WV	SB 366	Ch. 182	Creates the Patient Protection and Transparency Act which requires information to be given to and provides protections for persons who purchase insurance through the WV Health Benefit Exchange or an exchange website operated by the federal government. Specifies what information needs to be publicly available on the health exchange website, including: The names of the physicians, hospitals and other health care providers that are in network; a list of in network specialists; etc.
WY	HB 0057		Promotes insurance parity between mental health/substance use and medical/surgical benefits.
WY	SF 0064		The Wyoming Health Insurance Pool (WHIP) Act established an insurance program for people who cannot afford health insurance due to pre-existing conditions. This bill extends the program, but also allows the Insurance Commissioner more flexibility in denying people coverage.

Appendix 4: Workforce

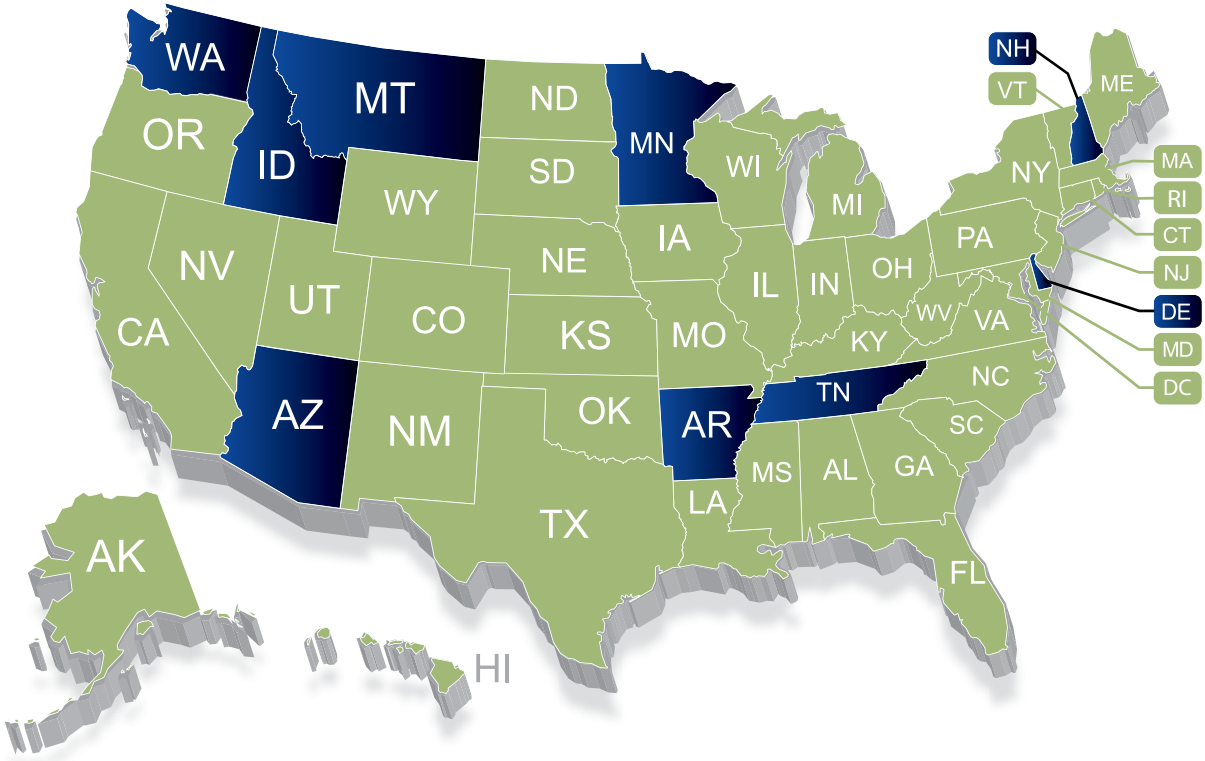


State	Bill	Chapter	Description
CO	HB 15-1032		Under current law, a professional person may render mental health services to a minor who is at least 15 years of age with the minor's consent. "Professional person" includes a person licensed to practice medicine or psychology. This new law allows other licensed mental health professionals, namely, licensed social workers, marriage and family therapists, professional counselors and addiction counselors, to render mental health services to minors in any practice setting.
GA	SB 53		Extends sunset allowing Licensed Professional Counselors to sign forms for authorizing transport to an Emergency Receiving Facility (ERF) to June 30, 2018.
MN	HF 1535	Ch. 78	Peer specialists can now be case manager associates. The commissioner of human services, with input from stakeholders, must also study and report on how peer specialists are used in the mental health system. It will include an assessment of the use of certified peer specialists within existing resources, an evaluation of the benefits of using certified peer specialists in hospital settings and intensive residential treatment services (IRTS), an analysis of the existing duties of certified peer specialists, options for expanding their duties and the benefits of expanding their duties, methods for obtaining reimbursement for services they provide, an analysis of the cost of expanding reimbursement and any necessary proposed legislation. In assessing the use of certified peer specialists in hospital settings and IRTS, the commissioner shall make recommendations on how to obtain reimbursement for wraparound services by these specialists and warm handoffs to community services that facilitate the successful transition of persons with mental illness to the next level of care.
MN	SF 1458	Ch. 71	Expands the existing rural loan forgiveness program to all mental health professionals. Adds four psychiatric residency slots.

State	Bill	Chapter	Descriptions
MT	HB 358		Transfers the duties related to regulating licensed addiction counselors from The Department of Labor and Industry to the Board of Social Work Examiners and Professional Counselors. Revises the membership of the Board of Social Work Examiners and Professional Counselors. Requires applicants for addiction counselor licensure to submit a background check.
ND	HB 1049		Creates and enacts a new section of the North Dakota Century Code relating to loans for certain behavioral health professions and duties of the board of addiction counseling examiners. Requires the board to evaluate licensure coursework requirements and clinical training requirements.
ND	HB 1274		Amends qualifications for appointment, membership and the powers and duties of the state board of psychologist examiners.
NE	LB 196		Establishes a loan repayment program that will provide financial incentives to medical residents who agree to practice in a designated health profession shortage area within Nebraska full-time for one year and accept Medicaid patients.
NH	SB 23	Ch. 144	Allows certain advanced practice registered nurses to authorize involuntary commitment and voluntary admission to state institutions.
NV	SB 489	Ch. 383	Provides for the regulation of peer support recovery organizations.
OK	SB 701		In the definition of "licensed mental health professional," removes the requirement for special training or experience in mental health from the physician's assistant and advanced practice nurse definitions.
OR	SB 832	Ch. 798	Requires Oregon Health Authority to prescribe by rule standards for integrating behavioral health services and physical health services in patient centered primary care homes and behavioral health homes. Permits patient centered primary care homes and behavioral health homes to use billing codes applicable to physical and mental behavioral health services provided in primary care and urgent care settings.
OR	SB 840		Authorizes licensed independent practitioners to initiate or approve prehearing detention in a hospital or nonhospital facility of a mentally ill person who is subject to civil commitment proceedings. Amends the definition of a licensed independent practitioner involved in civil commitment procedures to include certified nurse practitioners. Declares an emergency effective on passage.
SD	HB 1057		Makes an appropriation to reimburse certain eligible health care professionals who have complied with the requirements of the rural health care facility recruitment assistance program. Declares an emergency.
SD	HB 1151		Improves public safety through confidential stress management services for emergency service providers.
SD	HB 1190		Makes an appropriation for community-based provider workforce improvement and declares an emergency.
TN	SB 112	Ch. 153	Authorizes the Board for Licensing Healthcare Facilities and the Departments of Mental Health and Substance Abuse Services, Human Services and Intellectual and Developmental Disabilities to amend licensure rules to be consistent with the federal regulations pertaining to home-based and community-based settings.
TX	SB 18		Requires the Texas Higher Education Coordinating Board to award one-time graduate medical education planning and partnership grants to hospitals, medical schools and community-based, ambulatory patient care centers - including mental health hospitals and community mental health centers - located in this state that seek to develop new graduate medical education programs with first-year residency positions. Requires the comprehensive health professions resource center to conduct research to identify all medical specialties and subspecialties that are at critical shortage levels along with the geographic location of the physicians in those specialties and subspecialties.

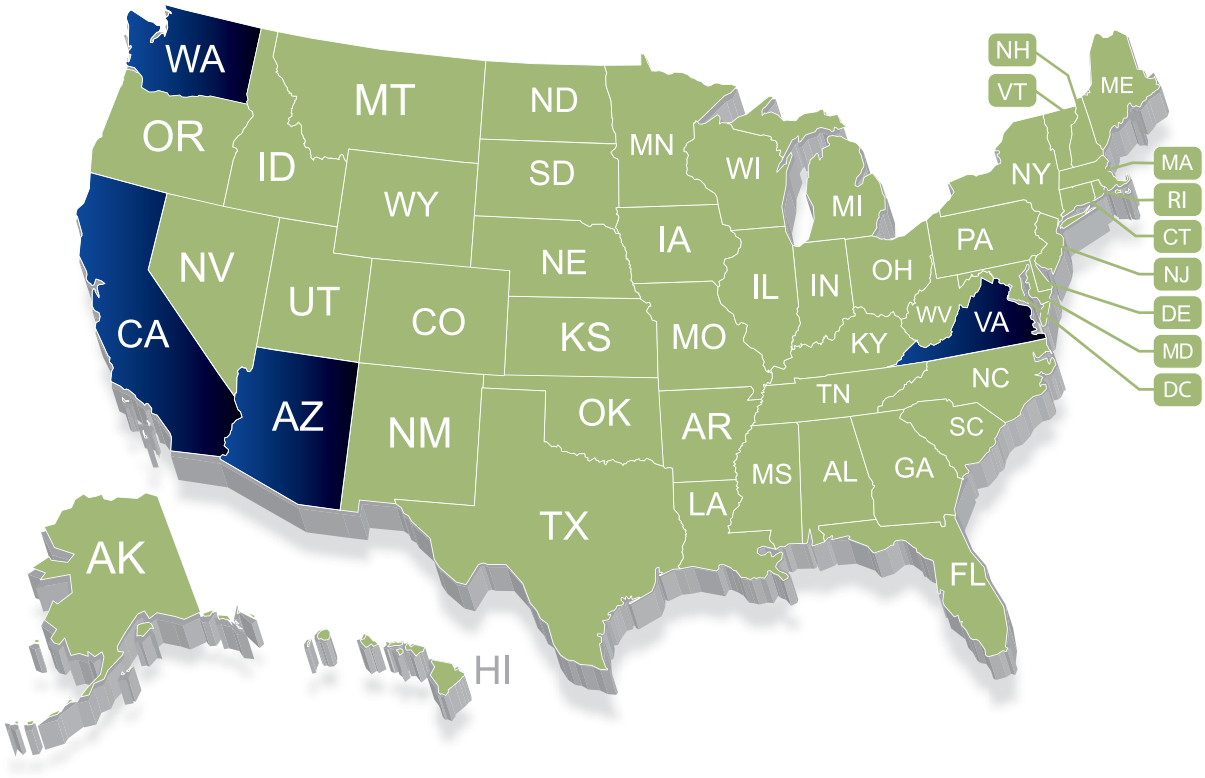
	State	Bill	Chapter	Description
★	TX	SB 239		Allows the Texas Higher Education Coordinating Board to establish a program to provide assistance in the repayment of student loans for mental health professionals who apply and qualify for the assistance.
★	TX	SB 674		Requires that a person receive, as part of any minimum academic qualifications for a certificate that requires a person to possess a bachelor's degree, instruction regarding mental health, substance abuse and youth suicide.
	TX	HB 1430		Requires the inclusion of mental health in the public services endorsement on a public school diploma and in information about health science career pathways.
	UT	SB 108		Amends provisions of the Mental Health Professional Practice Act. Provides that an individual may represent oneself as a social worker if the individual possess certified transcripts from an accredited institution. Amends the qualifications for licensure as a clinical social worker, certified social worker and social service worker.
	VA	HB 2243	Ch. 359	Allows a psychologist who completes more than 14 hours of continuing education in a single year to carry up to seven hours forward to meet the requirements for the next year.
★	WY	HB 71		Authorizes loans for doctorate level nursing degrees and provides that the repayment obligation can be forgiven by teaching nursing at a Wyoming community college. Removes an eligibility requirement that the applicant has taught nursing in Wyoming for one year before receipt of the loan.
	WY	HB 88		Increases loan support for providers agreeing to practice in underserved areas in Wyoming.
	WY	SF 102	Ch. 64	Provides that mental health services can be provided by mental health professionals holding a provisional license.

Appendix 5: Telehealth



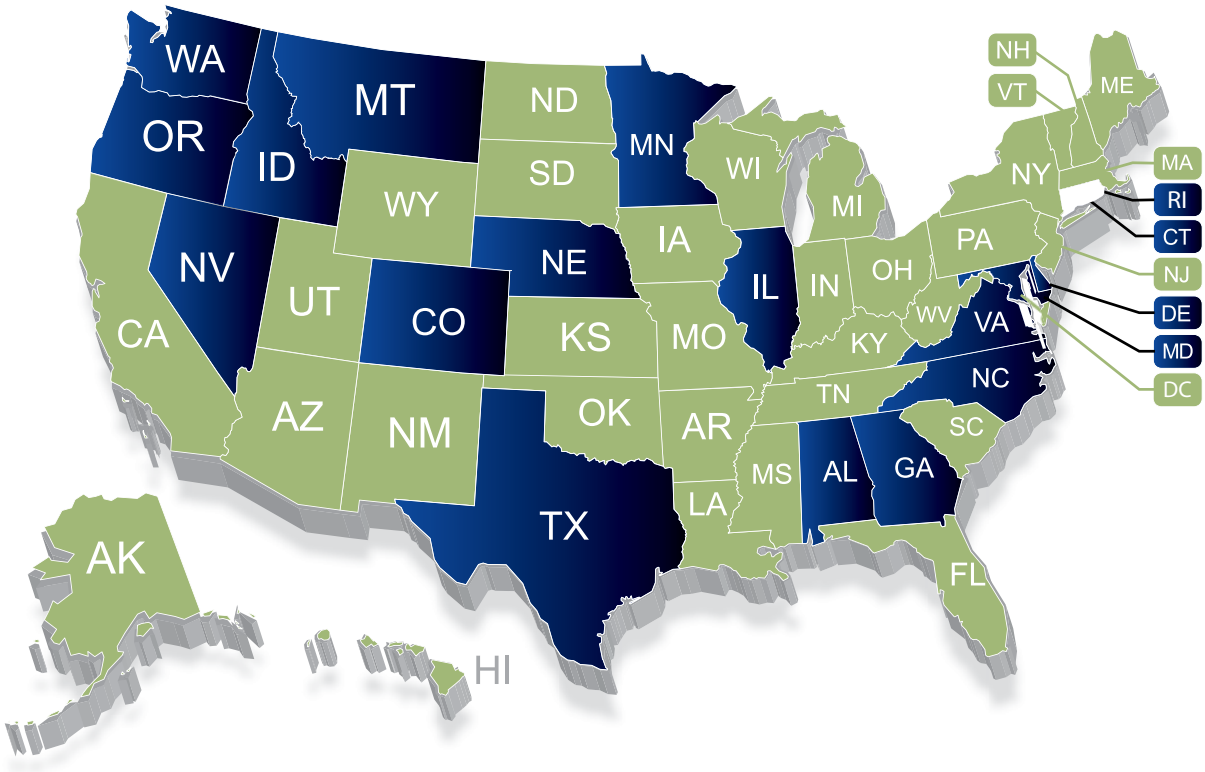
State	Bill	Chapter	Description
AR	SB 133		Encourages the use of telemedicine to reduce healthcare disparities, improve access to care and address maldistribution of primary care and specialty care. Authorizes reimbursement and regulation of services provided through telemedicine and declares an emergency.
AZ	SB 1212		Amends Arizona Revised Statutes to include definition of "telepractice."
DE	HB 69		Amends the Delaware Code to add language and definitions around telemedicine. Establishes guidelines for insurers and healthcare providers around telemedicine services and coverage.
ID	HO189		Adds to existing law to establish the Idaho Telehealth Access Act.
MN	SF 1458	Ch. 71	Increases telehealth provider reimbursement rates to make them equivalent to an in-person office visit.
MT	SB 77		Provides the Board of Medical Examiners with rulemaking authority for telemedicine. Establishes that telemedicine is a form of medical practice.
NH	SB 84		Clarifies when it is appropriate to use telemedicine in practitioner-patient medical practice. A practitioner treating patients in community mental health programs may prescribe certain controlled drugs by telemedicine.
TN	HB 699	Ch. 261	Establishes requirements and protections for healthcare providers that practice telehealth. Defines "telehealth" or "telemedicine" as the use of real-time audio, video or other electronic media and telecommunications technologies that enable interaction between the healthcare provider and the patient, or also store-and-forward telemedicine services for the purpose of diagnosis, consultation or treatment of a patient in another location where there may be no in-person exchange.
WA	SB 5175		Recognizes the application of telemedicine as a reimbursable service by which an individual receives medical and mental health services from a health care provider.

Appendix 6: Integrated Care



	State	Bill	Chapter	Description
★	AZ	SB 1283	CH. 158	Outlines requirements for the co-location of health care, behavioral health care or counseling service facilities. Requires the ADHS Director to adopt licensing provisions that facilitate the co-location and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services.
	CA	SB 36	Ch 759	Requires State Department of Health Care Services to submit an application to CMS for a waiver to implement a demonstration project that, among other things, continues the state's momentum and successes in innovation achieved under the demonstration project to improve care coordination for seniors and persons with disabilities and maximization of opportunities to reduce the number of uninsured individuals.
	VA	SB 894	Ch. 533	Community Integration Advisory Commission: Expands citizen membership eligibility to include one individual who has received services in a state hospital, one who has received services in an intermediate care facility for individuals with intellectual disability and one current or former resident of a nursing facility. Under current law, membership includes one individual who is currently receiving services in a state hospital, one who is currently receiving services in a state training center and one current resident of a nursing facility.
	WA	HB 1879	Ch. 283	Directs the health care authority to issue a request for proposals for integrated managed health and behavioral health services for foster children.

Appendix 7: Children and Youth

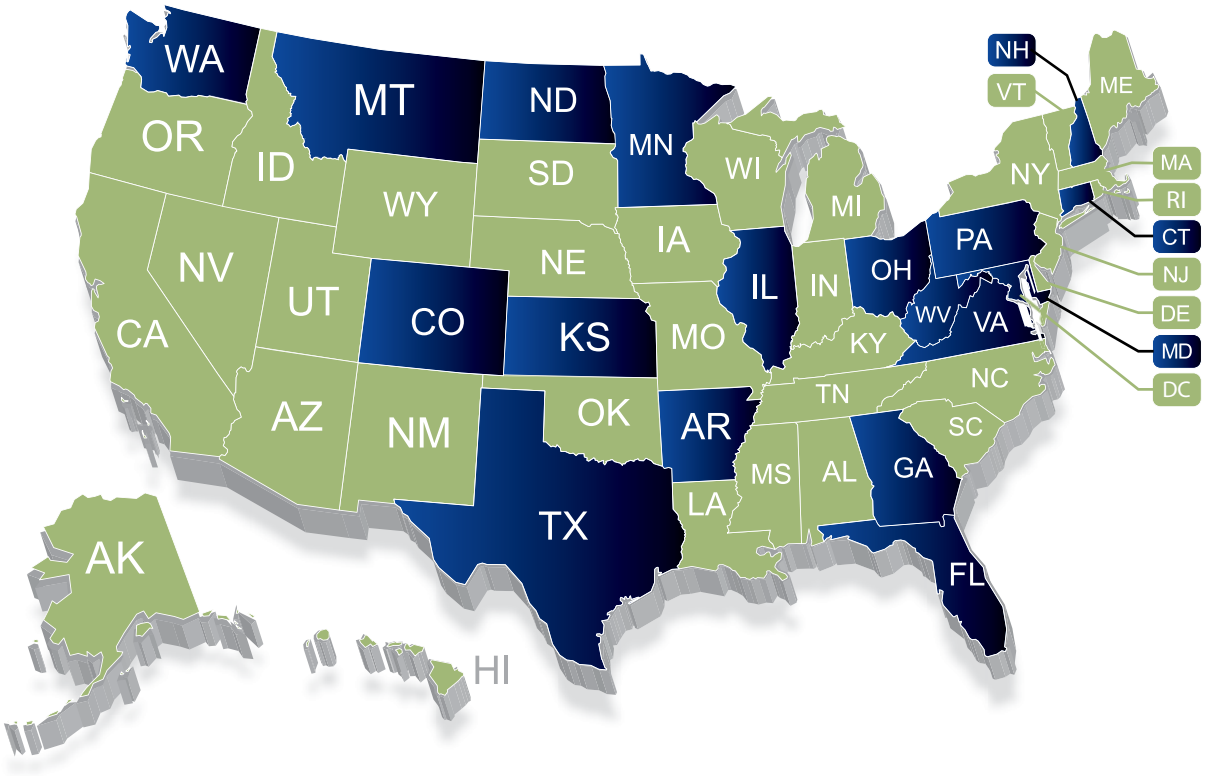


State	Bill	Chapter	Description
AL	SB 142		Allows the parent or legal guardian of a minor who is at least 14 years of age and under 19 years of age to authorize medical treatment for any mental health services even if the minor has expressly refused such treatment services. This authorization can only occur if the parent/legal guardian and a mental health professional determine that clinical intervention is necessary and appropriate.
CO	HB 15-1032		Under current law, a professional person may render mental health services to a minor who is at least 15 years of age with the minor's consent. "Professional person" includes a person licensed to practice medicine or psychology. This new law allows other licensed mental health professionals (licensed social workers, marriage and family therapists, professional counselors, and addiction counselors) to render mental health services to minors in any practice setting.
CO	HB 15-1186		Increases the age limit for children receiving services under the autism waiver program from 6 years of age to 8 years of age. The current cap on the annual dollar amount of services that may be provided to a child in the program of $25,000 is removed and will, instead, be set annually by the medical services board based upon the general assembly's appropriations. The bill states that it is the intent of the general assembly that there will be no waiting list for services for eligible children who apply for the waiver program, so the bill removes language about prioritizing placement in the waiver program.
CT	SB 303		Establishes a task force to study the state-wide response to minors exposed to family violence.
CT	SB 841		Establishes the Children's Mental, Emotional and Behavioral Health Plan Implementation Advisory Board, which will advise the collaboration of agencies, providers, advocates and other stakeholders to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children.

State	Bill	Chapter	Description
DE	SB 56		Establishes authority for the Department to file a petition with Family Court to compel an uncooperative parent or guardian to complete a drug or alcohol evaluation or mental health evaluation for themselves or to get a developmental screen for their child, if the child protection investigation reveals that substance abuse, mental health, or developmental delays may be placing the child at risk.
GA	HR 641		Creates the House Study Committee on Children's Mental Health. Requires if the committee adopts any specific findings or recommendations, the chairperson shall file a report with the Clerk of the House of Representatives. The committee will be abolished December 1, 2015.
ID	H 0232		Changes the fiscal year 2015 appropriation to the Department of Health and Welfare with a one-time transfer of General Funds from Adult Mental Health to Children's Mental Health; changes the fiscal year 2015 appropriation for the Substance Abuse Treatment and Prevention Program with the transfer of 2.0 FTP from the Southwest Idaho Treatment Center and provides an additional appropriation of $796,700 from federal funds.
IL	HB 0217		Creates the Youth Mental Health Protection Act. Provides that no mental health provider shall engage in sexual orientation change efforts with a person under the age of 18. Provides that a mental health provider shall not refer a client or patient to any individual for the purpose of sexual orientation change efforts. Further provides that any sexual orientation change effort attempted on a person under the age of 18 or any referral made by a mental health provider shall be considered unprofessional conduct and shall be subject to discipline by the licensing entity or disciplinary review board with competent jurisdiction.
IL	HB 4096		Amends the Mental Health and Developmental Disabilities Administrative Act. Defines the terms and provides procedures under which children are eligible to receive funds for an Individual Care Grant (ICG) for residential placement due to their mental illness, including alternative in-home or community services in lieu of residential placement, when clinically appropriate. Supersedes Department of Human Services rules.
MD	SB 157		Alters the health care providers who provide consultation, diagnosis, and treatment of a mental or emotional disorder to which minors who are 16 years old and older have the same capacity as an adult to consent. Provides that the capacity to consent does not include the capacity to refuse consultation, diagnosis, or treatment for a mental or emotional disorder by health care providers for which a specified individual has given consent.
MN	SF 1458	Ch. 71	Funding of $260,000 is available to mental health providers to provide evidence-based interventions for youth at risk of developing and experiencing a first episode of psychosis and for a public awareness campaign on the signs and symptoms of psychosis. Evidence-based programs include the programs under the RAISE project that offers coordinated specialty care including case management, psychotherapy, psychoeducation, support for families, cognitive remediation and supported employment and/or education.
MT	HB 422		Authorizes a pilot project meant to improve outcomes for youth in the children's mental health system. Requires an interim study of evidence-based outcomes and allows public participation in development of evidence-based outcomes. Provides for development of options for performance-based reimbursement.
NC	SB 423	2015-135	Requires the Department of Health and Human Services, Division of Medical Assistance, to design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance in home and community-based settings. Allows the Department to submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly. Requires the Department to report the draft waiver, other findings, and any other options or recommendations to best serve children with Serious Emotional Disturbance to the Joint Legislative Oversight Committee on Health and Human Services.
NE	LB 240		Changes the termination date of the Behavioral Health Screening and Referral Pilot Program to 2017.

State	Bill	Chapter	Description
NV	AB 307	Ch. 307	Establishes a pilot program to provide certain intensive care coordination services to children with intellectual disabilities and related conditions who are diagnosed as having behavioral health needs.
OR	SB 561		Directs the Oregon Health Authority to develop a plan for communication among local mental health authorities and systems to improve notifications and information-sharing when death suspected to be suicide involves an individual 24 years of age or younger. Directs Department of Human Services to submit report to interim legislative committees regarding occurrences of suicide and status of suicide prevention efforts in Oregon. Requires local mental health authority to inform Oregon Health Authority within seven days after suicide death of individual 24 years of age or younger.
RI	HB 6016		Mandates the development of a transition plan by the Department of Children, Youth and Families and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals for all children under the jurisdiction of the family court who are developmentally delayed or seriously emotionally disturbed prior to the child turning age 21.
TX	SB 125		Requires that within 45 days of entering conservatorship of the Department of Family and Protective Services, a child receives a developmentally appropriate comprehensive assessment including a screening for trauma.
TX	SB 219		Amends the duties of the Department of Aging and Disability Services. Removes outdated language from the Family Code.
VA	HB 1717	Ch. 504	Amends the criteria for admitting an objecting minor 14 years of age or older for psychiatric treatment to match the criteria for determining whether a non-objecting minor or a minor younger than 14 years of age should be admitted. Provides that if a minor 14 years of age or older who did not initially object to treatment objects to further treatment, the mental health facility where the minor is being treated shall immediately notify the parent who consented to the minor's treatment and provide to such parent a summary, prepared by the Office of the Attorney General, of the procedures for requesting continued treatment of the minor.
VA	HB 1940	Ch. 604	Requires health insurers, health care subscription plans, and health maintenance organizations to provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals from age two through age 10. Currently, such coverage is required to be provided for individuals from age two through age six. The provision applies with respect to insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2016.
VA	HB 2083	Ch. 305	Directs community policy and management teams to establish a process for parents and individuals with primary physical custody of a child to refer children in their care to family assessment and planning teams or a multidisciplinary team approved by the State Executive Council for Comprehensive Services for At-Risk Youth.
VA	HB 1400		Provides $2.0 million in new funding to expand and strengthen children's mental health crisis response and psychiatric services.
WA	HB 1879	Ch. 283	Directs the health care authority to issue a request for proposals for integrated managed health and behavioral health services for foster children.

Appendix 8: School Mental Health

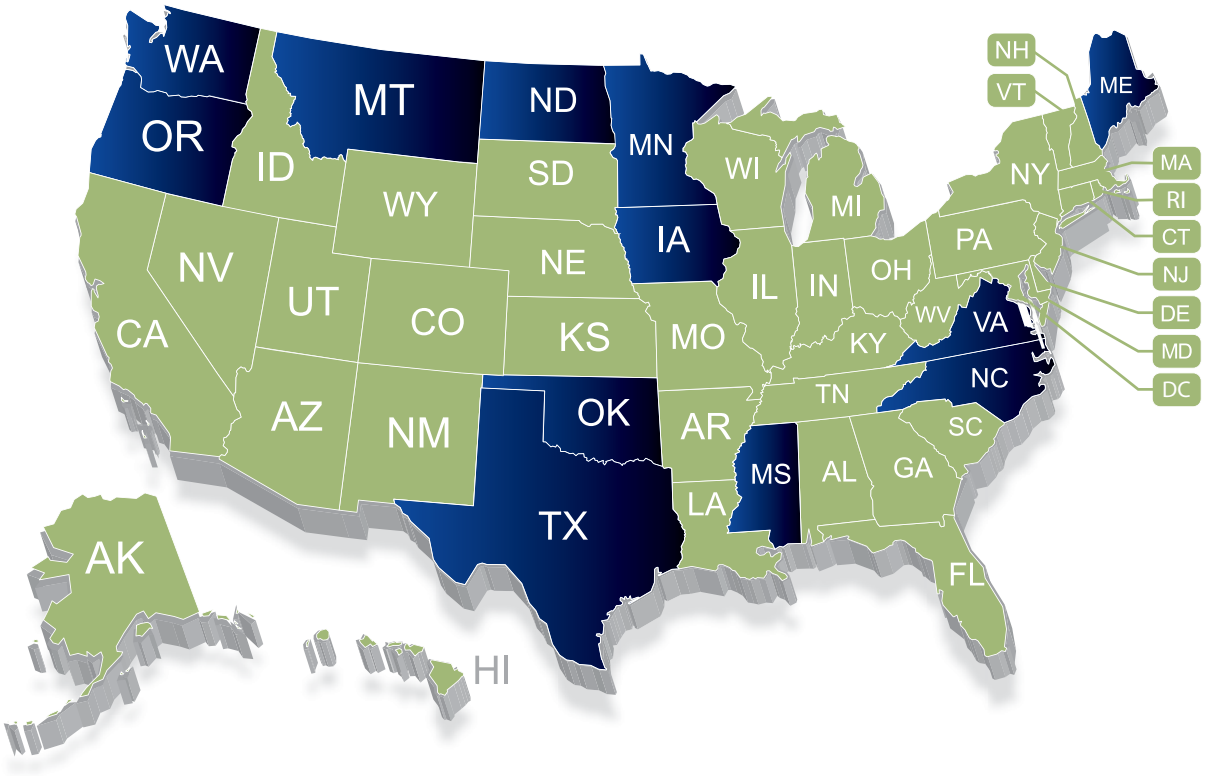


State	Bill	Chapter	Description
AR	HB 1552		Establishes the Succeed Scholarship for students with disabilities.
CO	SB 15-213		Amends the "Colorado Governmental Immunity Act" to recognize that a duty of reasonable care exists with respect to public school districts and their employees to protect students, faculty, staff and others from reasonably forseeable harm within the school facilities or during school-sponsored activities.
CO	SB 15-214		Creates the school safety and youth in crisis committee to: study and evaluate programs and methods for identifying and monitoring students in crisis and develop standardized criteria for school personnel to use in assessing the potential threat posed by one or more students.
CT	SB 927		Prevents the use of physical restraint or seclusion on students for anything other than emergency situations. Provides guidelines on restraint, seclusion and other de-escalation techniques.
CT	SB 1053		Prohibits out-of-school suspensions and expulsions for students enrolled in a preschool program or grades kindergarten to two. Additionally, the bill requires school-based primary mental health programs administered by local and regional boards of education to include a component for systematic early detection and screening to identify children experiencing behavioral or disciplinary problems.
FL	SB 954	Ch. 2015-67	Requires school health services plans to include notification requirements when a student is removed from school, school transportation or a school-sponsored activity for involuntary examination.
GA	HB 198	Act 91	Requires that all certified school personnel receive annual training in suicide prevention and awareness.

	State	Bill	Chapter	Description
★	IL	HR 478		Urges the members of the General Assembly to have discussions and forums with their communities to promote awareness of mental health issues and access to mental health resources. Encourages the members of the General Assembly and all school districts in Illinois to post information on mental health issues and local treatment resources on their public websites. Encourages all school districts to implement mental health screenings to properly identify students with mental health problems. Encourages the federal government to improve mental health awareness, treatment and funding to improve the lives of citizens struggling with mental health issues.
★	IL	HB 3599		Creates the Student Optional Disclosure of Private Mental Health Act. Provides that all institutions of higher learning shall, at or near the time that an incoming student enrolls at the institution of higher learning, provide that student the opportunity to pre-authorize in writing the disclosure of certain private mental health information to a designated person. Provides that all institutions of higher learning shall prepare a form for the purpose of such pre-authorization. Provides that all institutions of higher learning shall create a policy to ensure that every new student is given the opportunity to complete and submit the form if he or she so desires.
★	KS	HB 2170		Creates the freedom from unsafe restraint and seclusion act. Places limitations, requires training and promulgates standards under which restraint or seclusion may be used in schools.
	MD	HB 197		Establishes the Youth Wellness Leadership Pilot Program in Prince George's County. Requires the Prince George's Board of Education, after consultation with the Department of Health and Mental Hygiene, to implement the Program for 125 students in public high schools in Prince George's County. Authorizes the Board of Education to collaborate with specified local community organizations, specifies the purpose of the Program and requires the Board of Education to report annually.
★	MN	SF 1458	Ch. 71	Expands the funding for suicide prevention grants by 54% to: (1) provide evidence-based suicide prevention and intervention to school staff and people who work with youth; and (2) to provide evidence-based postvention training to mental health professionals and practitioners in order to provide technical assistance to communities after a suicide. Appropriates money to tribes to address the suicide rate among American Indians. Requires the commissioner of health to submit a plan on improving the use and timeliness of suicide-related data.
	MT	HB 374		Requires the Office of Public Instruction to develop suicide awareness and prevention training materials for school district employees. Recommends at least 2 hours of training every 5 years.
	MT	HB 374	Ch. 351	Requires the Office of Public Instruction to provide guidance and technical assistance to schools on suicide prevention training and awareness materials and recommends that such training be made available to school personnel who work directly with students on an annual basis.
	ND	SB 2048		Amends the North Dakota Century Code to require teacher licensure on youth mental health. Requires a minimum of training on youth mental health to elementary, middle and high school teachers and administrators.
	ND	SB 2209		Requires school districts to provide annual suicide prevention training to all middle school and high school instructional staff, teachers and administrators.
	NH	HB 206		This bill establishes a committee to study non-academic information gathering surveys or questionnaires administered by a public school to its students. The bill also requires school districts to adopt a policy regarding student participation in non-academic surveys or questionnaires.
★	OH	HB 28		Requires each state institution of higher education to develop and implement policies to advise students and staff on suicide prevention programs available on and off campus. Requires the Board of Regents and the Department of Mental Health and Addiction Services to post free suicide prevention materials and program information on their websites. Requires each state institution of higher education to provide incoming students with information about mental health topics, including available depression and suicide prevention resources.

	State	Bill	Chapter	Description
★	PA	HB 1559	Ch. 71	Mandates that public schools shall require faculty members to complete four hours of professional development and suicide awareness training every five years. Requires that the Department of Education (PDE) provides each public school with needed resources at no cost to the school.
	TX	SB 133		Expands mental health first aid training to school district employees and school resource officers and establishes supplemental grants for training select educators in mental health first aid.
	TX	HB 197		Requires certain public institutions of higher education to post information regarding mental health resources available to students on the institution's website.
	TX	HB 440		Adapts the public school physical education curriculum to meet the needs of students of all physical ability levels, including students who have a chronic health problem, disability (mental retardation, emotional disturbance, learning disability, autism, speech disability or traumatic brain injury) or other special need that precludes the student from participating in regular physical education instruction.
★	TX	SB 1624		Requires a general academic teaching institution to provide, to each entering full-time undergraduate, graduate or professional student, information about available mental health and suicide prevention services offered by the institution or associated organizations and early warning signs for a person who may be considering suicide.
	VA	HJ 586		Requests the Department of Behavioral Health and Developmental Services to study the benefits of offering voluntary mental health screenings to students in public elementary schools.
	VA	SB 1122	Ch. 716	Amends student mental health policies to require procedures for notifying the institution's student health or counseling center for certain set forth purposes when a student exhibits suicidal tendencies or behavior.
	VA	HB 1443	Ch. 142	Requires the Board of Education to adopt regulations on the use of seclusion and restraint in public schools. The bill requires that such regulations be consistent with certain existing guidance documents; include definitions of terms, criteria for use, restrictions on use, training requirements, notification requirements, reporting requirements and follow-up requirements; and address distinctions between certain student populations.
	VA	HB 1715	Ch. 663	Requires each public institution of higher education's policies to contain procedures for notifying the institution's student health or counseling center when a student exhibits suicidal tendencies or behavior.
	WA	HB 1138		Creates a task force on mental health and suicide prevention in higher education to determine what policies, resources and technical assistance may be needed to support the institutions of higher education in improving access to mental health services and improving suicide prevention responses.
	WV	HB 2535	Ch. 225	Creates "Jamie's Law" which requires all public middle school and high school administrators to provide opportunities to discuss suicide prevention awareness in schools. Also requires all public and private middle schools, high schools and institutions of higher education to make resources and information on suicide prevention and depression awareness available to students and faculty.

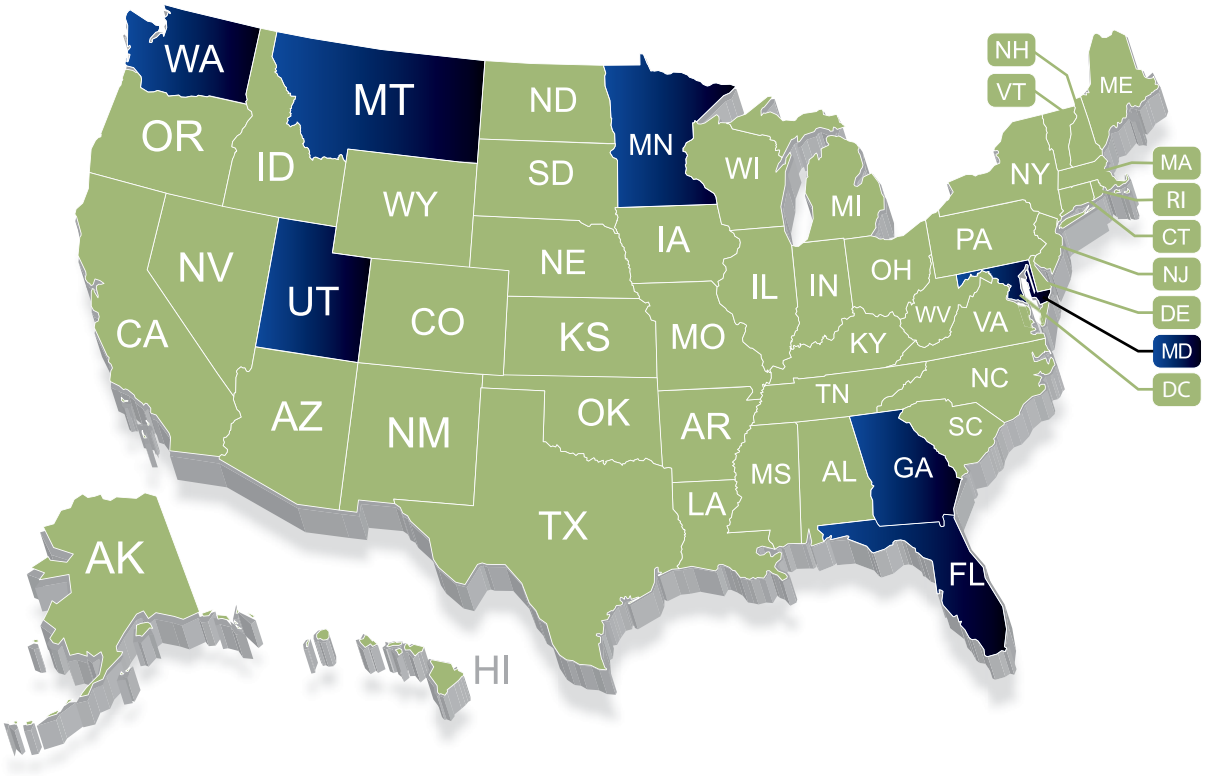
Appendix 9: Inpatient Care



State	Bill	Chapter	Description
IA	HF 449		Directs Department of Human Services (DHS) to develop and implement an Inpatient Psychiatric Bed Tracking System. Requires clerk of courts to use the system to find openings and arrange placements. Allows DHS to certify/recognize crisis stabilization programs operating in psychiatric medical institutions for children that provide children with mental health, substance abuse treatment. Allocates $200,000 in FY 2016.
ME	LD 1368		Requires the documentation of the use of seclusion and restraint at mental health institutions in the state.
MN	SF 1458	Ch. 71	Funds were allocated to add 15 state hospital beds and expand Assertive Community Treatment (ACT) teams.
MN	SF 1120		Expands fourth-degree assault protections for secure treatment facility employees working directly with mentally ill and dangerous patients.
MS	SB 2108		Authorizes hospitals to provide each patient or the patient's legal guardian an opportunity to designate a lay caregiver after the patient's admission into a hospital and before the patient's discharge to the patient's residence.
MT	HB 34		Appropriates funds for additional secure psychiatric treatment beds.
MT	HB 35		Appropriates money for short-term voluntary inpatient mental health treatment in community centers.
NC	HB 560	Ch. 97	Provides that it is a class 1 felony to assault hospital personnel and licensed healthcare providers who are providing or attempting to provide services in a hospital.

	State	Bill	Chapter	Description
	ND	SB 2047		Amends and reenacts sections of the North Dakota Century Code, relating to psychiatric residential treatment facilities for children and rulemaking authority of the Department of Human Services. Defines "qualified mental health professional."
	OK	HB 1562		Allows hospitals and community-based crisis centers to define in policy which allied health professionals may be allowed to determine if the use of restraints is necessary and appropriate. Clarifies who may provide a face-to-face examination when a restraint is applied. Clarifies that every use of a restraint, regardless of who ordered it, shall be a part of the clinical record and signed by the attending physician. Creates a policy consistent with CMS standards.
★	OR	HB 2363		Requires a treating physician to document in the clinical record any seclusion of a person alleged to have mental illness who is confined in hospital or nonhospital facility.
	OR	HB 2023	Ch. 466	Specifies requirements for hospital policies for discharge planning involving patient who is hospitalized for mental health treatment.
	TX	SB 1507		Requires the commission, with input from local mental health authorities, local behavioral health authorities, stakeholders, and the forensic director to divide the state into regions for the purpose of allocating to each region state-funded beds in the state hospitals and other inpatient mental health facilities for patients who are: (1) Voluntarily admitted to a state hospital or other inpatient mental health facility. (2) Admitted to a state hospital or other inpatient mental health facility for emergency. (3) Ordered by a court to receive at a state hospital or other inpatient mental health facility inpatient chemical dependency treatment or inpatient mental health services. (4) Committed to a state hospital or other inpatient mental health facility to attain competency to stand trial. (5) Committed to a state hospital or other inpatient mental health facility to receive inpatient mental health services following an acquittal by reason of insanity.
★	VA	HB 2118	Ch. 116	Requires state facilities, community services boards, behavioral health authorities and private inpatient psychiatric service providers to update information included in the acute psychiatric bed registry whenever there is a change in bed availability for the facility, board, authority or provider or, if no change in bed availability has occurred, at least once daily.
	WA	HB 2212		Exempts certain hospital mental health projects and psychiatric hospitals provided grant funding by the Department of Commerce from certificate of need requirements for the addition of new psychiatric beds.

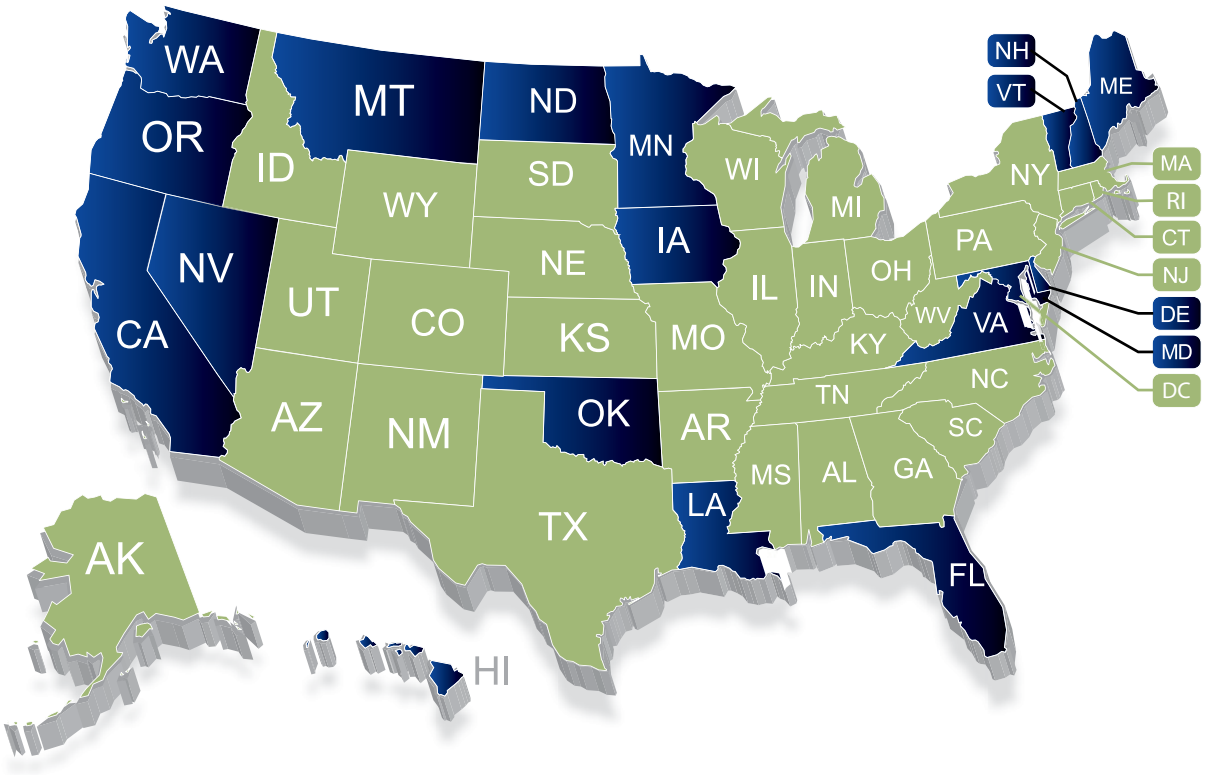
Appendix 10: Crisis Response



	State	Bill	Chapter	Description
	FL	HB 79	Ch. 102	Directs the Department of Children and Families to develop, implement, and maintain a data system whereby behavioral health managing entities collect utilization data from psychiatric public receiving facilities (crisis stabilization units where emergency mental health care is provided).
	GA	SB 131	Act 179	Provides for the certification of Crisis Stabilization Units rather than the licensure of such facilities.
★	MD	HB 367	Act 416	Requires the Crisis Response System to evaluate the outcomes of services through the annual collection of data on behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations, hospital diversions, arrests and detentions and diversion of arrests and detentions of individuals with behavioral health diagnoses.
★	MN	SF 1458	Ch. 71	Requires health plans to cover mobile mental health crisis services under the emergency services category. Appropriates $8 million over fiscal years 2016 and 2017 to fund mental health crisis services. Requires the Department of Human Services to create one phone number for crises, establish a statewide pool of experts, expand crisis services across the state, establish and implement state standards and fund crisis beds. Funds 'protected transport' providing for Medicaid reimbursement of transportation to civil commitment in an unmarked car, rather than in a law enforcement vehicle or an ambulance.
	MN	HB 1458	Ch. 71	The Department of Human Services will, in consultation with stakeholders, develop recommendations on funding for children's crisis residential services that will allow for timely access without requiring county authorization or child welfare placement.

	State	Bill	Chapter	Description
★	MT	HB 33	Ch. 403	Appropriates money for expanding crisis intervention and jail diversion service to areas of the state that lack services and maintains or increases the level of state matching funds provided to counties that received funds in the previous year.
★	MT	HB 47	Ch. 208	Appropriates funding of $1.2 million to the Department of Public Health and Human Services for the biennium for a youth mental health crisis diversion pilot program. The department will grant money to up to six licensed children's mental health providers for the development of community-based youth mental health crisis diversion services.
	UT	SB 175	Ch. 442	Establishes a state-wide school crisis line for youth.
	WA	HB 1721		Amends duties of regional emergency medical services and trauma care councils to identify procedures to allow for the appropriate transport of patients to mental health facilities or chemical dependency programs, as informed by the alternative facility guidelines. Allows an ambulance service to transport patients to nonmedical facilities. Instructs the authority to develop a reimbursement methodology for ambulance services when transporting a person to a mental health facility or chemical dependency program.

Appendix 11: Civil Commitment and Court-Ordered Treatment



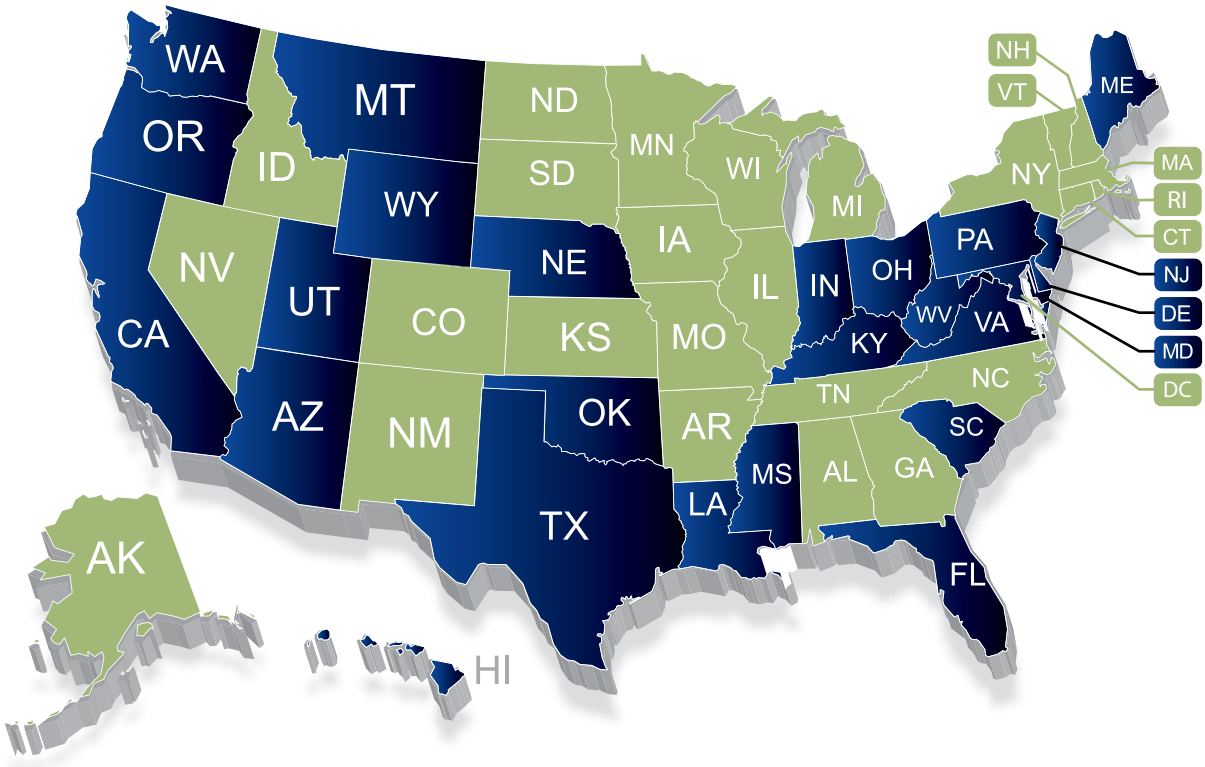
State	Bill	Chapter	Description
CA	AB 1194	Ch. 570	Seeks to require law enforcement to consider as much information as possible before deciding to involuntarily detain an individual.
CA	AB 1300		**Pending:** Would make changes to standardize the 72-hour hold process and ease the transfer of psychiatric patients, including allowing non-designated professionals to place and release 72-hour holds, and counties to appoint liaisons to move patients from emergency rooms to psychiatric facilities.
DE	HB 8		Amends the definition of credentialed mental health screener to include Veterans Affairs doctors working in Delaware. This will allow Veterans Affairs doctors to hold patients for involuntary observation and treatment of mental conditions.
FL	HB 335		Requires psychiatric nurses to hold national advanced practice certification as a psychiatric mental health advanced practice nurse. Authorizes a psychiatric nurse to approve the involuntary examination or release of a patient from a receiving facility.
HI	SB 729		Clarifies the role of advanced practice registered nurses in sections of the Hawaii Revised Statutes relating to emergency hospital admission and involuntary hospitalization.
HI	SB 961		Amends hearing requirements for petitions for assisted community treatment, including for deadlines, notice, court-appointed counsel and examinations. Requires treating providers to provide information for purposes of the Department of Health's annual report.
IA	SF 401		Allows, after a hospitalization hearing has been held, a court to order a person to be involuntarily committed on an inpatient basis to a subacute care facility that provides mental health services for a period of time over 24 hours. Currently, courts can only order placement to an inpatient (acute care) facility.

State	Bill	Chapter	Description
IA	SF 440		Allows counties or regions to contract with a public or private entity in a bordering state to provide substance abuse or mental health treatment for persons being civilly committed on a voluntary or involuntary basis.
IA	HF 468		Changes how mental health advocates are appointed for people who are involuntarily hospitalized. Under the bill, mental health advocates would be county employees and the county would both pay for and supervise the mental health advocate.
LA	HB 301		Increases the maximum initial period of outpatient treatment to four consecutive 6 month to one year periods and increases the maximum period of subsequent treatment to one to two years.
MD	SB 195		Alters the circumstances under which a specified unit of a State facility may admit a minor under a specified provision of law for the treatment of a mental disorder to allow for the assent to the admission to be made by a psychiatric nurse practitioner and a physician. Alters the requirement that a certificate accompany an application for involuntary admission to a facility or Veterans' Administration hospital under specified provisions of law to allow for a psychiatric nurse practitioner to complete a certificate; etc.
MD	HB 293		Authorizes a court to appoint a guardian of the person of a disabled person for a limited period of time under specified circumstances. Specifies that certain rights, duties, and powers that a court may order include the duty to file a specified report. Authorizes a declarant to waive specified rights when making an advance directive.
ME	LD 1145		Establishes that a medical practitioner can administer involuntary treatment to a person who is being held or detained by a hospital against the person's will if the following conditions are met: A. As a result of mental illness, the person poses a serious and immediate risk of harm to that person or others; B. The person lacks the decisional capacity either to provide informed consent for treatment or to make an informed refusal of treatment; C. A person legally authorized to provide consent for treatment on behalf of the person is not reasonably available under the circumstances; D. The treatment being administered is a currently recognized standard of treatment for treating the person's mental illness and is the least restrictive form of treatment appropriate in the circumstances; E. For purposes of evaluation for emergency involuntary treatment, the medical practitioner considers available history and information from other sources.
MN	SF 1458	Ch. 71	Establishes that those committed as mentally ill and dangerous will now have a review at least every three years by the special review board. In addition, the special review board must submit a report to the commissioner summarizing the barriers faced by people whose petitions were denied for not progressing in their treatment and include any recommendations to help people progress.
MT	HB 517		Revises laws regarding the commitment of incapacitated persons and provides admission alternatives for incapacitated persons with certain conditions. If the ward is unwilling or unable to give informed consent to treatment for a person with a primary diagnosis of a major neurocognitive disorder, a guardian may seek admission of the ward for stabilization and treatment to a hospital or another appropriate treatment facility. If admitted to the Montana mental health nursing care center, the court is required to review every 90 days whether it is the appropriate placement or whether a less restricted alternative exists.
NH	SB 23	Ch. 144	Allows certain advanced practice registered nurses to authorize involuntary commitment and voluntary admission to state institutions.
ND	HB 1040		Authorizes advanced practice registered nurses and physician assistants to participate and practice in involuntary commitment and continuing treatment petitions and proceedings. Certifies that these professionals can be penalized for false petition.
NV	SB 7	Ch. 496	Expands the list of persons authorized to file an application for the admission and release of a person with mental illness and a petition for the involuntary court-ordered admission of such a person to certain facilities and programs.

State	Bill	Chapter	Description
NV	SB 15	Ch. 309	Requires a mental health professional to take certain actions if a patient communicates an explicit threat in certain circumstances.
OK	SB 715		Directs courts to issue certain orders relating to competency restoration services and prohibits courts from committing incompetent persons. If person found to be incompetent because he/she requires behavioral health treatment, the court will suspend criminal proceedings and order the Department of Mental Health and Substance Abuse Services to provide treatment, therapy or training which is calculated to allow the person to achieve competency.
OK	SB 751		Allows law enforcement agencies to contract with third parties to provide transport services for people needing mental health services. The Department of Mental Health and Substance Abuse Services will determine minimum standards for contractors, not to exceed standards required by law enforcement.
OR	SB 465		Specifies duties and liabilities of community mental health programs with respect to commitment proceedings initiated for individuals with mental illness.
OR	SB 840		Authorizes licensed independent practitioners to initiate or approve prehearing detention in a hospital or nonhospital facility of a mentally ill person who is subject to civil commitment proceedings. Amends the definition of a licensed independent practitioner involved in civil commitment procedures to include certified nurse practitioners. Declares an emergency effective on passage.
VA	SB 779	Ch. 535	Increases from 96 to 120 hours the length of time a minor 14 years of age or older who objects to admission for inpatient treatment or who is incapable of making an informed decision may be admitted to a willing mental health facility.
VA	SB 1114	Ch. 659	Provides that a court may issue an order for temporary detention for medical testing, observation, and treatment for a person who is also the subject of an emergency custody order for evaluation and treatment of mental illness.
VA	SB 1264	Ch. 540	Provides that certain information related to persons adjudicated incapacitated or ordered to involuntary inpatient or outpatient treatment or to persons who were subject to a temporary detention order who agreed to voluntary admission may be disseminated to a full-time or part-time employee of a law-enforcement agency for purposes of the administration of criminal justice.
VA	HB 1693	Ch. 297/308	Provides that a magistrate may authorize alternative transportation for a person subject to an emergency custody order or temporary detention order when there exists a substantial likelihood that the person will cause serious physical harm to himself or others. Current law prohibits the use of alternative transportation when there exists a substantial likelihood that the person will cause serious physical harm to himself or others. Provides liability protection for alternative transportation providers.
VA	HB 1694	Ch. 504	Removes the requirement that a person subject to a temporary detention order remain in the custody of the community services board for the duration of the order.
VA	HB 1717	Ch. 504	Amends the criteria for admitting an objecting minor 14 years of age or older for psychiatric treatment to match the criteria for determining whether a non-objecting minor or a minor younger than 14 years of age should be admitted.
VA	HB 2368	Ch. 742	Directs the Commissioner of Behavioral Health and Developmental Services to review the current practice of conducting emergency evaluations for individuals subject to involuntary civil admission and to develop a comprehensive plan to authorize psychiatrists and emergency physicians to evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations.
VT	HB 241		Enacts the Commissioner of Mental Health to adopt rules on emergency involuntary procedures for adults and children in the custody or temporary custody of the Commissioner who are admitted to a psychiatric inpatient unit.

State	Bill	Chapter	Description
WA	HB 1258		Establishes Joel's Law. If a designated mental health professional decides not to detain a person for evaluation and treatment or forty-eight hours have elapsed since the designated mental health professional received notice of such a person and has not taken action to have the person detained, an immediate family member or guardian or conservator of the person may petition the superior court for review of the designated mental health professional's decision.
WA	HB 1450	Ch. 250	Modifies involuntary outpatient mental health treatment provisions relating to persons in need of assisted outpatient mental health treatment being committed to less restrictive alternative treatment. Establishes a procedure for filing an involuntary outpatient evaluation petition and a process for ordering and modifying a court-ordered less restrictive alternative treatment. Additionally, lists the minimum of services included in less restrictive alternative treatment and provides that this act is null and void if appropriations are not approved.
WA	SB 5649	Ch. 269	Makes amendments regarding involuntary outpatient mental health treatment. Establishes a single bed certification process to provide additional treatment capacity for persons suffering from a mental disorder; requires a report; amends procedure for dismissal of a commitment petition.

Appendix 12: Criminal Justice



State	Bill	Chapter	Description
AZ	HB 2310	Ch. 54	In counties that have a population of less than 250,000 persons, the presiding judges of the superior court may agree to establish a regional mental health court. A superior court judge of a court that participates in a regional mental health court may refer a case to the regional mental health court.
CA	SB 11	Ch. 468	Would require Police Officer Standards and Training (POST) to review the training module on persons with a mental illness, intellectual disability, or substance abuse disorder in its basic training course, and develop additional training to better prepare law enforcement officers to recognize, deescalate, and appropriately respond to persons with mental illness, intellectual disability, or substance use disorders.
CA	SB 29	Ch. 469	Mandates that POST require field training officers who are instructors for the field training program to have at least 8 hours of crisis intervention behavioral health training, as specified. The bill also requires at least 4 hours of training that addresses interaction with persons who have mental illness or intellectual disabilities.
CA	SB 219	Ch. 762	This bill would provide that an inmate's existing psychiatric or medical condition that requires ongoing care is not a basis for excluding the inmate from eligibility for the program under which female inmates who are committed to state prison may be allowed to participate in a voluntary alternative custody program in lieu of confinement in state prison.
CA	SB 453	Ch. 260	Amends Section 1370 of the Penal Code, relating to prisons and involuntary medication of a medically incompetent defendant. Authorizes the treating psychiatrist to request an acting psychiatrist to act in their place for purposes of seeking an order for involuntary medication. This requires the treating psychiatrist to brief the acting psychiatrist of the relevant facts of the case and would require the acting psychiatrist to examine the patient prior to the hearing.

	State	Bill	Chapter	Description
	CA	SB 621	Ch. 473	Would authorize the funds from a Mentally Ill Offender Crime Reduction grant to be used to fund specialized diversion programs that offer appropriate mental health and treatment services.
	CA	AB 1156	Ch. 378	This bill would authorize the court to recall a sentence of imprisonment in a county jail of a prisoner convicted of a felony who is terminally ill or permanently medically incapacitated, upon the court's own motion or the recommendation of the county correctional administrator.
	DE	HJR 5		Commissions an independent examiner to study and make findings and recommendations concerning the use of restrictive housing in Delaware correctional facilities and its contribution to mental health issues and barriers to reentry.
★	FL	HB 1069		Requires a trial problem-solving court to transfer certain criminal cases involving participants in specified programs to another jurisdiction having such a program. Describes the conditions under which the transfer can occur and stipulates that all parties involved must agree to the transfer. In addition, clarifies which documents and materials must be included in a transfer of a post-adjudicatory versus a pre-trail problem-solving court case.
	HI	HB 158		Appropriates funds to the department of the prosecuting attorney of the county of Maui for the prosecution of cases under the drug court and mental health court programs.
	IL	HJR 53		Creates the Behavioral Health Prison Diversion Commission. Provides that the Commission shall gather information, review studies, and identify areas of best practice with respect to how the criminal justice system should handle persons with behavioral health disorders including mental illness, substance use disorders, and intellectual disabilities.
⚑	IL	HB 2673		Provides that the circuit court has jurisdiction over all persons alleged to be in need of psychotropic medication or electroconvulsive therapy, whether or not they are charged with a felony.
	IL	HB 4112		Amends the Illinois Police Training Act. Provides that the Illinois Law Enforcement Training and Standards Board shall create a standard curriculum for a certified training program in crisis intervention addressing specialized policing responses to people with mental illnesses. Further provides that officers who have successfully completed this program shall be issued a certificate attesting to their attendance of a Crisis Intervention Team (CIT) training program.
★	IN	SB 380		Requires the law enforcement training academy to include an overview of crisis intervention team (CIT) training model in initial training. Establishes the Indiana technical assistance center for crisis intervention teams to: (1) identify grants and other funds that may be used to fund CIT programs; (2) create and support a statewide CIT advisory committee; and (3) provide training, information, and technical assistance.
★	IN	HB 1242		Requires police reserve officers to complete mandatory in-service training: (1) in interacting with persons with mental illness, addictive disorders, mental retardation, autism, developmental disabilities, and Alzheimer's disease or related senile dementia; and (2) concerning human and sexual trafficking and high risk missing persons. Changes the term "mental retardation" to "intellectual disability".
★	IN	HB 1269		Makes the Department of Corrections (DOC) an inmate's authorized representative for applying for Medicaid for inmates who are potentially eligible for Medicaid and who incur medical care expenses that are not otherwise reimbursable. Provides that the DOC or the sheriff shall assist a committed offender in applying for Medicaid and securing certain treatment upon discharge from the DOC or a county jail.
	IN	HB 1448		Authorizes the office of Medicaid policy and planning to require prior authorization for addictive medication used as medication assisted treatment for substance abuse. Allows money in the forensic treatment services account to be used to fund grants and vouchers for licensed mental health or addiction providers. Requires information and training to judges, prosecutors and public defenders concerning diversion programs, probationary programs and involuntary commitment.

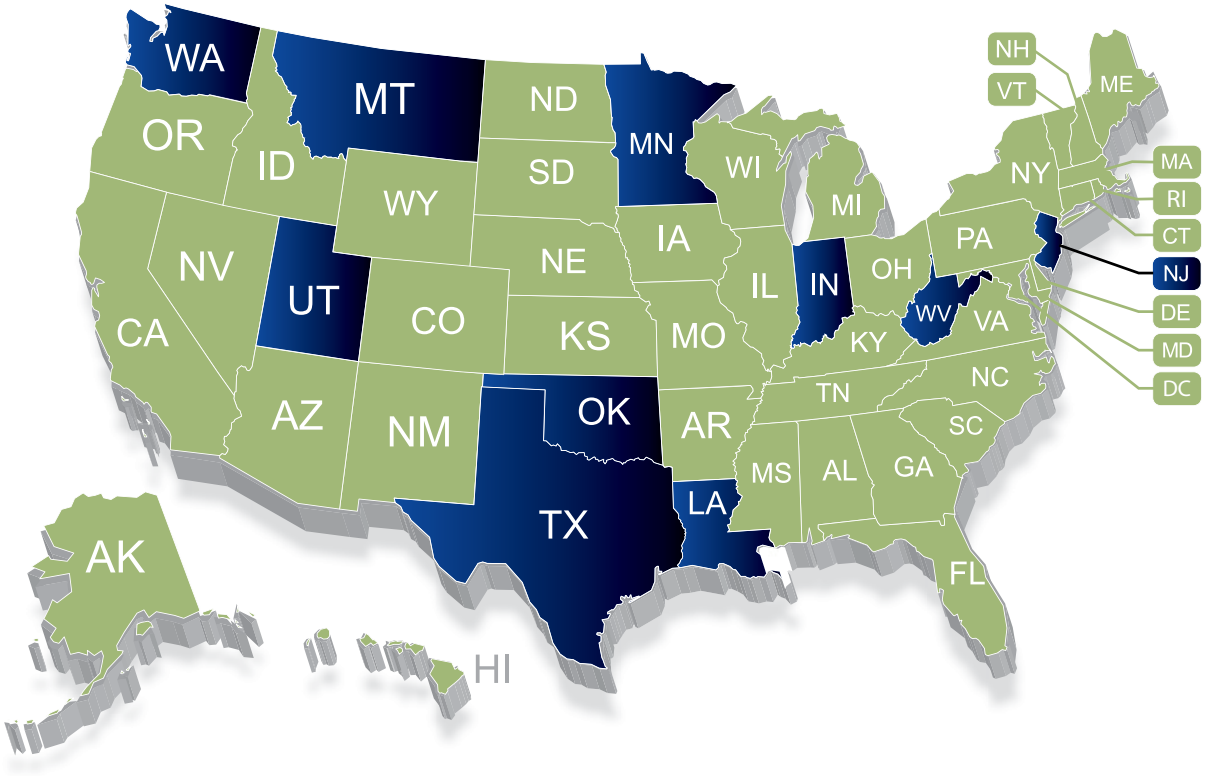
State	Bill	Chapter	Description
IN	HB 1531		Allows certain court proceedings involving a person confined to the Department of Corrections to be conducted by video conferencing with the consent of the confined person. Allows a person confined in a county jail to receive a mental health evaluation for the purpose of mental health assessment and treatment by means of video conferencing. Specifies that a mental health evaluation for the purpose of: (1) determining competency to stand trial; or (2) establishing a defense to a crime; may not be conducted by video conferencing. Prohibits recording of a mental health evaluation.
KY	HB 428		Allows Department of Corrections (DOC) officers to have the authority and powers of peace officers while carrying out their duties. Removes the requirement that offenders released by DOC present a birth certificate in order to obtain a driver's license and ensures that local correctional facility governing bodies are notified of jail inspection and condition findings. Allows a person in custody of the DOC and placed in a local jail to be released from custody to receive medical treatment.
LA	SCR 138		Requests strategies to provide offenders committed to the Department of Public Safety and Corrections and confined in parish correctional facilities the necessary education, job skills and training, and needed mental health care to facilitate successful reentry upon release.
LA	HR 203		Provides education, job skills and training, and mental health services for offenders to facilitate successful reentry upon release.
MD	SB 321	Ch. 126	Requires the Baltimore City and Baltimore County police departments to establish behavioral health units to consist of at least six officers who are specially trained to understand the needs of individuals with mental health, substance use, or co-occurring mental health and substance use disorders and in cultural sensitivity and cultural competency. Requires the Baltimore City Police Department to complete a study and make recommendations regarding the establishment of a behavioral health unit, including recommendations on the structure, size, cost, potential funding sources, and timeline for establishing the behavioral health unit.
ME	LD 1434		Amends the laws governing law enforcement's access to, and access to information about, certain persons in hospitals and mental health facilities. A law enforcement agency may 1) request access to a defendant receiving care in the hospital for the purpose of serving a protection from abuse order and 2) request a hospital provide notice of upcoming release. The hospital may 1) provide access if request is consistent with provisions, and 2) is exempt from civil and criminal liability arising from compliance with this law.
MS	HB 1267		Allows the parole board to parole any offender who has not committed a crime of violence and served 25% or more of his sentence after the senior circuit judge authorizes the offender to be eligible for parole consideration. Revises the expunction of a felony record to include any first offender who has been convicted of a misdemeanor that is not a traffic violation. Clarifies that any person who committed a felony when under the age of 21 may petition for an expunction of a conviction; however, eligibility for expunction does not apply to certain classified felonies of violence.
MT	HB 100		Allows certain mental health professions to examine and evaluate the mental health of a peace officer candidate to examine for any mental health conditions that might adversely affect performance. Allows substitution of a standardized mental health evaluation instrument for the mental health examination. Revises the duties of public safety officer standards and training council related to certification of public safety officers.
ND	HB 1106		Provides for a legislative management study of issues relating to criminal defendants who are veterans or currently serving in the armed forces, including whether additional treatment and sentencing options should be considered if a defendant is suspected to have PTSD or other behavioral health conditions and what steps the state needs to take to ensure that these persons are best handled in the state's criminal justice system.

	State	Bill	Chapter	Description
★	NE	LB 268		Eliminates the death penalty and removes all provisions relating to the death penalty. Revises the categorization of felonies, classifies murder in the first degree as a Class IA felony and mandates that criminal proceedings in which the death penalty has been imposed but not carried out be changed to life imprisonment. The changes made in the bill do not alter the authority of the court to order restitution as part of a sentence and the authority of the Department of Correctional Services to determine appropriate security measures.
	NE	LB 504		Provides a judge, probation officials, alcohol and drug counselors and mental health practitioners access to any offender's substance abuse evaluations. Allows the court to permit inspection of the presentence report, substance abuse evaluation or psychiatric examination by any other person with a proper interest only if it is in the offender's best interest. Mandates that if an offender is sentenced to imprisonment, substance abuse evaluations must be accessible to DOC Services and the Supreme Court for research purposes.
	NE	LB 598		Adopts the Office of Inspector General of the Nebraska Correctional System Act to establish a full-time program of investigation and performance review of the Nebraska correctional system. Requires the Director to adopt rules and regulations for risk assessment, inmate management, ensure that all incarcerated persons receive a full mental health screening within the first two weeks of intake and ensure the provision of adequate individualized treatment and care. If it is found by a DOC physician or psychologist that a committed person is mentally ill, the person may be segregated from others in the facility, in the least restrictive manner possible. Mandates the adoption of rules to establish evidence-based criteria to identify that a person nearing release should be mentally evaluated. Modifies the use of restrictive housing, establishes a long-term restrictive housing work group (including mental health professionals) and establishes a policy for prison overcrowding.
	NE	LB 605		Amends felony classification and the definition of select felonies and misdemeanors. Establishes a procedure for when the court desires more detailed information as a basis for determining which sentence to impose upon an offender. Amends duties of the probation administrator and officers, provides for individualized post-release supervision and transition plans and alters parole supervision procedure. Authorizes the dissemination of criminal history record information for research purposes. Requires a reward matrix to be developed for compliance and positive behaviors for use in deterring substance abuse violations. Creates the Committee on Justice Reinvestment Oversight and the County Justice Reinvestment Grant Program. Amends committed adult structured programs and treatment services to include cognitive behavioral intervention and inmate-led self-betterment clubs. Orders for program evaluation. Changes provisions relating to victims' rights and provides for suspension of medical assistance for inmates.
	NJ	S 2380	Ch. 11	Mandates that the Commissioner of Human Services and Corrections will create a plan to provide prison-based mental health and substance use disorder treatment programs and services to inmates. Lists plan requirements including procedures for screening and evaluation, service provision and enumeration, termination of treatment and assistance in a person's community reintegration after discharge.
★	OH	SB 5		**Pending:** Makes peace officers, firefighters, and emergency medical workers diagnosed with post-traumatic stress disorder arising from employment without an accompanying physical injury eligible for compensation and benefits under Ohio's Workers' Compensation Law.
★	OH	SB 162		**Pending:** Provides that a person convicted of aggravated murder who shows that the person had a serious mental illness at the time of committing the offense cannot be sentenced to death for the offense. Provides a mechanism for resentencing the person.
	OK	SB 64		Amends the definition of "currently undergoing treatment for mental illness" for peace officer background investigation to include a diagnosis by a licensed mental health professional. Allows CLEET to subpoena or request a court to subpoena records. Any confidential information received shall retain its confidential character while in the possession of CLEET.

	State	Bill	Chapter	Description
	OK	SB 715		Directs courts to issue certain orders relating to competency restoration services and prohibits courts from committing incompetent persons. If a person is found to be incompetent because he/she requires behavioral health treatment, the court will suspend criminal proceedings and order the Department of Mental Health and Substance Abuse Services to provide treatment, therapy or training which is calculated to allow the person to achieve competency.
	OK	HB 1518		Authorizes courts to depart from mandatory minimum sentencing requirements if the court finds that the minimum sentence is not necessary for the protection of the public, would result in injustice to the defendant or if the defendant is eligible for an alternative court, diversion program or community sentencing. Establishes that the court cannot depart from the mandatory minimum sentencing on convictions for specific criminal offenses.
	OR	HB 2420	Ch. 130	Provides that when the court has reason to doubt the defendant's fitness to proceed by reason of incapacity, the court shall order that a community mental health program director consult with the defendant to determine the availability of supervision and services in the community to safely restore the defendant's fitness.
	OR	HB 2429	Ch. 201	Authorizes the Psychiatric Security Review Board to conduct relief hearings for persons found guilty except for insanity of certain misdemeanors. Authorizes the Board to conduct hearings with members from an adult and/or juvenile panel.
	OR	HB 2557	Ch. 320	Creates a process by which a person found guilty except for insanity can apply to the court for entry of an order setting aside the judgement finding the person guilty except for insanity.
★	PA	HB 221		Requires that at least every six years, the continuing education program for magisterial district judges shall include the identification of mental illness, intellectual disabilities and autism and the availability of diversionary options for individuals with mental illness, intellectual disabilities or autism. Amends the powers and duties of the commission to include the provision of training for police officers with respect to recognition of mental illness, proper techniques to interact with and deescalate situations involving persons with mental illness and instruction on mental health services.
★	SC	S 426		Establishes a Mental Health Court Program to divert mentally ill offenders to appropriate treatment programs rather than incarceration, sets parameters for eligibility to participate in mental health court, provides that each solicitor must establish a program and requires that solicitors who accept state funding for the program establish it within 180 days.
	TX	SB 578		Requires the Department of Criminal Justice to identify organizations that provide reentry and reintegration resources guides and to collaborate with those organizations to make those guides available to all inmates.
	TX	HB 1083		Requires that before the Texas Department of Criminal Justice may confine an inmate in administrative segregation, an appropriate medical or mental health care professional must perform a mental health assessment of the inmate. The department may not confine an inmate if the assessment performed indicates that type of confinement is inappropriate for the inmate's medical or mental health.
★	TX	SB 1507		Creates a Forensic Director. Requires that judges and lawyers receive information about treatment alternatives to inpatient commitment. Requires the state health agency to ensure that each Local Mental Health Authority operates a free telephone hotline that enables a person to call a single number to obtain information about mental health services, substance abuse services, or both.
★	TX	HB 1908		Ensures that each offender with a mental impairment is identified and qualified for the continuity of care and that the legislation serves adults with severe and persistent mental illness who are experiencing significant functional impairment due to a mental health disorder.

	State	Bill	Chapter	Description
★	UT	HB 348		Requires the Division of Substance Abuse and Mental Health to establish standards for mental health and substance abuse treatment, create and track performance goals and outcome measures for treatment programs, determine the benefits of treatment as an alternative to incarceration and evaluate costs and needed resources. Requires that criminal risk factors be considered in providing individuals mental health and substance abuse treatment through governmental programs. Modifies penalties for specified offenses, amends provisions regarding probation, parole compliance and violations to address recidivism.
★	VA	HB 1400		Provides $1.8 million in new funding to expand therapeutic assessment centers for criminal justice diversion. Therapeutic assessment centers provide a location where law enforcement officers executing an emergency custody order can transfer custody of an individual in acute mental health crisis where the individual can be evaluated for treatment.
	VA	SB 1264	Ch. 540	Provides that certain information related to persons adjudicated incapacitated or ordered to involuntary inpatient or outpatient treatment or to persons who were subject to a temporary detention order who agreed to voluntary admission may be disseminated to a full-time or part-time employee of a law-enforcement agency for purposes of the administration of criminal justice.
	WA	SB 5311	Ch. 87	Requires a minimum of 8 hours of CIT training for law enforcement officers. Requires that said training be incorporated into the basic training program.
⚑	WA	SB 5889	Ch. 5	Addresses performance targets and maximum time limits for the completion of accurate and reliable evaluations of competency to stand trial and admissions for inpatient restoration services related to competency to proceed or stand trial for adult criminal defendants. Increases the time limit for competency evaluations from 7 days to 14 days.
	WA	HB 5177	Ch. 7	Encourages the Department of Social and Health Services to develop increased access to competency restoration services for individuals who do not require in-patient psychiatric hospitalization level services.
	WA	SB 1599	Ch. 253	If a person committed to custody for treatment as criminally insane presents an unreasonable safety risk, which is not manageable in a state hospital setting, and the secretary has given consideration to reasonable alternatives that would be effective to manage the behavior, the secretary may place the person in any secure facility operated by the DOC.
	WA	SB 5107		Authorizes, funds and encourages the establishment of therapeutic courts.
	WV	HB 2880		Requires the Secretary of Health and Human Resources to create an addiction treatment pilot program for offenders within the criminal justice system. Establishes program and participant requirements. Requires submission of a report. Permits the department to invite the Division of Corrections and the Supreme Court of Appeals to participate in the program. Allows the Department to limit the number of participants and requires additional support services if medication-assisted treatment is provided.
	WY	HB 15		Amends provisions relating to the restoration of voting rights to eligible felons and procedure for the issuing of a voting certificate. Mandates that if the individual is convicted of a nonviolent felony, the DOC requires an application for restoration of voting rights before issuing a certificate. Describes provisions for determining a person's eligibility and procedure for certificate filing.

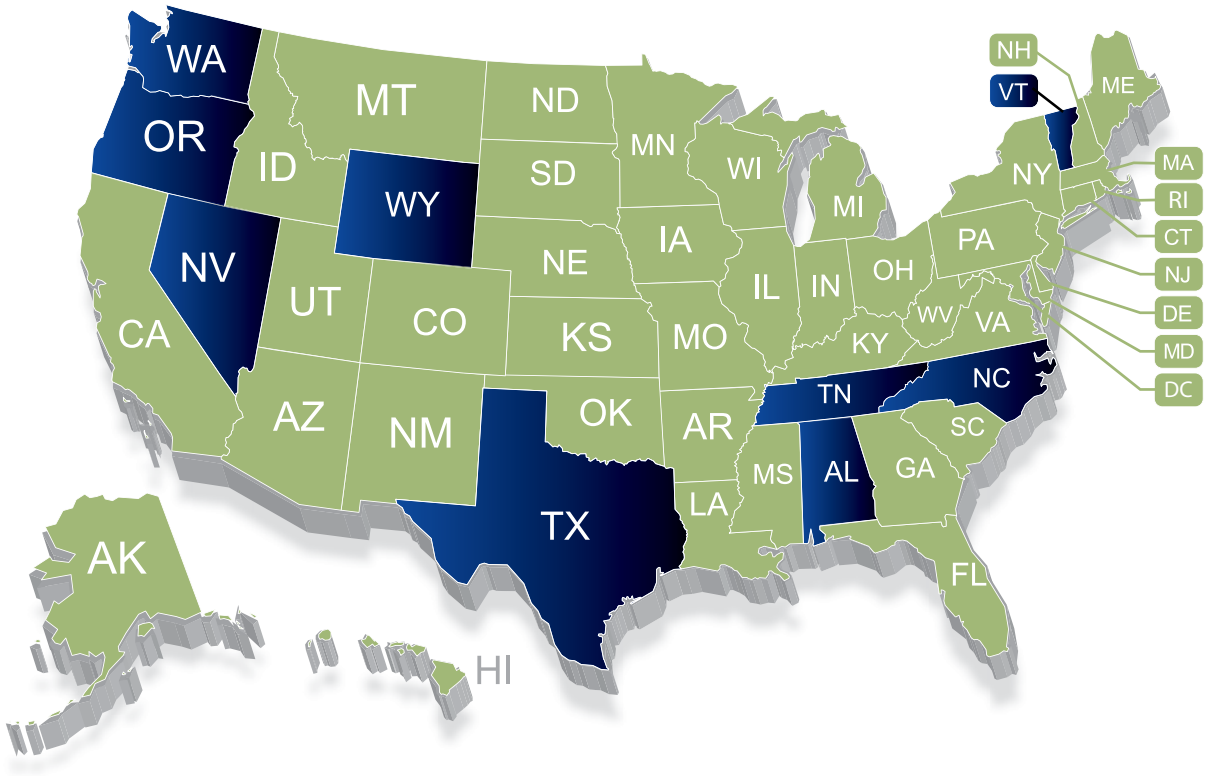
Appendix 13: Juvenile Justice



	State	Bill	Chapter	Description
★	IN	HB 1304	PL-187	Allows a person with an intellectual disability, developmental disability or autism spectrum disorder to participate in a forensic diversion program. Authorizes a prosecuting attorney to require a person participating in a prosecutorial diversion program to receive mental health treatment to reduce recidivism and allows diversion and deferral fees to be used to fund mental health treatment programs to reduce recidivism. Allows a criminal court to appoint a forensic advocate to assist a person with an intellectual disability, developmental disability, or autism spectrum disorder who is charged with a criminal offense. Provides that a juvenile shall not be restrained in court unless the court determines the juvenile is dangerous or potentially dangerous. Allows individuals with SUDs charged with or convicted of certain felonies to request treatment for addictions.
★	LA	HB 2092		Requires that early intervention programs be implemented with fidelity to the 16th Judicial District's prosecution early intervention program model. The Prosecutor's Early Intervention Program (PEIP) is a prevention-based program/diversion that facilitates a conduit between the home, school, social service agencies and the legal system in order to identify and intervene with children who are exhibiting behavioral and/or school performance problems.
★	MN	SF 1458	Ch. 71	Funds a pilot of the Minnesota Model of School-Based Diversion for students with co-occurring disorders in three schools. The pilots will be a collaborative effort between the Department of Human Services (DHS), the MN Chiefs of Police, the schools and local law enforcement and county attorneys' offices. The model assists schools and their partners in becoming more selective about making referrals to the juvenile justice system. Helps them develop alternatives to address incidents. $65,000 is appropriated for the second year of the biennium and then $161,000 each year of the next biennium.

	State	Bill	Chapter	Description
	MT	HB 233		Revises juvenile delinquency laws regarding youth with mental disorders. Authorizes the department to ask a cost containment review panel to make recommendations about the most appropriate placement for a youth suffering from a mental disorder. The department will consider the panel's recommendations before making its placement decision.
	NC	HB 669		Establishes that when a juvenile is placed in the non-secure custody of a county department of social services, the director may arrange for, provide, or consent to psychiatric, psychological or mental health examination, and care or treatment that is in the juvenile's best interest, with consent from the juvenile's guardian. Authorizes the department to disclose confidential information deemed necessary for assessment and treatment to a health care provider serving the juvenile.
	NJ	SB 2003		Reforms aspects of juvenile justice system. The court may deny a motion by the prosecutor to waive jurisdiction of a juvenile delinquency case if it is convinced that the prosecutor abused his discretion in considering factors in deciding whether to seek a waiver, including diagnoses concerning mental capacity or cognitive development, evidence of mental health concerns or substance abuse or emotional instability.
	OK	SB 457		Provides for child competency proceedings and specifies what should be in a competency report to the court. Specifies that a competency evaluation shall be done by a credentialed forensic evaluator and the required education and training for the designation. The Oklahoma Commission on Children and Youth is responsible for establishing procedures for ensuring proper qualifications and providing a list of evaluators to the courts. Provides for competency attainment services.
	TX	SB 1149		Requires the juvenile board or local juvenile probation department to submit all pertinent information, including a person's mental health records, to the Texas Department of Criminal Justice before the board or probation department transfers a person for release on parole supervision. Instructs a juvenile board or local juvenile probation department to accept a child with a mental illness who is committed to the custody of the board or department and establishes a procedure for discharging a child with a mental illness or intellectual disability. Requires psychological examination before discharge. Establishes procedure for petitioning the juvenile court that entered an order of commitment for a child for the initiation of mental health commitment proceedings if the child is committed.
	UT	SB 167		Sets a presumption that juveniles are not to be shackled when appearing in court unless ordered by the court.
	WA	SB 5870	Ch. 87	Prohibits the use of aversion therapy in the treatment of minors.
★	WV	SB 393	Ch. 150	Amends the Code of West Virginia to introduce evidence-based services, pilot programs and changes in current juvenile justice reform policies to support restorative justice programs, substance abuse recovery services, mental health programs and family therapies. Establishes community-based reporting centers, a Juvenile Justice Reform Oversight Committee with accompanying multidisciplinary team and prepetition review team.

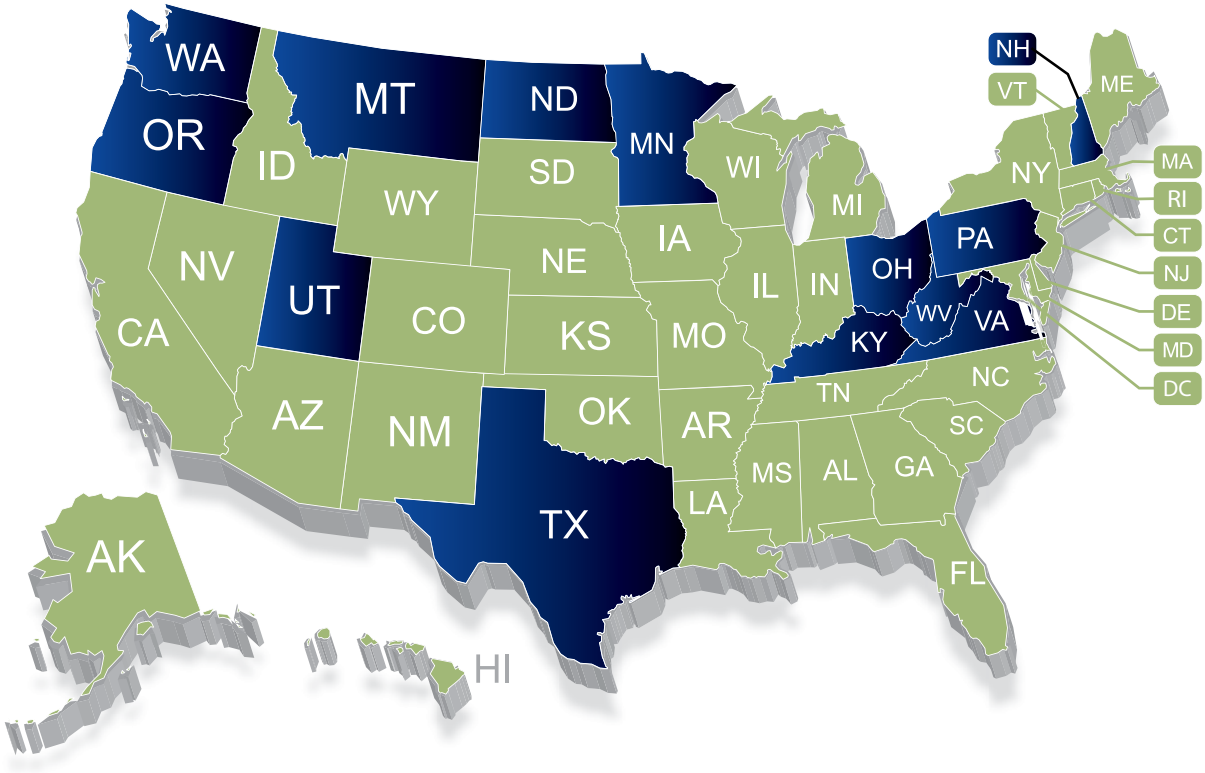
Appendix 14: Gun Ownership



State	Bill	Chapter	Description
AL	HB 47	Act 341	Among provisions related to gun ownership, provides for the entry of certain mental health information into the National Instant Criminal Background Check System. Allows a person who has been found insane, mentally incompetent or not guilty by reason of mental disease or defect to petition for the removal of applicable firearm prohibitions.
NC	HB 562		Amends firearm laws to require a firearm applicant to sign a release that authorizes and requires disclosure to the sheriff of any court orders concerning the mental health or capacity of the applicant. Reports mental illness as a firearm permit disqualifier.
NV	SB 240	Ch. 329	Requires a court to transmit certain records of adjudication concerning a person's mental health to the Central Repository for Nevada Records of Criminal History for purposes related to the purchase or possession of a firearm. Requires the Central Repository to conduct a background check on a person who wishes to acquire a firearm and prohibits certain persons from having possession, custody or control of a firearm. Requires a mental health professional to apply for the emergency admission of a patient to a mental health facility when a patient makes explicit threats of imminent serious physical harm or death.
OR	SB 941		Allows the court to prohibit a person from purchasing or possessing a firearm during the period of assisted outpatient treatment if there is a reasonable likelihood the person would constitute a danger to self or others or to the community at large as a result of the person's mental state, as demonstrated by past behavior.
TN	HB 1304	Ch. 459	Establishes procedures for the petitioning of a court for relief from firearms disabilities established for a prior judicial commitment or adjudication order for mental illness.

State	Bill	Chapter	Description
TX	SB 11		Amends provisions relating to the carrying of handguns on the campuses of and certain other locations associated with institutions of higher education. Provides for a criminal penalty.
VT	S 141		Requires the Court Administrator to report to NICS when a person is: (A) subject to a hospitalization order after a determination by a court that the person is a danger to self/ others; or (B) found not responsible for a crime by reason of insanity or incompetent to stand trial due to a mental illness.
WA	SB 5381	Ch. 130	Known as Sheena's Law, creates a protocol for the return of firearms in the possession of law enforcement agencies. Requires notification to a victim if a released perpetrator has a gun returned.
WY	HB 154		Amends provisions relating to the preparation and certification of a report of hunting licenses sold and issued in the previous year. Specifies the cost of a licensing fee related to the distribution of hunting licenses to individuals with disabilities.

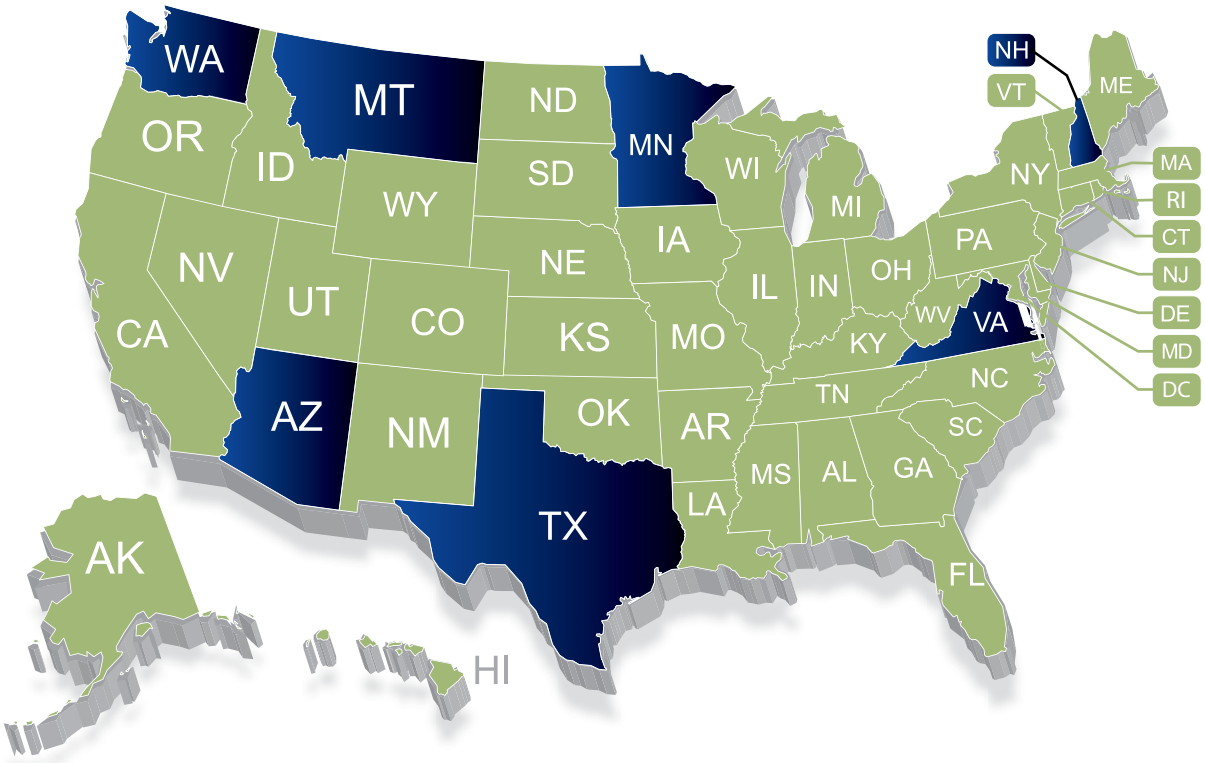
Appendix 15: Suicide Prevention



	State	Bill	Chapter	Description
	GA	HB 198	Act 97	Requires that all certified school personnel receive annual training in suicide prevention and awareness.
★	KY	HR 54		The House of Representatives encourages suicide prevention training for all healthcare professionals throughout the Commonwealth, recognizing the integral role they play in caring for the citizens of Kentucky.
★	MN	SF 1458	Ch. 71	Expands the funding for suicide prevention grants by 54% to 1) provide evidence-based suicide prevention and intervention to school staff and people who work with youth and 2) to provide evidence-based postvention training to mental health professionals and practitioners in order to provide technical assistance to communities after a suicide. Appropriates money to tribes to address the suicide rate among American Indians. Requires the commissioner of health to submit a plan on improving the use and timeliness of suicide-related data.
★	MT	HB 374	Ch. 351	Requires the Office of Public Instruction to provide guidance and technical assistance to schools on suicide prevention training and awareness materials and recommends that such training be made available to school personnel who work directly with students on an annual basis.
	ND	SB 2209		Requires school districts to provide annual suicide prevention training to all middle school and high school instructional staff, teachers and administrators.
★	NH	SB 33	Ch. 27	Requires that mental health professionals receive evidence-based suicide prevention education as part of their biennial licensure renewal.

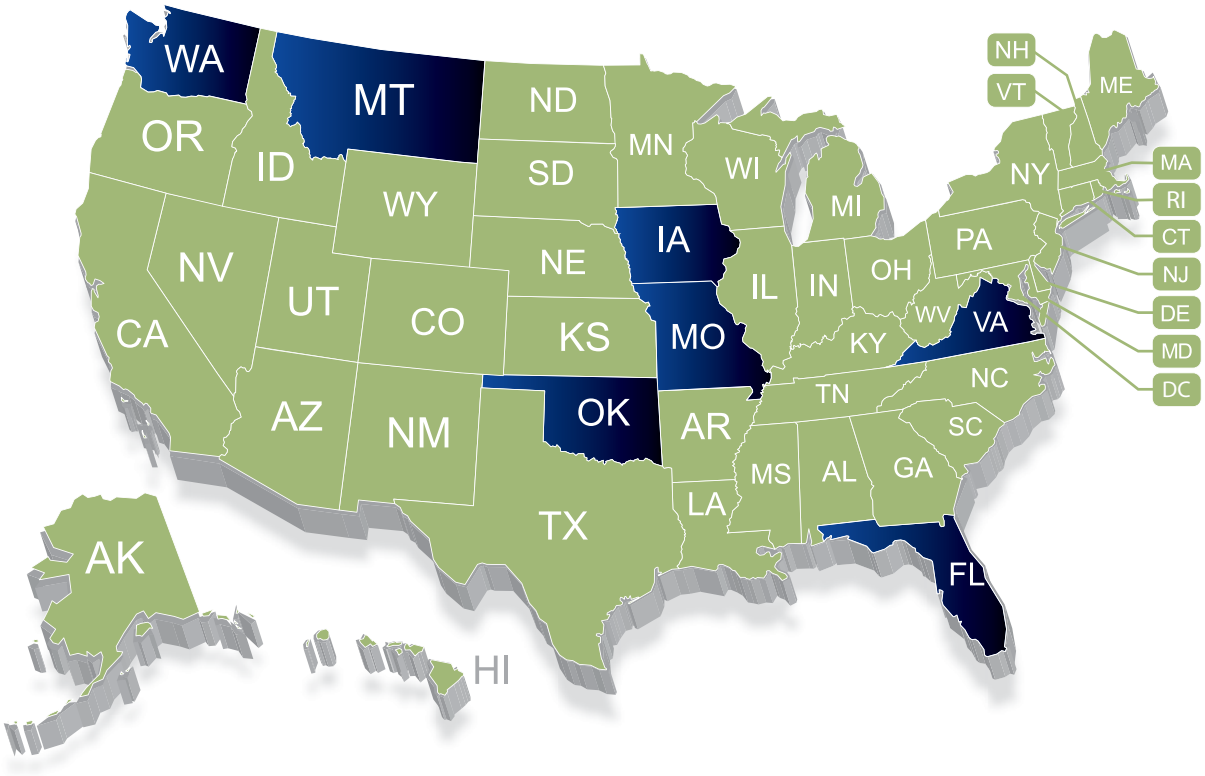
State	Bill	Chapter	Description
OH	HB 28		**Pending:** Requires each state institution of higher education to develop and implement policies to advise students and staff on suicide prevention programs available on and off campus. Requires the Board of Regents and the Department of Mental Health and Addiction Services to post free suicide prevention materials and program information on their websites. Requires each state institution of higher education to provide incoming students with information about mental health topics, including available depression and suicide prevention resources.
OR	SB 561		Directs the Oregon Health Authority to develop a plan for communication among local mental health authorities and systems to improve notifications and information-sharing when death suspected to be suicide involves an individual 24 years of age or younger. Directs Department of Human Services to submit report to interim legislative committees regarding occurrences of suicide and status of suicide prevention efforts in Oregon. Requires local mental health authority to inform Oregon Health Authority within seven days after suicide death of individual 24 years of age or younger.
PA	HB 1559	Ch. 71	Mandates that public schools require faculty members to complete four hours of professional development and suicide awareness every five years. Requires that the Department of Education provide each public school with needed resources at no cost to the school.
TX	SB 1624		Requires a general academic teaching institution to provide, to each entering full-time undergraduate, graduate or professional student, information about available mental health and suicide prevention services offered by the institution or associated organizations and early warning signs for a person who may be considering suicide.
UT	HB 209	Ch. 77	Mandates that certain behavioral health professionals must complete a minimum of two hours of suicide prevention training in order to obtain or renew a license.
UT	HB 364	Ch. 85	Appropriates additional funding for suicide prevention and anti-bullying programs to the Utah State Board of Education and to the Division of Substance Abuse and Mental Health.
VA	SB 1122	Ch. 716	Amends student mental health policies to require procedures for notifying the institution's student health or counseling center for certain set forth purposes when a student exhibits suicidal tendencies or behavior.
WA	HB 1138		Creates a task force on mental health and suicide prevention in higher education to determine what policies, resources and technical assistance may be needed to support the institutions of higher education in improving access to mental health services and improving suicide prevention responses.
WA	HB 1424	Ch. 249	Directs the department to adopt rules establishing minimum standards for suicide prevention training programs and consult with experts.
WV	HB 2535	Ch. 225	Creates "Jamie's Law" which requires all public middle school and high school administrators to provide opportunities to discuss suicide prevention awareness in schools. Requires all public and private middle schools, high schools and institutions of higher education to make resources and information on suicide prevention and depression awareness available to students and faculty.

Appendix 16: Housing and Employment



	State	Bill	Chapter	Description
★	AZ	HB 2488	Ch. 312	Establishes the Seriously Mentally Ill Housing Trust Fund. Allows the fund to be used for rental assistance for those with a serious mental illness.
★	MN	HF 3	Ch. 1	Appropriates an additional $1 million a year to continue projects converted to Individual Placement and Support (IPS) Supported Employment.
★	MN	SF 1458	Ch. 71	The Department of Human Services will analyze and recommend methods to fund mental health services, especially programs with separate funding for room and board. Requires consultation with stakeholders and experts. $5.5 million funded for the report and to stabilize intensive services such as Assertive Community Treatment (ACT), Intensive Residential Treatment (IRTS) and crisis residential beds. Adds $10.8 million through FY2017 for supportive housing for people with mental illness. Adds $2.5 million for Bridges, a Section 8 program for people with mental illness.
	MT	SB 405		Creates the Montana Health and Economic Livelihood Partnership (HELP) program. Improves the readiness of participants to enter the workforce or obtain better-paying jobs.
	NH	SB 47	Ch. 40	Prohibits employers from employing individuals with disabilities at a rate lower than minimum wage.
	TX	SB 219		Amends the duties of the Department of Aging and Disability Services. Requires each facility and community center to annually assess the feasibility of converting entry level support positions into employment opportunities for individuals with mental illness or an intellectual disability.
	VA	HB 1400		Provides $2.1 million in new funding for permanent supportive housing. Funding will provide supportive housing, including rental subsidies, to an estimated 150 persons with serious mental illness in order to avoid costly hospitalizations, incarceration, and homelessness.
	WA	HB 2263	Ch. 24	Provides local governments with options to increase options to provide services and facilities for people with mental illness, developmental disabilities, and other vulnerable populations. Contains a local option to use sales tax for housing and related services.

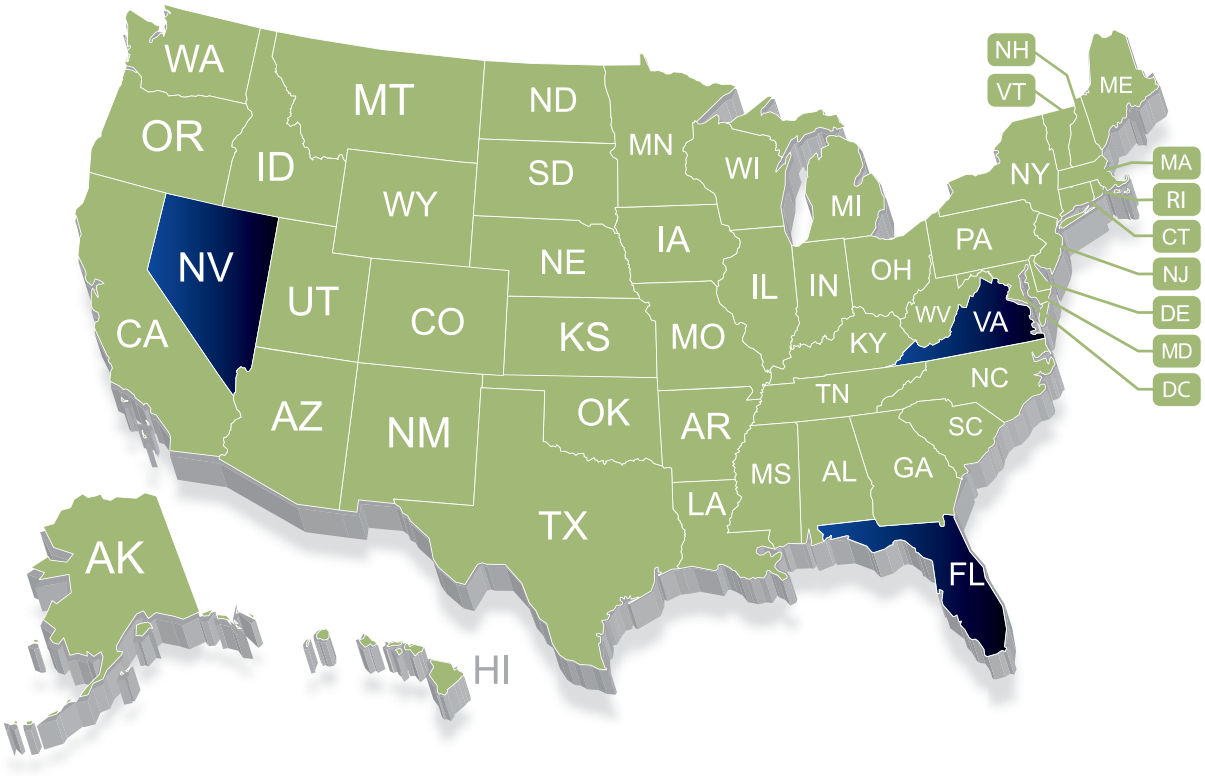
Appendix 17: Confidentiality and Family Involvement



State	Bill	Chapter	Description
FL	HB 889	Ch. 153	Provides an exception for a patient who has designated a surrogate to make health care decisions and receive health information without a determination of incapacity being required. Revises provisions relating to the designation of health care surrogates. Provides for the designation of health care surrogates for minors and specifies that a principal's wishes are controlling while he or she has decision making capacity.
IA	SF 201		Current law requires certain physicians, physician's assistants and nurses to contact the nearest court magistrate if it is believed that the patient is mentally ill and will hurt themselves or another. The bill eliminates the requirement of a supervising physician needing to approve the findings of the physician assistant before a magistrate is contacted.
MO	SB 426		Requires specified residential facilities, mental health programs, and mental health facilities to disclose information and confidential records to Department of Mental Health-designated community mental health liaisons for the purpose of care and service coordination. Additionally, confidential records and files maintained by any court in civil commitment proceedings shall be made available to community mental health liaisons. The court may impose appropriate restrictions or require a showing of good cause before releasing such records.
MT	HB 513		Revises and clarifies rules of evidence for mental health professional-client privilege by adding psychiatrists, licensed professional counselors and clinical social workers as mental health professionals.

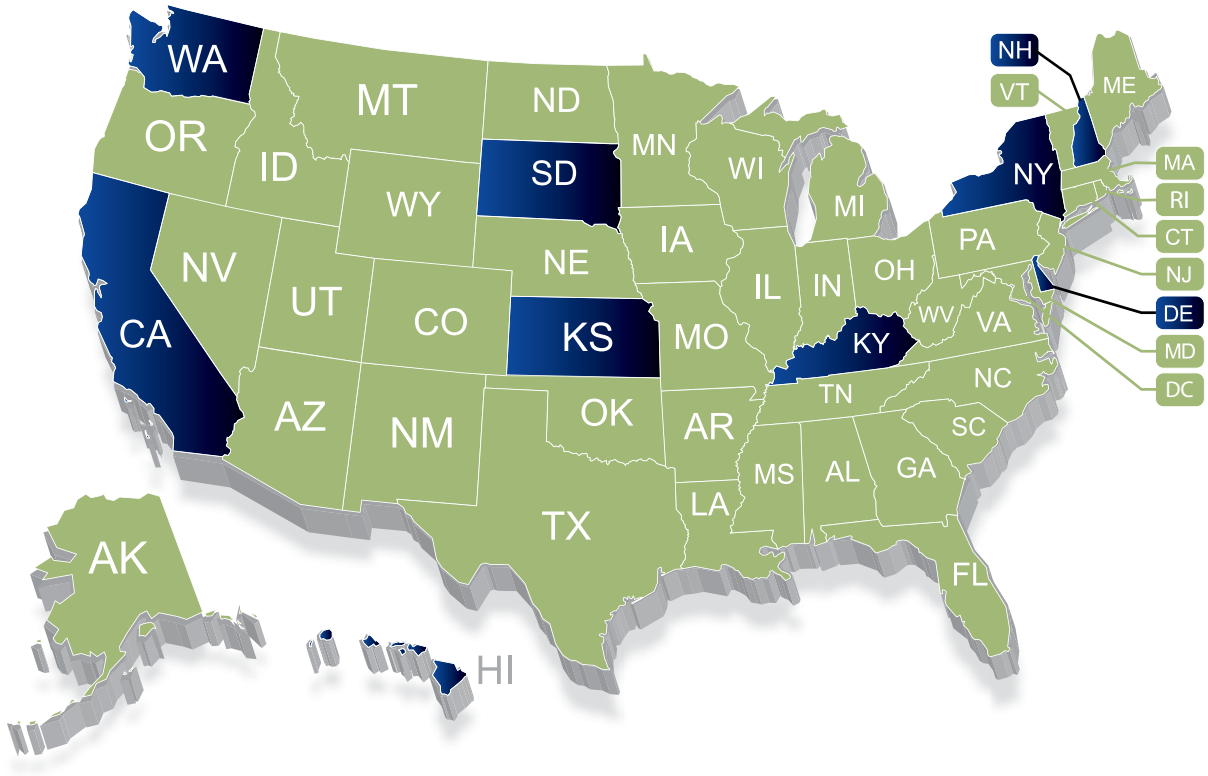
	State	Bill	Chapter	Description
	OK	SB 64		Amends definition of "currently undergoing treatment for mental illness" for peace officer background investigation to include a diagnosis by a licensed mental health professional. Allows CLEET to subpoena or request a court to subpoena records. Any confidential information received shall retain its confidential character while in the possession of CLEET.
★	VA	HB 1413	Ch. 106	Requires hospitals to provide each patient admitted as an inpatient or his or her legal guardian the option to designate an individual who will care for or assist the patient in his residence following discharge from the hospital and to whom the hospital shall provide information regarding the patient's discharge plan and any follow-up care, treatment and services that the patient may require.
	VA	HB 2083	Ch. 305	Directs community policy and management teams to establish a process for parents and individuals with primary physical custody of a child to refer children in their care to family assessment and planning teams or a multidisciplinary team approved by the State Executive Council for Comprehensive Services for At-Risk Youth.
★	WA	HB 1258		Establishes Joel's Law. If a designated mental health professional decides not to detain a person for evaluation and treatment or forty-eight hours have elapsed since the designated mental health professional received notice of such a person and has not taken action to have the person detained, an immediate family member or guardian or conservator of the person may petition the superior court for review of the designated mental health professional's decision.

Appendix 18: Older Adults



State	Bill	Chapter	Description
FL	HB 1001	Ch. 126	Strengthens the enforcement of current regulations for assisted living facilities (ALF) by clarifying existing enforcement tools, revising the Agency for Health Care Administration's (AHCA) ability to impose administrative penalties, and requiring an additional inspection for facilities having significant violations. The bill: • Clarifies the responsibilities of an ALF and of mental health care services providers regarding community living support plans for ALF mental health residents. • Requires an ALF that serves any mental health residents to obtain a limited mental health sublicense.
NV	AB 223	Ch. 485	Revises provisions concerning the reporting of abuse, neglect, exploitation, isolation or abandonment of an older person, requires that the name and other identifying information of a person who reports the abuse, neglect, exploitation, isolation or abandonment of an older person be redacted before certain data or information concerning the report is made available in certain circumstances. Prohibits the abandonment of an older person or a vulnerable person, proves a penalty and provides other matters properly.

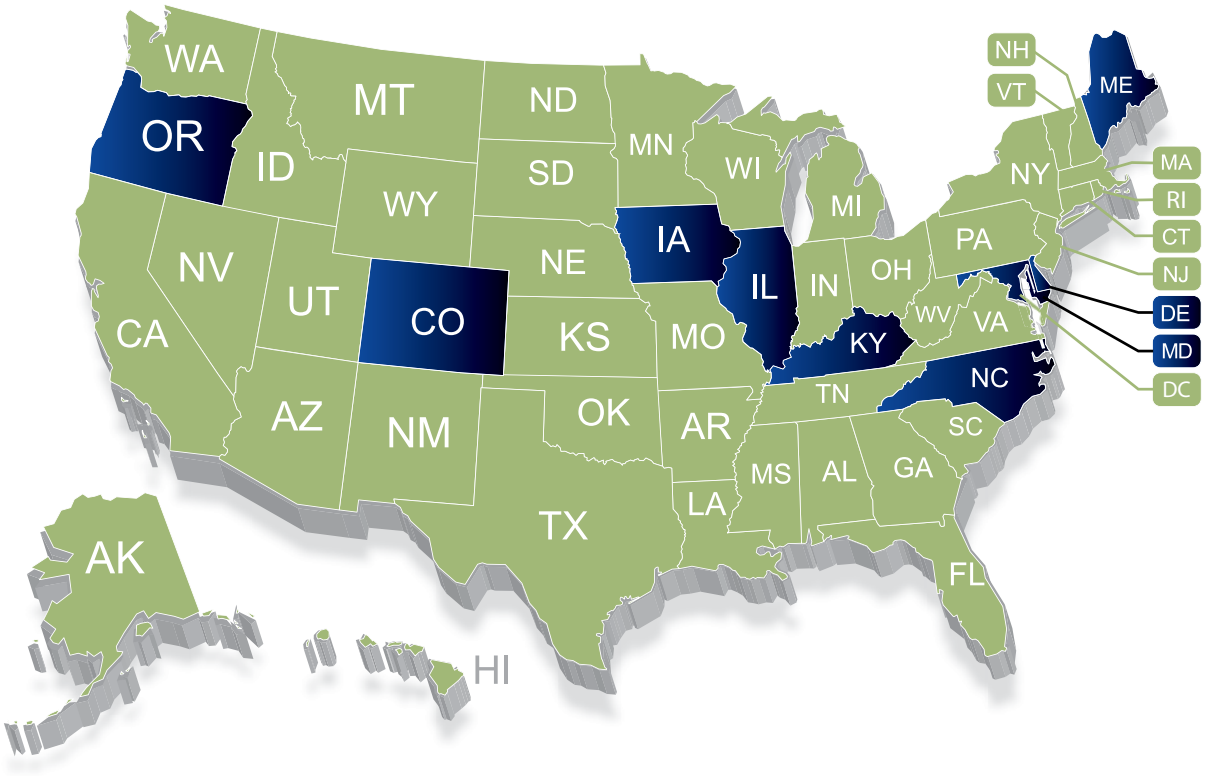
Appendix 19: Prescription Drugs



State	Bill	Chapter	Description
CA	AB 374	Ch. 621	Would authorize a request for an exception to a health care service plan's or health insurer's step therapy process for prescription drugs to be submitted in the same manner as a request for prior authorization for prescription drugs, and would require the plan or insurer to treat, and respond to, the request in the same manner as a request for prior authorization for prescription drugs.
DE	HB 111		Defines the level of medication administration permitted by unlicensed personnel and the settings in which they can administer medications.
HI	SB 1106	Ch. 20	Removes language that refers to specific programs and replace it with "Medicaid managed care." Authorizes all Medicaid managed care health plans to subject prescription drugs for conditions covered in section 346-352, Hawaii Revised Statutes, to prior authorization procedures.
KS	HB 2149		Allows the Medicaid Drug Utilization Review Board to impose restrictions on drugs used to treat mental illnesses. Establishes a Mental Health Medication Advisory Committee to review all proposed psychiatric medication coverage restrictions within Medicaid. Provides for composition of the Committee and duties to advise the Medicaid Drug Utilization Review Board.
KY	SB 44	Ch. 39	Permits Medicaid patients with multiple chronic conditions, in consultation with their medical providers, to permit medication synchronization when part of a plan between provider, patient and pharmacist. Patients may elect to place all medications in the synchronization program.
KY	HB 377	Ch. 118	Permits a collaborative agreement to be made between more than one pharmacist and practitioner if certain agreement provisions are met.

State	Bill	Chapter	Description
NH	SB 84		Clarifies when it is appropriate to use telemedicine in practitioner-patient medical circumstances. A practitioner treating patients in community mental health programs may prescribe certain controlled drugs by means of telemedicine.
NH	HB 564	Ch. 199	Requires that a managed care organization offering prescription drug benefits to Medicaid recipients shall suspend prior authorization requirements for a community mental health program on drugs used to treat mental illnesses.
NY	S 3419		**Pending:** Regulates step therapy policies. Requires clinical review criteria used to establish step therapy protocols be based on clinical practice guidelines endorsed by independent experts, based on high quality studies and be created by a transparent process. Requires that patients and health care providers have access to a clear and convenient process to request a step therapy exception determination.
SD	SB 118		Provides additional transparency for prescription drug plans.
VA	HB 1942	Ch. 515	Requires certain health insurance contracts under which an insurance carrier or its intermediary has the right or obligation to require preauthorization for a drug benefit to include provisions governing the preauthorization process. Required provisions address (i) acceptance by carriers of telephonic, facsimile or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems and health information exchange platforms that utilize certain standards; (ii) time limits for communicating to the prescriber that a request is approved, denied or requires supplementation; (iii) providing reasons for denial of a request; (iv) honoring a prior authorization approved by another carrier; (v) use of a tracking system for prior authorization requests; and (vi) making formularies, drug benefits subject to prior authorization, prior authorization procedures and certain forms available through the carrier's website. The measure also requires certain organizations to convene a workgroup to identify common evidence-based parameters for carrier approval of certain prescription drugs.
WA	SB 5441	Ch. 213	A health benefit plan issued or renewed after December 31 2015, that provides coverage for prescription drugs must implement a nine medication synchronization policy for the dispensing of prescription drugs to the plan's enrollees if an enrollee requests medication synchronization for a new prescription, the health plan must permit filling the drug.
WA	SB 5460	Ch. 234	Allowing practitioners to prescribe and distribute limited amounts of prepackaged emergency medications to patients being discharged from hospital emergency departments when access to a community or outpatient hospital pharmacy is not available.

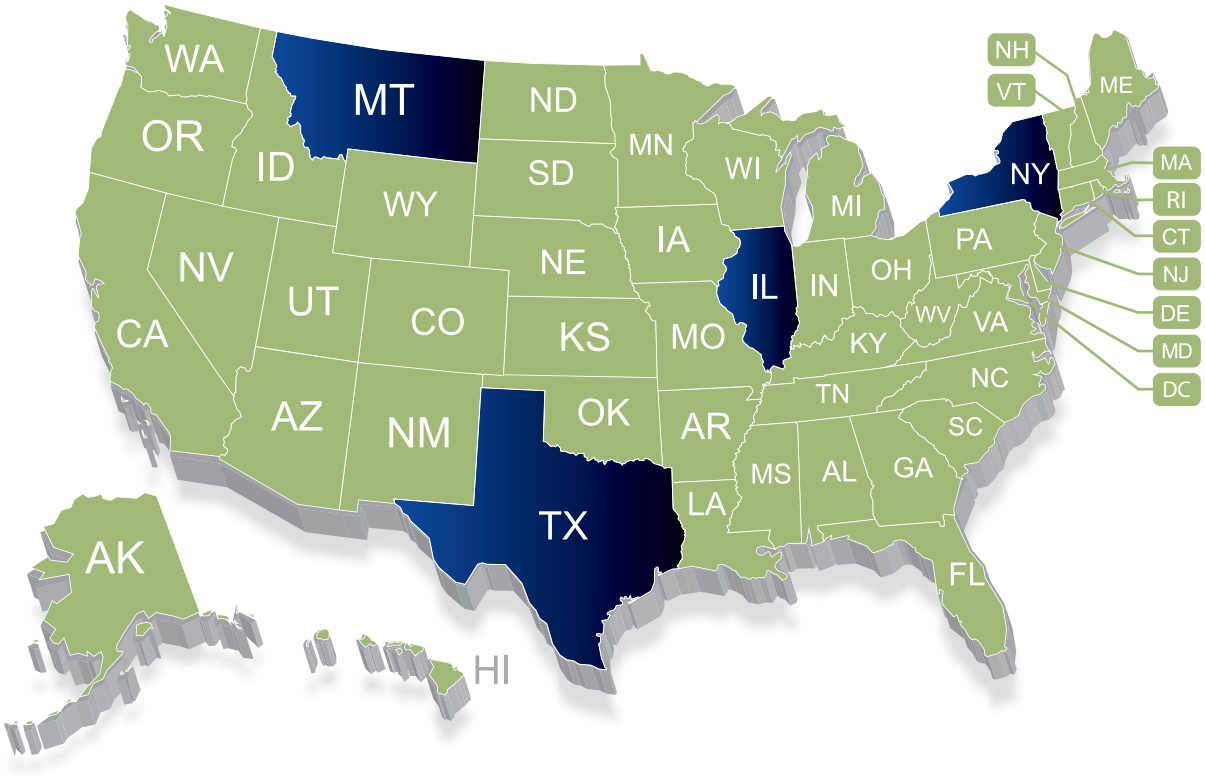
Appendix 20: Rights Protection



State	Bill	Chapter	Description
CO	SB15-109		Expands the requirement to report abuse or exploitation to also cover a person with a disability who is 18 years of age or older.
DE	HB 64		Authorizes the use of Medical Orders for Scope of Treatment in Delaware. This document, a "DMOST form," will allow Delawareans to plan ahead for health-care decisions, express their wishes in writing and both enable and obligate health care professionals to act in accordance with a patient's expressed preferences.
IA	SF 306		Protects the rights of adults under guardianship to communicate, visit or interact with persons of their own choice. Guardians may impose reasonable time, place and manner restrictions on such visits. However, guardians may not deny such visits or interaction unless granted approval by the court based on a showing of good cause.
IL	SB 834		Amends the Mental Health and Developmental Disabilities Code concerning court hearings under the Admission, Transfer and Discharge Procedures for the Mentally Ill Chapter of the Code. Deletes provision that any party may request a change of venue or transfer to any other county because of the convenience of parties or witnesses or the condition of the respondent. Provides that the court shall grant the request of the respondent to have the proceedings transferred to the county of his or her residence if and only if the court determines that the transfer is necessary to ensure the attendance of any material witness. Effective immediately.
KY	SB 47		Requires the Human Rights Commission to make reasonable accommodations to assist persons with disabilities in filing a complaint.

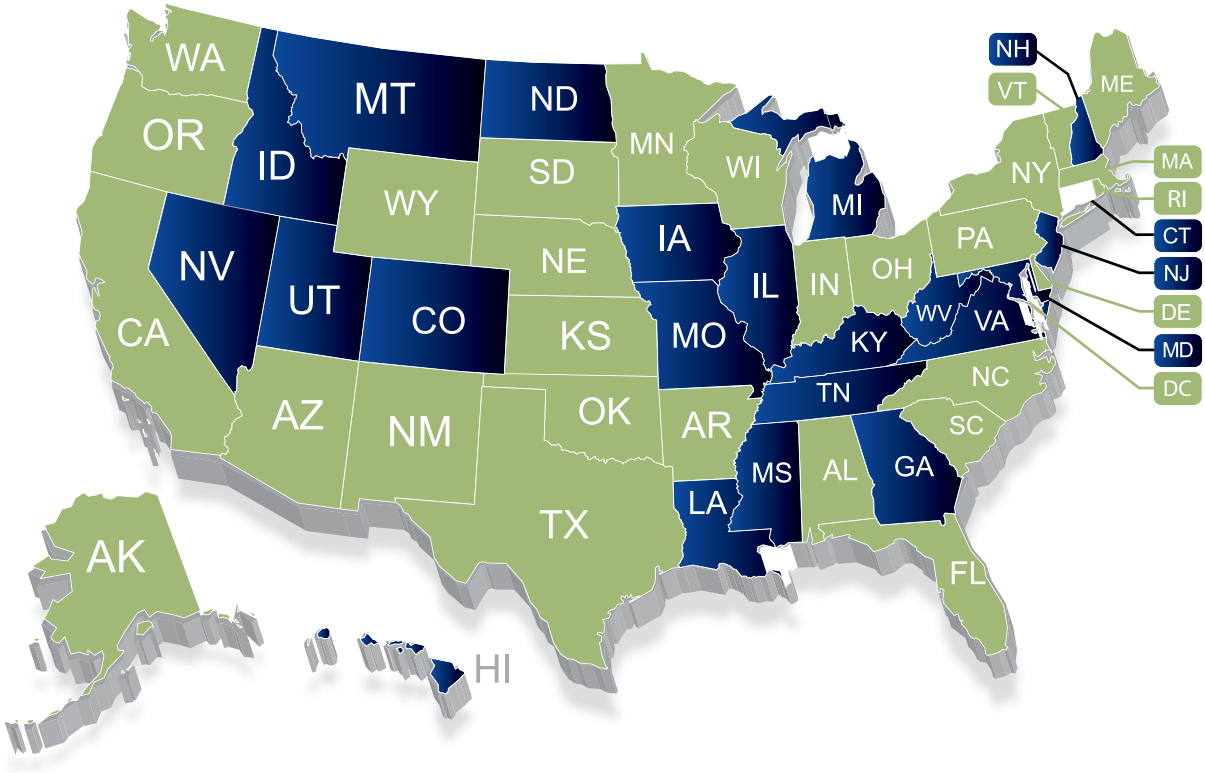
	State	Bill	Chapter	Description
	MD	HB 293	Ch. 412	Authorizes a court to appoint a guardian of the person of a disabled person for a limited period of time under specified circumstances. Specifies that certain rights, duties and powers that a court may order include the duty to file a specified report. Authorizes a declarant to waive specified rights when making an advance directive.
	ME	LD 1434		Amend the Laws Governing Law Enforcement's Access to, and Access to Information about, Certain Persons in Hospitals and Mental Health Facilities. Law enforcement agency may 1) request access to a defendant receiving care in the hospital for the purpose of serving a protection from abuse order and 2) request a hospital provide notice of upcoming release. Hospital may 1) provide access if request is consistent with provisions and 2) is exempt from civil and criminal liability arising from compliance with this law.
	NC	SB 445		Enhances protections for clients of facilities whose primary purpose is to provide services for the care, treatment, habilitation and rehabilitation of individuals with mental illness, developmental disabilities or substance abuse disorders. Increases punishments for client abuse, exploitation or neglect. Adds a requirement that the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services establish standardized procedures to train and keep records of the measures used to comply with the employee and volunteer reporting requirements.
	OR	HB 2368	Ch. 82	Provides that if person has either valid health care instruction or valid power of attorney for health care and declaration for mental health treatment, that inconsistencies in documents are governed by declaration for mental health treatment.

Appendix 21: Stigma Reduction



State	Bill	Chapter	Description
IL	HB 4049		Amends the Statute on Statutes, the Disabled Persons Rehabilitation Act, the Mental Health and Developmental Disabilities Administrative Act, the Illinois Public Aid Code and other various Acts. Changes all occurrences of “disabled persons” to “persons with disabilities” and changes all occurrences of “the mentally and developmentally disabled” to “persons with mental and developmental disabilities.”
MT	HB 382		Revises terminology relating to mental illness replacing references to “mental defect” and similar phrases with references to “mental disease or disorder.”
NY	S 632		Allows New Yorkers to designate a portion of their tax return to be used to start a fund for the New York State Office of Mental Health to use for a mental health public awareness campaign.
TX	HB 2079		Designates May as Postpartum Depression Awareness Month.

Appendix 22: System Improvement and Planning

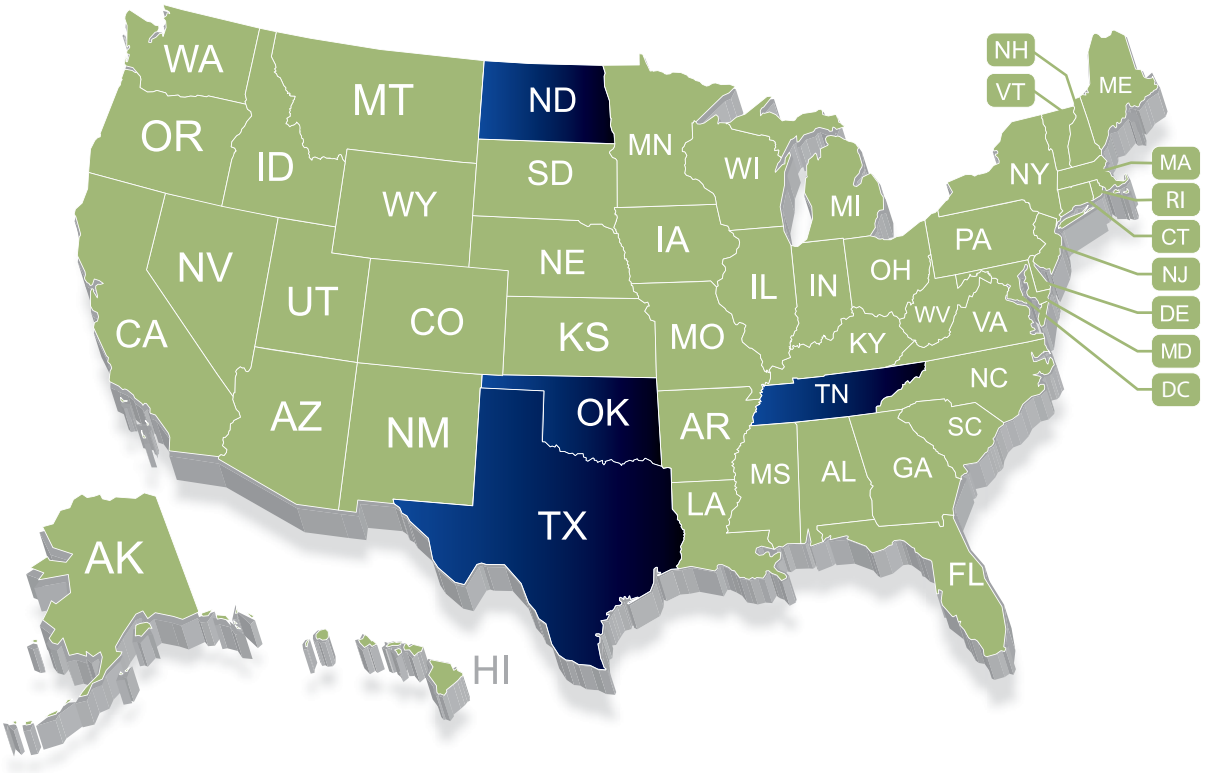


State	Bill	Chapter	Description
CT			State Innovation Model (SIM) is a process for planning a health delivery and payment system (Medicaid and beyond) to coordinate care and share savings with providers. Builds on existing health reform efforts including medical home, accountable care organization (ACO) and primary care/ behavioral health integration initiatives. Advocates are currently working on establishing safeguards for this vulnerable population to ensure that the risk of under-service and barriers to services will be minimized.
CO	HB 15-1359		Authorizes establishment of an Achieving a Better Life Experience (ABLE) savings program that conforms to the federal ABLE Act of 2014.
GA	HB 288	Act 90	Modifies the Behavioral Health Coordinating Council membership, meetings and obligations. Provides for two additional members to serve on said Council and repeals conflicting laws.
GA	HB 512		Changes certain terminology and provisions relating to the governing and regulation of mental health and to the administration of mental health as it relates to regional and local administration and services; to provide for related matters; to repeal conflicting laws; and for other purposes.
HI	HB 119	Ch. 206	Establishes the Hawaii ABLE Savings Program by authorizing the Director of Finance to establish savings accounts that empower individuals with a disability and their families to save private funds to support the individual with a disability. Creates the Hawaii ABLE Savings Program Trust Fund.
IA	SF 463		Redesigns mental health and disabilities services administered by regions comprised of counties.

	State	Bill	Chapter	Description
	IL	HR 160/ SR 148		Encourages the Administration, including the Department of Human Services Divisions of Mental Health and Alcoholism and Substance Abuse, the Department of Healthcare and Family Services and the Governor's Office, to prioritize application for a planning grant for the State of Illinois. Urges the aforementioned to collaborate in this effort with key stakeholders, including organizations representing individuals with serious mental illnesses, community-based mental health providers, substance use treatment facilities, federally-qualified health centers, hospitals, supportive housing providers and rural health clinics.
★	IL	HB 3117	Ch. 120	Creates the "Achieving a Better Life Experience" (ABLE) account plan to assist individuals and families in saving private funds for the purposes of supporting persons with disabilities. Establishes requirements for the plan.
	KY	SB 51		Expands the definition of "patient" to include persons currently under the care or treatment of mental health professionals.
	LA	SCR 132		Requests the Department of Health and Hospitals to conduct a study on access to psychiatric medications and the costs for non-access to such medications.
	LA	HCR 186		Commissions a study to establish baseline data on access to health care in Louisiana and make recommendations concerning health system reforms that emphasize prevention and wellness.
	MD	SB 174	Ch. 328	Establishes a Behavioral Health Advisory Council in the Office of the Governor to promote a quality system of care that integrates specified practices and strategies to enhance behavioral health services across the State and to advocate for specified services that promote wellness and recovery for individuals with behavioral health disorders. Requires submission of an annual report to the Governor and General Assembly.
	MD	HB 1109	Ch. 469	Establishes specified powers, duties and responsibilities of the Director of the Behavioral Health Administration in the Department of Health and Mental Hygiene. Requires core service agencies, local addictions authorities and local behavioral health authorities to submit a specified plan to the Director. Authorizes the Director to deny approval and cease funding or request the return of unspent funds under specified circumstances.
	MD	HB 896		Establishes the Joint Committee on Behavioral Health and Opioid Use Disorders. Specifies the purposes of the Joint Committee are to review the final report of the Governor's Heroin and Opioid Emergency Task Force, review and monitor the activities of the Governor's Inter-Agency Heroin and Opioid Coordinating Council, monitor the effectiveness of specified programs, policies and practices, review compliance with specified federal and State laws by health insurance carriers and identify areas of concern and corrective measures; etc.
	ME	LD 525	Ch. 18	Directs the Department of Health and Human Services to report on efforts to reach, in rural areas, persons who are elderly, disabled or mentally ill.
	MI	HB 4444	Ch. 59	Codifies, revises, consolidates and classifies laws relating to mental health. Prescribes the powers and duties of certain state, local and private entities. Regulates certain mental health and substance use agencies and facilities. Provides for charges and fees. Establishes civil admission and guardianship procedures. Establishes procedures regarding individuals with mental illness, substance use disorder or disability who are in in the criminal justice system. Provides for penalties and remedies.
	MO	SB 174		Creates the "Missouri Achieving a Better Life Experience (ABLE) Program." Establishes that a participant may make tax-deductible contributions to an account established for the purpose of financing the qualified disability expenses of a designated beneficiary. Clarifies the eligibility of a designated beneficiary.

State	Bill	Chapter	Description
MT	SB 405		Creates the Montana Health and Economic Livelihood Partnership (HELP) Act to expand health care coverage to additional individuals, improve access to mental health care services, improve the readiness of program participants to enter the workforce or obtain better-paying jobs and control health care costs. Establishes a Health Care Coverage Program to provide certain low-income Montanans with access to health care services using Medicaid funds and arrangement with a third-party administrator.
MT	SB 418		Authorizes transfers to implement provisions of appropriations act. Requires legislature to monitor and evaluate how well the State Department of Health and Human Services is implementing legislation, including mental health.
ND	HB 1048		Provides for behavioral health licensure boards to develop a plan, in collaboration with the other boards, for the administration and implementation of licensing and reciprocity standards for licensees.
ND	SB 2049		Provides for a Department of Human Services study and report to the legislative management regarding statutory references to mental health professionals.
NH	HB 455	Ch. 259	Extends the commission to study mental health implementation in New Hampshire.
NJ	SB 2373		Requires the Division of Mental Health and Addiction Services to annually prepare a substance use treatment provider performance report and make it available to public.
NV	SB 35	Ch. 223	Ratifies and enacts the Interstate Compact on Mental Health to address issues relating to the treatment of persons with mental illness. Provides for the transfer of any patient to another state for treatment when clinical factors indicate that care and treatment would be improved through such a transfer.
TN	SB 112	Ch. 153	Authorizes the board for licensing healthcare facilities and the Departments of Mental Health and Substance Abuse Services, Human Services and Intellectual and Developmental Disabilities to amend licensure rules to be consistent with the federal home-based and community-based settings final rule. Prohibits the use of emergency rulemaking to promulgate such rules. Requires that licensure survey and enforcement be conducted in a manner consistent with any rule issued under this act.
UT	HB 272		Amends the composition and responsibilities of the Forensic Mental Health Coordinating Council.
★ VA	HB 1400		Provides $3.0 million in new funding to create three new Programs of Assertive Community Treatment (PACT) in fiscal year 2016, bringing the total number of PACT teams to 26 statewide. PACT is an evidence-based program with an interdisciplinary team that provides intensive service to individuals with severe and persistent mental illness who are at high risk for hospitalization, emergency room intervention, arrest, and displacement from housing.
★ WV	HB 2902	Ch. 85	Establishes the WV ABLE Act to allow savings accounts for individuals with a disability and their families to save private funds to support the disabled individual.

Appendix 23: Veterans



	State	Bill	Chapter	Description
	ND	HB 1106		Provides for a legislative management study of issues relating to criminal defendants who are veterans or currently serving in the armed forces, including whether additional treatment and sentencing options should be considered if a defendant is suspected to have PTSD or other behavioral health conditions and what steps the state needs to take to ensure that these persons are best handled in the state's criminal justice system.
★	OK	SB 713		Directs the Department of Mental Health and Substance Abuse Services to develop seven peer-supported drop-in centers for the specific purpose of serving Oklahoma veterans.
★	TN	SB 711	Ch. 453	Enacts the Criminal Justice Veterans Compensation Act of 2015. The act establishes specialized veterans treatment courts to meet the problems faced by veteran defendants, including mental illness and substance abuse.
	TX	HB 19		Requires the Department of Family and Protective services to develop and implement preventative services programs to serve veterans and military families who have committed or experienced or who are at high risk of family violence or abuse or neglect.
	TX	SB 55		Requires the commission to establish a grant program for the purpose of supporting community mental health programs providing services and treatment to veterans and their families.
	TX	SB 1304		Creates a women veterans mental health initiative within the mental health intervention program for veterans.
	TX	SB 1305		Creates a rural veterans mental health initiative within the mental health intervention program for veterans.

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