Mental Illness Policy Org.
Unbiased Information For Policymakers + Media
50 East 129 St., PH7 New York, NY 10035
office@mentalillnesspolicy.org mentalillnesspolicy.org

Comparing Provisions Important to people with Serious Mental Illness in House Bill 2646 and Senate Bill 1945

Unproofed Rough Draft (8/25)-Fact Check First

Summary: Both bills establish an Assistant Secretary for Mental Health and Substance Abuse to coordinate mental health policy and better focus it on *evidence* based practices for the *seriously ill* that reduce *meaningful* outcomes like reduced homelessness, arrest, incarceration, violence, suicide, and hospitalization. This is important because much of the federal government's mental health efforts, especially those of SAMHSA, are not aimed at the core issue: helping those already known to have serious mental illness avoid the worst consequences. Federal spending is often not based on independent evidence, and do not improve meaningful outcomes like reducing homelessness, violence, arrest, incarceration, suicide or hospitalizations.

Recommendations: Both bills need stronger language to address the hospital bed shortage even if it requires appropriation or allocating money from non-evidence based programs to it. Both bills need clearer language to solve the problem with HIPAA that prevents families from receiving information they need to facilitate treatment and protect health safety and welfare. Both bills should make it clear that the evidence use to declare a program "evidence-based" must be "independent."

The Senate bill is missing the critical provisions of House bill (funding of Assisted Outpatient Treatment and reform of Protection and Advocacy program) that are specifically targeted to reduce homelessness, arrest, incarceration and violence in people with serious mental illness. The Senate bill fails to focus SAMHSA on improving meaningful outcomes in people with serious mental illness.

Below is a comparison of some of the provisions. **Bold=provisions that should be in both bills.** *Italic= provisions that are in both bills*. **Blue = information for which there is a question. check all information before relying on it. This is an unchecked DRAFT. In particular check info in BLUE.** Page number/line number in bill shown as (00/00). The page/line numbers for Senate bill are based on a version circulating prior to introduction. If changes were made, it is likely that page/line numbers may have changed. Please email office@mentalillnesspolicy.org if you see any changes or mistakes.

Issue	House Bill HR 2646	Senate Bill S 1945	Recommendation
Assistant Secretary of Mental Health and Substance Abuse	***Creates office of Assistant Secretary for Mental Health and Substance Abuse and requires Asst. Sec. to have strong professional mental illness credentials*** ***Encourages Sec. to focus on programs that have evidence***	***Creates office of Assistant Secretary for Mental Health and Substance Abuse and requires Asst. Sec. to have strong professional mental illness credentials*** ***Encourages Sec. to focus on programs that have evidence they improve meaningful***	**Assistant Secretary should be required to "identify programs that improve meaningful outcomes including reductions in homelessness, arrest, incarceration, suicide, and hospitalization, especially in persons with serious mental illness"**

	they improve meaningful outcomes in people with serious mental illness	***outcomes in people with serious mental illness*** Allows Assistant Secretary to be a social worker. (5/5)	Asst. Sec. should be M.D. with expertise in serious mental illness, not a social worker.
SAMHSA –It is well documented that SAMHSA rarely focuses on programs that help the most seriously mentally ill, and instead focuses on improving mental health of all others. SAMHSA funds anti-psychiatry, requires states to use Mental Health Block Grants on people without mental illness, refuses to focus on improving meaningful outcomes like reducing homelessness, violence, arrest, incarceration, and fails to require programs it supports to have independent evidence they work.	**Transfers SAMHSA responsibilities to a newly created office of the Asst. Sec. for Mental Health and Substance Abuse (163/1)** **Has Asst. Sec distribute the mental health block grants**	Reauthorizes Programs of Regional and National Significance and increases funding from $300 million to $337million (96/12) CK THIS. WHAT IS IT? IS THIS MHBG, TOTAL SAMHSA? TAC?	To improve services for the most seriously mentally ill, *requires* reforming or eliminating SAMHSA. The overall impact of SAMHSA is to prevent federal dollars from helping the most seriously ill. If not eliminated, the Administrator of SAMHSA and CMHS should be a psychiatrist with extensive experience with SMI, and language inserted requiring to focus on *seriously* mentally ill, using *independent* evidence, and improving *meaningful* outcomes like reducing homelessness, arrest, incarceration, violence and hospitalization
Mental Health Block Grant	**HOUSE has provisions that have Asst. Sec administer Block Grant (page 49, line 18)** ***Requires MHBG plans to have sections focused on individuals with serious mental illness" and to reduce homelessness, etc. (52/9)***	***Requires MHBG plans to have sections focused on individuals with serious mental illness" and to reduce homelessness, etc. (36/9)***	
IMD Exclusion- The Institutes for Mental Disease Exclusion is Medicaid provision that largely prohibits Medicaid from covering individuals 18-64 who have mental illness and need long term hospital care. As a result of this federal discrimination, states close hospitals that serve the seriously ill.	*Allows care in IMD if IMD has facility wide average length of stay less than 30 days (124/15 and 124/6) if Center for Medicaid and Medicare Services (CMS) certifies no additional cost.(127/3)*	*Allows care in IMD if IMD has facility wide average length of stay less than 30 days (85/15) if CMS certifies no additional cost.*	**Access to hospital care is critical for the seriously ill and federal discrimination that prohibits Medicaid from reimbursing for it should be removed. Both bills should eliminate requirement that CMS certify they won't increase Medicaid spending. Further, cost calculation should be offset with reductions in costs to taxpayers such as reduced jail, trial, homelessness, emergency hospitalization even though those costs are not borne at the federal level**.

	Allows Medicaid to pay for care in residential facilities (Page 124, line 17) with facility wide length of stay of less than 30 days		
Assisted Outpatient Treatment (AOT) Some of the most seriously ill are so ill they don't know they are ill, go off treatment and repeatedly become hospitalized, incarcerated and homeless. For this small group, AOT (a court order for the individual to stay in treatment, and for the mental health system to monitor them) reduces arrest, incarceration, homelessness, hospitalization in 70% range and cuts costs in half.	**Gives a 2% bump in Mental Health Block Grants to states with AOT. (This is about $10 million, to be divided by states.)** **Ups the amount provided to states for AOT in Protecting Access to Medicaid Act by $5 million to $20 million** annually (48/1) Extends the Protecting Access to Medicaid grants for AOT through 2018. (20% to existing programs and 80% to new programs.) ***Requires Asst. Sec to report on effectiveness of AOT. (24/19) and clearly establishes what report should include*** *Requires report on effectiveness of AOT to compare AOT to voluntary services* ***and defines the comparison group as those "eligible to [participate in aot] by nature of their history." (25/18)*** **Requires states to include AOT in assertive outreach strategies (55/11 and 56/5)**	***Extends Protecting Access to Medicaid grants to 2020*** (34/1) ***Requires Asst. Sec to report on effectiveness research of AOT. (18/105)*** *Requires report on effectiveness of AOT to compare AOT to voluntary service (18/14)*	AOT is the only program in either bill designed to help those too sick to volunteer for services. Without this provision both bills only serve the higher functioning. AOT should be robustly funded It is important to include house language. There is no doubt that voluntary services work, but AOT has to be judged on whether those who refuse treatment do better on AOT or not, so comparison group must be those who refuse treatment.
AOT in Certified Behavioral Health Clinics.	Sets up certified behavioral health clinic demonstration project, that allows prospective payments to clinics (rather than fee for service)(134/1) Requires the clinics to offer AOT (143/23) and allocates $25 million annually to the clinics which may support the AOT effort (148/17)		This already passed as part of section 223 of the Protecting Access to Medicare Act of 2014.
AOT in State Mental Health Block Grant Plans	***Requires state mental health block grant applications to describe programs that reduce suicide, crime, incarceration, nonadherance to medication, etc. including Assisted***	***Requires state mental health block grant applications to describe programs that reduce suicide, crime, incarceration, nonadherance to medication, etc. including Assisted***	

	Outpatient Treatment (51/8) **Requires states "to engage persons with serious mental illness who are substantially unlikely to voluntarily seek treatment".**	***Outpatient Treatment (36/18)***	
Protection and Advocacy (P&A/PAIMI) –Was created with noble purpose of providing legal representation to prevent abuse of institutionalized mentally ill, but has morphed into a powerful lobbying enterprise that often opposes treatments that help the seriously ill. Ex., hospitals, AOT, Adult Homes, getting care to incapacitated, protecting ability of families to help. Etc.	**Returns P&A to focus on what Congress originally intended: preventing abuse and neglect of seriously mentally ill (167/17)** **Prevents P&A from using its funds to lobby. (166/19)** **Prevents P&A from counseling someone to do what P&A wants when the person lacks capacity or is refusing treatment over the objections of a caregiver. (166/22)** **Gives PAIMI ability to protect rights of parents (caregivers) to get HIPAA protected information to extent that HIPAA allows (167/11).** **Provides grievance procedure if PAIMI engages in prohibited anti-treatment activities.**		**It is critical that house language be included in any bill that passes.** Giving PAIMI responsibility for ensuring family caretakers are not denied information they need to help is important, but a bit moot if HIPAA is not strengthened sufficiently beyond what is in either bill
HIPAA – HIPAA prevents doctors and health care providers from giving families that provide housing, case management, and financial support to mentally ill loved ones out of love, the same information paid providers receive. Families need the info to see medications are picked up, transportation to appointments are arranged, and proper treatment given.	**Clarifies doctors may receive information from families. (117/1)** Allows an entity normally required to maintain patient confidentiality to share some very limited information (not psychotherapy notes) with caregivers under a complex and very limited circumstances if needed to protect health safety and welfare. (115/18) Defines an individual who has SMI (118/13) as someone who has been evaluated, treated, and diagnosed within the prior year.	Adds what factors should be considered when determining when disclosure is in best interest (page 78, line 16). Creates $5 million dollar program to educate on HIPAA (like a bill introduced by Doris Matsui)	**Both bills address, but neither fixes the problems in HIPAA. Clear simple language should state that if the protected information is needed to be disclosed to a caretaker to protect health safety and welfare of patient or others, disclosure should be allowed. Limitations on who it applies to, and what info can be disclosed should be removed from House bill. Senate bill should then comport to house bill.** No funding would be needed for education of providers or public if the legislative language was clear. That money should be allocated to actual services.

FERPA – FERPA	**Fixes FERPA so parents of students who develop mental illness can get the health information they need to help them (119/5)**		FERPA reform should be part of Senate bill
Medicare	**Eliminates 180 day cap on inpatient hospitalization under Medicare (130/12)** if CMS certifies it doesn't increase spending. *Allow people with MI to receive services on same day for both their mental and physical illness. (121/16)* Keeps mental illness meds on Medicare formulary (128/8) and Medicaid (129/8). ***Requires Asst. Secretary to require hospitals to develop stronger hospital discharge plans (131/14)***	*Allow people with MI to receive services on same day for both their mental and physical illness. (83/4)* ***Requires Asst. Secretary to require hospitals to develop stronger hospital discharge plans (90/6)***	**Senate should add house provisions eliminating 180 day cap on hospitalization under Medicare. Neither bill should require a certification that it won't increase spending.** Q: Didn't this pass as part of some other bill? Q: Didn't this pass as part of some other bill?
NIMH Violence Reduction Research	***$40 million for NIMH Funding on violence (149/1)***	***$40 million for NIMH Funding on violence (92/13)***	
Peer Support – Peer support places someone with mental illness under the paid guidance of someone else with mental illness. There is little *independent* research on peer support or the effect on people with *serious* mental illness. There is no research showing it improves *meaningful* outcomes like reducing homelessness, arrest, incarceration or violence. There is weak research showing it improves soft outcomes like improving "sense of hopefulness." There is no research comparing support provided by a peer with the same support provided by a professional.	*Defines peer support specialists as someone with formal training and who works under supervision of licensed mental health professional (20/14)* Requires Asst. Secretary to develop national strategy designed to support…peer support (9/22), identify areas underserved by peer support (10/8), and increase peer support (11/11) Requires Asst. Sec. to issue a report after 12 months on best practices for peer support **including psychopharmacology (21/12)**	*Defines peer support specialists as someone with formal training and who works under supervision of licensed mental health professional (14/4)* Requires Asst. Secretary to report on peer support (13/16)	**There is virtually no *independent* research on peer support, research on its effects on people with serious mental illness or research showing it improves meaningful outcomes (reductions in homelessness, arrest, incarceration, violence, etc.). There is no research comparing the addition of peer support with the addition of non-peer support. Finally, it is well documented that peer support networks created by SAMHSA and Mental Health Block Grants are used to lobby, especially against reforms that help the seriously ill (like AOT and hospitals).** **Given the dearth of evidence that peer support helps seriously mentally ill, improves meaningful outcomes or is better than**

			non-peer support, government should not allocate funds to expanding it, but rather should research it to fill these voids in research. The first research should determine if peer support improves meaningful outcomes in people with SMI better than other support, and if so, a second report on how to expand. **If government is to promote it, it should regulate it. The house bill contains language to do that. Obviously the peer support community wants the fed funds without the regulation.**
Wellness Recovery Action Plan -		Requires SAMHSA and NIMH to report on assertive community outreach that includes Wellness Recovery Action Plans and Housing First (AOT is not listed).	**As WRAP is not an independently evidence based-practice, and is not shown to improve meaningful outcomes, it should not be promoted.** Likewise, while Housing First works for some, many of the most seriously ill need stabilization first and congregate housing, not independent housing.
Innovation Grants	*Require at least 1/3 of innovation grants to go to kids. (38/8)*	*Require at least 1/3 of innovation grants to go to kids. (27/8)*	**Under bills 100% can go to kids as a minimum, but no maximum is set. There should be a low maximum.** Serious mental illness in kids is rare. Most illness in kids is mild ADHD or anxiety. The elephant in room is adults. The bills should ensure a lion's share goes to adults.
Demonstration Grants	*Requires at least 50% of these grants to go to people below age 26 (40/18)*	*Requires at least 50% of these grants to go to people below age 26 (28/18)*	This would allow 100% of grants to go to those below 26, and therefore prevents funds from being used for those with well developed serious mental illness since it manifests in late teens and early twenties. **Both bills should require a highe minimum account go to adults and require reporting on reductions in homelessness, arrest, incarceration, hospitalization or suicide to encourage the**

			demo grants to go to programs that reduce those metrics.
Suicide	Creates special Youth Suicide grant (87/7) funded at (part of?) $29 million (98/7) Creates a campus suicide reduction program. (99/1) and allocates $4.9 million to it. (104/21) Reauthorizes Garrett Lee Smith suicide efforts (84/9).		There is not evidence that these suicide programs are successful. Further, students and youth are least likely to commit suicide. **It would be better to allocate these funds to those most likely to commit suicide (previous attempters, first degree relatives of those who completed suicide, people with SMI, elderly and prisoners)** Senate does not, reauthoraize Garett Lee Smith, but that may be because another bill that passed Congress already did it.
Stigma	House has Asst Sec. conduct stigma education campaign (82/19)		**Provision and funding for it not needed.** Stigma is not a major barrier to care. Cost, anosognosia, distance, are all greater barriers. Stigma campaigns are often created to hide the seriously ill and convince public that all persons with mental illness can be high functioning and productive.
National Mental Health Policy Lab	**Requires NMHPL to be staffed by scientists and credentialed researchers(35/5)** **Includes numerous standards that grants by NMHPL must comply with that are not in Senate bill. One of those (33/7) is that they focus on SMI.**	**Requires NMHPL to recognize importance of family. (23/23)**	Both bills establish appropriation.
Advance Directives		Senate requires states to facilitate advance directives (42/19)	Senate bill claims Advance Directives help "reduce legal proceedings related to involuntary treatment" We are unaware of what research that refers to. We are aware of cases in Canada where people with advance directives became legally untreatable because they signed a directive prohibiting treatment even

			when they become psychotic and lose capacity.