MENTAL ILLNESS POLICY ORG.
UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA
50 EAST 129 ST., PH7 NEW YORK, NY 10035
OFFICE@MENTALILLNESSPOLICY.ORG MENTALILLNESSPOLICY.ORG

HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT 2015
HR 2646

On June 4, 2015, Rep. Tim Murphy (R. PA) and Rep. Eddie Bernice Johnson (D. TX) introduced the Helping Families in Mental Health Crisis Act of 2015 ("HFMHCA", HR 2646) which updates the 2013 version which did not pass (HR3717). Following is a summary of the provisions related to serious mental illness.

SAMHSA Replaced by an Assistant Secretary of Mental Health and Substance Use Disorders
Background: The Substance Abuse and Mental Health Services Administration (SAMHSA) has failed to focus it's efforts on serious mental illness, use science to develop policy, hire employees with medical expertise, or focus on reducing important metrics like rates of homelessness, arrest, incarceration, suicide, violence or hospitalization in people with mental illness. It primarily focuses on 'wellness' for the highest functioning and embraces pop-psychology.

The Helping Families in Mental Health Crisis Act replaces SAMHSA and it's administrator with Assistant Secretary for Mental Health and Substance Abuse Treatment who must be a licensed Psychiatrist or Clinical Psychologist. This raises the profile of mental health in the government org chart and ensures that the lead policy official for mental health policy knows something about mental illness. The Assistant Secretary will administer responsibilities formerly administered by SAMHSA.

The Helping Families in Mental Health Crisis Act requires the Asst. Sec to focus on improving the most important metrics like **r**ates of suicide and attempts, emergency psychiatric hospitalizations, emergency room boarding; arrests, incarcerations, victimization, and homelessness. The bill dramatically tightens the definition of evidence to be used in determining the efficacy of programs. It establishes a coordinating committee to advise the secretary that includes significant representation from criminal justice.

Mental Illness Policy Org strongly supports the elimination of SAMHSA and replacing it with an assistant secretary who is required to rely on independent evidence when deciding what to fund and is required to prioritize services that improve meaningful metrics like reducing homelessness, arrest, violence, incarceration, hospitalization and suicide.

Mental Health Block Grant Applicants Required to Address Serious Mental Illness
Background: Mental Health Block Grants (MHBGs) are roughly $500 million in federal funds allocated to SAMHSA to distribute as "block grants' to the states. Both SAMHSA and the Block Grants are supposed to serve people with Serious Mental Illness, but SAMHSA gives guidance to the states to divert the money from people with serious mental illness.

The Helping Families in Mental Health Crisis Act requires states applying for block grants to "include a separate description of case management services and provide for activities leading to reduction of rates of suicides, suicide attempts, substance abuse, emergency hospitalizations, incarceration, crimes, arrest, victimization, homelessness, joblessness, medication" and other important outcomes.

Assisted Outpatient Treatment Programs Receive Modest Funding
Background: Assisted Outpatient Treatment (AOT) allows judges to order a small group of seriously

mentally ill who already accumulated multiple episodes of arrest, violence and hospitalization as a result of failing to comply with treatment to stay in mandated and monitored treatment while in the community. This has reduced their incarceration, arrest, homelessness and hospitalization by 70% each and saved money for taxpayers by reducing the use of expensive jails and hospitals. In 2013 Rep Murphy inserted a provision in the 2014 Protecting Access to Medicare Act (a/k/a "SGR" or "DocFix") that provided $15 million annually for AOT.

The Helping Families in Mental Health Crisis Act of 2015 ups the amount provided to states for AOT by $15 million to $20 million annually and extends the grants through 2018. (20% to existing programs and 80% to new programs.) Further, states with an AOT law on their books will receive a 2 percent increase in their block grant funding. (Roughly $10 million annually split between them)

The Helping Families in Mental Health Crisis Act requires the Asst. Sec to measure outcomes in states with AOT which will help strengthen the evidence for it. Relatedly, states with a need for treatment standard will also receive a 2 percent increase in their block grant funding (about $10 million nationally).

Mental Illness Policy Org believes the amount allocated to Assisted Outpatient Treatment should be increased, in light of the extensive independent evidence that it reduces homelessness, arrest, violence, incarceration, hospitalization and suicide in people with serious mental illness.

HIPAA/FERPA Regulations Slightly Modified to Allow Helpful Disclosures to Caregivers
Background: Parents who provide case management, housing, income support and other services out of love to their children, are prohibited by HIPAA and FERPA from getting information about diagnosis, medications and next appointments of loved ones. Therefore they can't make sure prescriptions are filled, transportation to appointments arranged and help facilitate compliance. Doctors and mental health programs also falsely claim that HIPAA prevents them from receiving information from family members.

The Helping Families in Mental Health Crisis Act makes it clear that providers may receive information from caregivers. It defines "caregivers" as "an immediate family member; someone who assumes primary responsibility for providing a basic need of such individual; a personal representative; someone who can establish a longstanding involvement and is responsible with the individual." That is an important change supported by Mental Illness Policy Org.

The Helping Families in Mental Health Crisis Act allows an entity normally required to maintain patient confidentiality to share some limited information with "caregivers". HIPPA disclosure is limited to information about the diagnoses, treatment plans, appointment scheduling, medications, and medication related instructions, but does not include any personal psychotherapy notes. The Helping Families in Mental Health Crisis Act does not put a limit on which FERPA-protected information may be disclosed. It establishes numerous complex requirements to be met before the information can be disclosed and therefore might not have as much impact as it should.

The Helping Families in Mental Health Crisis Act also provides that HIPAA protected information may be disclosed if the patient is over 18 and has "serious mental Illness" (Serious mental illness means diagnosed by a doctor that results in functional impairment of the individual that "substantially interferes with or limits one or more major life activities of the individual.") HIPAA protected information for people without serious mental illness may not be disclosed. FERPA protected information can be disclosed without those limitations.

Disclosure of information can only be made if all the following conditions are met for HIPAA protected information or the first condition only is met for FERPA protected information.

- Such disclosure is necessary to protect the health, safety, or welfare of the individual or general public.
- The information to be disclosed will be beneficial to the treatment of the individual if that individual has a co-occurring acute or chronic medical illness.
- The information to be disclosed is necessary for the continuity of treatment of the medical condition or mental illness of the individual.
- The absence of such information or treatment will contribute to a worsening prognosis or an acute medical condition.
- The individual by nature of the severe mental illness has or has had a diminished capacity to fully understand or follow a treatment plan for their medical condition or may become gravely disabled in absence of treatment.

Mental Illness Policy Org believes all information, including case notes, should be allowed to be disclosed if they are needed to protect the health safety and welfare of the patient, caregiver or others. Additional criteria, or limiting what information can be disclosed, makes it more difficult to protect health safety and welfare.

IMD Exclusion Slightly Ameliorated to End Discrimination Against Seriously Mentally Ill who Need Hospital Care

Background: IMD's are "Institutes for Mental Disease" colloquially known as state psychiatric hospitals, but does include other residential facilities in excess of 16 beds. Likewise any facility, like an adult homes with more than 50% mentally ill are also IMDs. The IMD provision of Medicaid prevents states from getting reimbursed for people 18-64 who need long-term care in these IMDs. That is why states lock the front door of hospitals, open the back, and kick patients out of the hospitals and into the community where Medicaid will pick up 50% of the cost of care. Many of these individuals cannot live in the community and end up in jail or homeless. Rep. Eddie Bernice Johnson (D. TX), and a former head of psychiatric nursing at a VA hospital has been a stellar proponent of eliminating the IMD Exclusion and helping people with the most serious mental illnesses.

The Helping Families in Mental Health Crisis Act allows states to get Medicaid reimbursement for care of adults in IMDs where the facility-wide average length of stay is less than 30 days. It also provides language preventing residential facilities from being declared IMDs. These provisions only take place if the Congressional Budget Office (CBO) gives a good score.

Mental Illness Policy Org believes the IMD Exclusion should be eliminated as it is federally sanctioned discrimination against people with serious mental illness that prevents them from gaining access to hospital care when needed. The provisions in HR 2646 take a small step in that direction.

PROTECTION AND ADVOCAY (P&A, PAIMI, Disability Rights) Returned to Original Mission of Protecting Mentally Ill from Abuse and Neglect

Background: The Protection and Advocacy for Individuals with Mental Illness (PAIMI/P&A) program was set up by Congress with the noble purpose to establish 50 state organizations to protect institutionalized individuals from neglect and abuse. (These frequently go by name of "Disability Rights [Name of State]). The programs moved beyond that purpose and used other language in the legislation to take on the mission of stopping treatment for the seriously ill, lobbying for laws to close hospitals, kicking people out of adult homes and opposing AOT. Many a state mental health director who has tried to improve care, and families of the seriously ill who have tried to facilitate it have found these federally funded lawyers opposing them.

The Helping Families in Mental Health Crisis Act returns PAIMI to it's original mission of protecting patients against "abuse and neglect." Outside the legislation "abuse" and "neglect" are defined.

> 42 USC § 10802:
> (1) The term "abuse" means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as—
> (A) the rape or sexual assault of an individual with mental illness;
> (B) the striking of an individual with mental illness;
> (C) the use of excessive force when placing an individual with mental illness in bodily restraints; and
> (D) the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with Federal and State laws and regulations.
>
> (5) The term "neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a [1] individual with mental illness or which placed a [1] individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a [1] individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to a [1] individual with mental illness, or the failure to provide a safe environment for a [1] individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

The Helping Families in Mental Health Crisis Act requires those who get PAIMI contracts to agree to refrain from "lobbying or retaining a lobbyist for the purpose of influencing a Federal, State, or local governmental entity or officer; and "counseling an individual with a serious mental illness who lacks insight into their condition on refusing medical treatment or acting against the wishes of such individual's caregiver." Importantly, it also adds a grievance process so state mental health directors, family members and consumers who feel PAIMIs are violating their mission and impeding care can be reported to a third party for investigation.

Mental Illness Policy Org is in strong support of the PAIMI provisions.

Eliminates Discrimination in Medicare Against Mentally Ill who Need Long-term Care
Background: Medicare discriminates against those with serious mental illness by imposing a 190 day lifetime cap on inpatient psychiatric hospitalizations.

The Helping Families in Mental Health Crisis Act eliminates the 190 day lifetime cap on inpatient psychiatric hospitalization in Medicare if CMS gives it a good score. Mental Illness Policy Org believes the lifetime cap should be eliminated. HR 2646 takes a step in that direction.

Requires Medicaid to Allow Two Services Within Same Day
Background: There is a proscription against Medicaid paying for two services in the same day for certain individuals. So those who go to a clinic can't see their primary physician and psychiatrist on same day, a particularly bothersome provision in rural areas where people have to travel.

The Helping Families in Mental Health Crisis Act allows payment for two services received in a single day.

Bans Medicaid Programs from Discriminating Against Medications Used to Treat Serious

Mental Illness
Background: Many treating authorities are trying to move people off expensive treatments and on to less expensive ones without regard to their efficacy.

The Helping Families in Mental Health Crisis Act protects the most seriously ill. For “major depression, bipolar (manic-depressive) disorder, panic disorder, obsessive-compulsive disorder, schizophrenia, and schizoaffective disorder, a State shall not exclude from coverage or otherwise restrict access to such drugs other than pursuant to a prior authorization program” The bill also requires managed care organizations to cover all mental illness medications.

Strengthens Hospital Discharge Procedures
Background: For many seriously mentally ill, the crack is the system. Hospital responsibility ends at discharge, and community programs have no responsibility for patients who don’t show up.

The Helping Families in Mental Health Crisis Act attempts to make the crack smaller, by requiring (medicare reimbursed?) hospitals to prepare discharge plans and facilitate connection with outpatient treatment for patients they are discharging.

This is an important provisions.

National Institute Of Mental Health
Background: Extensive research shows that most mentally ill seriously mental ill are not violent, but that seriously mentally ill who are not in treatment are as a group more violent than others. Historically, the mental health industry has refused to admit this for fear of causing stigma.

The Helping Families in Mental Health Crisis Act provides $40 million annually for four years specifically for NIMH to start studying violence to self and others plus the Brain Initiative.

Mental Illness Policy Org is strongly in support of this funding for an issue that has been historically swept under the rug and caused neeedless incarceration of the seriously ill.

Increases Minority Mental Health Workforce
Authorizes fellowships to increase the number of culturally competent behavioral health professionals. Mental Illness Policy Org supports this.

Creates Suicide Prevention Technical Assistance Center to Focus on those at High Risk for Suicide.
Background: Most investments in suicide prevention are made based on politics rather science. For example, programs aimed at preventing suicide in children are expanded, even though children are the least likely age group to commit suicide.

The Helping Families in Mental Health Crisis Act **will provide grants for “**prevention of suicide among all ages, particularly among groups that are at high risk for suicide.”

Mental Illness Policy Org believes suicide prevention funds should be directed at those most likely to commit suicide. Those include first degree relatives of those who completed suicide, persons with mental illness, people who previously attempted suicide and the elderly.

Establishes Interagency Serious Mental illness Coordinating Agency
Background: The federal government has dramatically expanded its mental health efforts by declaring things such as bad grades, bad marriages, lack of jobs, bullying and cyberbullying as mental illnesses and diverting funds to them. Government should help those who need help the most, not least.

The Helping Families in Mental Health Crisis Act establishes this committee to refocus efforts on the most seriously ill. In addition to those responsible for mental health policy, the Attorney General is on it. Other mandatory members include a judge, a law enforcement officer, and a corrections officials. By giving criminal justice a seat at the mental health table, it is hoped that fewer policies detrimental to the most seriously ill will be incorporated into policies.

Other Provisions

Reports on Best Practices to Train and Certify Peer Support Specialists
Background: “Peer Support” is a program that pays people with mental illness or substance abuse to guide others with it. Peer support has been shown to be a useful program to address substance abuse. For mental illness, there is solid evidence that those paid to deliver it like it. According to those paid to provide it, those who receive it feel more hopeful, more empowered, and have a better sense of wellness. However, there is no independent studies showing this. And no independent studies show meaningful improvements in the most important outcomes like homelessness, arrest, incarceration and suicide. No independent studies compare peer support with the same services delivered by non-peers. And no independent studies of peer support report on the effect on those serious mental illness. There is clear evidence the money SAMHSA historically distributed for peer support goes to organizations that lobby against treatments that help the most seriously ill like the availability of hospitals, AOT, ECT, and the 2013 version of the Helping Families in Mental Health Crisis Act (HR 3717). I.e, Peer support for mental illness has generally had a negative systemic impact even if those who receive it do receive some benefit.

The Helping Families in Mental Health Crisis Act requires the Assistant Secretary to prepare a biennial report on best practices for “training and certifying peer support and establishing and operating programs using peer-support”. It defines a peer support specialist as someone who has “been an active participant in mental health or substance use treatment for at least the preceding 2 years” and “uses his or her recovery from mental illness or substance abuse plus skills learned in formal training, …to work …with individuals with a serious mental illness or a substance use disorder, in consultation with and under the supervision of a licensed mental health or substance use treatment professional.” Members of the peer community are objecting to government setting standards for peer support, preferring to receive the funds without limitation.

Mental Illness Policy Org believes that before credentialing peer support, government should conduct an independent study to see if peer support is better than non peer support at improving meaningful metrics like reducing homelessness, arrest, violence, incarceration, hospitalization, suicide and other outcomes. If it is, then a credentialing mechanism like the one in HR 2646 makes sense.