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Detailed Summary of The Helping Families In Mental Health Crisis Act (H.R. 3717)

With findings of a year-long review by the Energy & Commerce Subcommittee on Oversight & Investigations of the nation's mental health system

Mental illness does not discriminate based on age, class or ethnicity. It affects all segments of society. More than 11 million Americans have severe schizophrenia, bipolar disorder, and major depression yet millions are going without treatment as families struggle to find care for loved ones.

To understand why so many go without treatment, the Energy and Commerce Subcommittee on Oversight and Investigations launched a top to bottom review of the country's mental health system beginning in January 2013. The investigation, which included public forums, hearings with expert witnesses, and document and budget reviews, revealed that the approach by the federal government to mental health is a chaotic patchwork of antiquated programs and ineffective policies across numerous agencies.

Not only is this frustrating for families, but when left untreated, those with mental illness may end up on the streets or in the criminal justice system. In some correctional facilities, between 20 and 50 percent of inmates have a serious mental illness. One-third of the homeless, an estimated 250,000 people, are mentally ill. The Helping Families in Mental Health Crisis Act fixes the nation's broken mental health system by focusing programs and resources on psychiatric care for patients and families most in need of services. The legislation has received significant coverage and bipartisan praise from parents, editorial boards, and organizations across the country including the American Psychiatric Association, National Sheriffs Association, and the National Alliance on Mental Illness.

This document describes what the Subcommittee investigation uncovered, and how these findings were translated into legislative language.

Table of Contents – Section-by-Section Summary

TITLE I—ASSISTANT SECRETARY FOR MENTAL HEALTH

What we learned:

- The federal government spends $125 billion on mental health, but there is little interagency coordination on programs.
- Agencies do not collect data on how mental health dollars are spent — let alone whether those dollars are being spent effectively.
- Federal grants and programs to treat the seriously mentally ill do not utilize the best available medical treatments and protocols. In some cases, grant programs are actively preventing the severely mentally ill from getting medical treatment.

Sec. 101. Assistant Secretary for Mental Health and Substance Use Disorders

This section creates an Assistant Secretary for Mental Health who will be responsible and accountable for HHS mental health programs and policies. The Assistant Secretary will evaluate and monitor mental health spending at all federal agencies as well as interface with any agency authorized to coordinate, reimburse, or deliver mental health services, training, or awareness programs.

The Assistant Secretary will oversee the existing Community Mental Health Services Block Grant ($460 million approx.) to ensure patients receiving treatment at community mental health centers are receiving the best available medical care. For the first time in the history of federal mental health spending, centers will measure and report back patient and public health outcomes like emergency room visits and mortality rates for individuals with serious mental illness. This approach is already used in the private sector where insurers collect data from providers to measure quality and promote best practices across different settings. Data on treatments and outcomes will be collected and analyzed by the National Mental Health Policy Laboratory within the Assistant Secretary's office.

The NMHPL is modeled on a successful project within the National Institute of Mental Health (NIMH). The NIMH pilot program has developed new models of care like the Recovery After Initial Schizophrenia Episode (RAISE) project. RAISE shows that early intervention, such as low-dose medication and support services for a person at risk of developing full-blown schizophrenia, can reduce suicide rates and help patients lead functional lives. But NIMH cannot disseminate this model to all community health centers in the country. Beginning in 2016, the Mental Health Policy Lab and Assistant Secretary will work with NIMH to ensure community mental health centers uniformly follow evidence-based practices like RAISE.

The NMHPL will be empowered to spend up to 5 percent of the block grant on models like RAISE when they are shown to reduce hospitalizations, suicide rates, improve the quality of care, and save money.

In their first year, the Assistant Secretary will audit all federal mental health programs for effectiveness and duplication. He or she would report to Congress with a plan about what programs are working well, and which programs are not. The Assistant Secretary would also recommend to Congress which behavioral and mental health programs within the Substance

Abuse and Mental Health Services Administration (SAMHSA) should be continued, and have the flexibility to redirect misspent money on better programs.

The Assistant Secretary must be a PhD/MD in psychology or psychiatry with research and clinical experience in practicing integrated care models.

The Assistant Secretary will also chair the Interagency Serious Mental Illness Coordinating Committee authorized under Title I of the bill.

Sec. 102. Interagency Serious Mental Illness Coordinating Committee
Modeled on a similar federal group helping to steer and prioritize autism research, the Serious Mental Illness Coordinating Committee will bring together different stakeholders across the public and private sector to maintain a strategic focus on treating serious mental illness.

The Committee will:

- Develop and annually update a summary of advances in serious mental illness research related to causes, prevention, treatment, early screening, diagnosis, intervention, and access to services and supports for individuals with serious mental illness.
- Monitor all federal activities with respect to serious mental illness.
- Develop and annually update a strategic plan for the conduct of, and support for, serious mental illness research, including proposed budgetary requirements.

Membership the committee will include directors of the NIMH, National Institute of Health and the Centers for Disease Control and Prevention. Law enforcement, physicians and mental health professionals, peers, and advocacy groups will also be included.

Sec. 103. Assisted outpatient treatment grant program

Authorizes $60 million over four years for grants to implement assisted outpatient treatment programs. Between forty and fifty percent of individuals with schizophrenia or bipolar disorder do not recognize they have a mental illness, making it exceedingly difficult for them to follow through on a treatment regimen. This lack of insight leads patients to stop taking medication, which sometimes results in erratic behavior. The patient may need to be taken to an emergency room to be stabilized, or arrested if a crime has occurred.

Family members want to get help for loved ones, but current law makes it exceedingly difficult to get a non-compliant patient — even one with repeated hospitalizations or arrests — into treatment. Assisted outpatient treatment, or AOT, allows courts to order certain mentally ill individuals with a history of arrest, hospitalization, and whose condition will worsen without medical care, to comply with treatment while living in the community.

A successful alternative to long-term inpatient care AOT has been proven to save money for state and local governments by reducing the rates of imprisonment, homelessness, substance abuse, and costly emergency room visits by the chronically mentally ill. In New York State, AOT known as Kendra's Law, reduced incarceration of persons with serious mental illness by 87%. 74 percent fewer experienced homelessness and 77 percent fewer experienced psychiatric hospitalization.

The costs related to medical care, social services, and imprisonment fell 46% for AOT-participants. The average yearly cost for a person before AOT was $104,753. In the year after, costs were $59,924.

In Ohio, AOT increased attendance to outpatient psychiatric appointments from 5.7 to 13.0 per year; it also increased attendance at day treatment sessions from 23 to 60 per year.

The Assistant Secretary for Mental Health shall establish a grant program to implement, monitor, and oversee assisted outpatient treatment programs by a State and local court with a grant awarded. Eligible participants for AOT must have a history of violence, incarceration, or medically unnecessary hospitalizations; without supervision and treatment, may be a danger to self or others in the community; unlikely to voluntarily participate in treatment; have a history of mental illness or condition that is likely to substantially deteriorate if the patient is not provided with timely treatment; and due to mental illness, lacks capacity to fully understand or lacks judgment to make informed decisions regarding his or her need for treatment, care, or supervision.

Sec. 104. Tele-psychiatry and primary care physician training grant program

104 would establish a $12 million four-year grant program to assist up to ten states in developing a tele-psychiatry and physician training program for treating and referring children and young adults with mental health disorders.

This grant would also be used to connect primary care physicians with psychiatrists or psychologists through the use of tele-health technology. This section is modeled on a successful state project in Massachusetts called the Child Psychiatry Access Project (MCPAP).

TITLE II—FEDERALLY QUALIFIED BEHAVIORAL HEALTH CLINICS

What we learned:

- Dispersal of federal tax dollars is not driven by data or best available clinical protocols. CMHCs do not report back data on outcomes or patient acuity to help refine and employ best practices.
- There is a need for integrating physical health with mental health at CMHCs.

Sec. 201. Demo Project - Federally Qualified Community Behavioral Health Clinic

This section creates a standard and a definition for Federally Qualified Community Mental Health Centers. Existing entities (community mental health centers) would have to meet specified requirements to earn this designation. This would be a ten-state pilot program. Qualifying states would be eligible for a slight increase in the Federal Medicaid Assistance Percentage (FMAP), which is the federal share of Medicaid reimbursement.

Under the demo program, the behavioral health clinics would be required to provide a range of mental health services, provide primary care services, and "maintain linkages" with other health

care providers and related agencies, such as psychiatric hospitals and law enforcement. Facilities would need to employ a core staff trained in child or adolescent psychiatry and psychology. In return for meeting these standards, the centers would be eligible to receive reimbursement under a prospective payment system similar to the federally-qualified community health center (FQHC).

Similar legislation has been introduced by Senators Stabenow (D-MI) and Blunt (R-MO), and Representatives Matsui (D-CA) and Lance (R-NJ).

TITLE III—HIPAA AND FERPA CAREGIVERS

What we learned:

- A lack of understanding and consistent misinterpretations of the HIPAA privacy rule and Family Educational Rights and Privacy Act (FERPA) have created enormous barriers for parents and caregivers of individuals with serious mental illness to both provide and receive information with clinicians.
- This problem has been especially pernicious for parents whose young adult mentally ill child lives at home.

Sec. 301. Parents and Caregivers as personal representatives under HIPAA

Sec. 301 amends HIPAA so that a caregiver can receive the private health information of an individual under their care who suffers from a serious mental illness. This provision empowers parents and caregivers by breaking down the barriers that prevent mental health professionals from talking to parents of a loved one who is suffering from an acute mental health crisis.

Sec. 301 applies only when an individual's mental illness prevents them from making an informed decision about their need for treatment and the sharing of health information is in the best interest of the patient. Similar to current guidance disseminated by the HHS Office of Civil Rights, under this section a physician is to use his or her best judgment when determining that sharing critical information related to the health, safety, and well-being of the family and severely mentally ill patient is in the best interest of the severely mentally ill patient and his or her family.

The term ''caregiver'' means, with respect to an individual with a serious mental illness, an individual (including a family member) who assumes primary responsibility for providing a basic need of such individual.

The term ''individual with a serious mental illness'' means an individual who is 18 years of age or older and has, within one year before the date of the disclosure, been evaluated, diagnosed, or treated for a mental, behavioral, or emotional disorder that is determined by a physician to be of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders and results in functional impairment of the individual that substantially interferes with or limits one or more major life activities of the individual.

Sec. 302. Parents and Caregivers as personal representatives under FERPA

When a college student breaks off communication or seemingly disappears for several weeks, possibly because of a mental illness, college administrators are too often reluctant to notify the parents. In some tragic cases, schools withheld information from parents about a child who then died by suicide. Sec. 302 would amend the Elementary and Secondary Education Act of 1965 to allow that contact in the same manner as described in the above section on the HIPAA privacy rule.

TITLE IV—DEPARTMENT OF JUSTICE REFORMS

What we learned:

- Police officers are too often serving as mental health social workers and first responders of incidents involving a violent psychotic episode. Many of these events are entirely preventable.
- Paramedics and EMS workers have little formal training on how to help individuals experiencing a psychotic break.
- The Department of Justice does not track the mental health of individuals involved in crimes.
- Prisons have seemingly replaced mental hospitals for caring for the mentally ill. While there is no precise number on the number of mentally ill in prisons, estimates vary between 20 and 50 percent of all inmates.
- Care in the prison system is more expensive than treating the mental illness.
- Assisted outpatient treatment, which is currently listed in the Department of Justice's registry of evidence-based practices, has been proven to reduce hospitalization, homelessness, violence, and save money. It ensures those with serious mental illness get the care they need and don't end up in the revolving door of psychiatric wards and prisons.

Sec. 401. Mental Health Awareness Training for First Responders

Expand what JAG Grants may be used for so that local police departments can use the grants:

- To provide specialized training to law enforcement officers to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness
- To provide specialized training to corrections officers to recognize individuals who have mental illness and to enhance the ability of corrections officers to address the mental health of individuals under the care and custody of jails and prisons.

Staffing for Adequate Fire and Emergency Response (SAFER):

- To provide specialized training to paramedics, EMS workers, and first responders to recognize individuals who have mental illness and how to properly intervene with individuals with mental illness

Sec. 402. Mentally Ill Offender Treatment and Crime Reduction Act Reauthorization

Section 402:

- Extends the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) for five years, thus continuing support for mental health courts and crisis intervention teams;
- Authorizes veterans treatment courts, which serve arrested veterans who suffer from PTSD, substance addiction, and other mental health conditions;
- Supports, through grants, the development of curricula for police academies to train officers on identifying and handling those with serious mental illness.

Sec. 403. Assisted outpatient treatment

This section encourages mental health courts to use AOT. For more information on AOT, see section 103 summary.

Sec. 404. Improvements to DoJ data collection and reporting

Current estimates on the number of homicides committed by a mentally ill person range from between several hundred and 1,600 (10% of 16,000+ annual homicides nationally). There is no solid data on the number of assaults involving a person with mental illness.

A joint report by the Treatment Advocacy Center and the National Sheriffs' Association suggests that "at least half of the people shot and killed by police each year in this country have mental health problems."

To understand the extent of how deeply law enforcement is responsible for mental health interactions, this section requires the that any data prepared by or submitted to the Attorney General or the Director of the Federal Bureau of Investigation with respect to the incidences of homicides, law enforcement officers killed and assaulted, or individuals killed by law enforcement officers shall include data with respect to the involvement of mental illness in such incidences.

Sec. 405. Report on the number of seriously mentally ill who are imprisoned

This section requires a GAO to study and publish a report on how many individuals in the criminal justice system have a medically diagnosed mental illness.

TITLE V—MEDICARE AND MEDICAID REFORMS

What we learned:

- Fifty years ago there were over 500,000 inpatient psychiatric beds in the United States and today there are fewer than 40,000.
- There is a need for long term treatment facilities for individuals suffering from the most debilitating form of serious mental illness.
- States have had success with integrating physical and mental health in the same location, even thought CMS regulations make that difficult.
- There is a shortage of psychiatrists, particularly child and adolescent psychiatrists in rural areas.

Sec. 501. Same Day Billing Under Medicaid, Inpatient Care Restrictions

501 removes regulations that currently prohibits the same-day billing under Medicaid for treatment of physical and mental health in the same location on the same day for the same patient.

Persons with serious mental illness may require weeks of hospitalization to be fully stabilized and given the right medication dosage to manage their illness. However, Medicaid will not reimburse for inpatient medical care at psychiatric hospitals for anyone between the ages of 22 and 64. Under current law, psychiatric hospitals are considered an Institution for Mental Disease (IMD) and therefore, are prohibited from receiving federal Medicaid matching payments for adult Medicaid individuals. This billing quirk has led states to dismantle state-run psychiatric hospitals, which has led to the severely mentally ill populating homeless shelters or jails.

Today, inpatient psychiatric hospital care is an integral component of community-based care for persons with serious mental illnesses. These hospitals provide life-saving psychiatric care just like acute care general hospitals provide life-saving care for other medical conditions.

Without access to these psychiatric hospitals persons with serious mental illnesses in crisis are not able to get the right care, at the right time in the right setting.

This section of the bill would provide states the option of receiving federal Medicaid matching payments for care of the mentally ill between the ages of 21-64 who receive short-term, acute psychiatric hospital care in a freestanding psychiatric hospital or an acute care unit of a state operated psychiatric hospital provided there is a facility-wide average length of stay of less than 30-days.

This section would also permit Medicaid to provide treatment for the severely mentally ill in a psychiatric residential treatment facility (PRTF) as defined under current law and regulation. Under current law and regulation, states, at their option, can cover Medicaid individuals under 21 years of age in a psychiatric residential treatment facility (PRTF). These facilities provide less intensive treatment than in a hospital, just like rehabilitation or skilled nursing facilities for other medical conditions.

This section of the bill would extend this coverage in psychiatric residential treatment facilities (PRTF), at the option of the state, to Medicaid individuals over the age of 21.

Sec. 502. Access to mental health prescription drugs under Medicare and Medicaid

Mental health medications are not interchangeable. For instance, a drug in the atypical antipsychotic class has not the exact same molecular structure or impact of other drugs the same class. Thus, physicians must be able to apply the right makeup of medications for each unique patient. The Centers for Medicare and Medicaid Services recognizes this concern by considering mental health medications to be a "protected class" of drugs within Medicaid and Part D formularies, just like it does for AIDS, cancer, and epilepsy. This section codifies the protected class for Part D and Medicaid. It is widely supported by mental health advocacy groups like the National Alliance on Mental Illness.

TITLE VI—RESEARCH BY NATIONAL INSTITUTE OF MENTAL HEALTH

Sec. 601. Increase in funding for certain research

Authorizes $40 million for the NIH Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. The BRAIN Initiative, which was initiated by the President, is meant to revolutionize our understanding of the human brain by accelerating the development and application of innovative technologies. Researchers are going to work on producing a new dynamic picture of the brain that, for the first time, shows how individual cells and complex neural circuits interact in both time and space.

Only three percent of NIMH research goes toward mental illness and violence. Most of this research is within a larger topic, such as schizophrenia (13% or $196M). NIMH also has programs meant to examine suicide, which is much more common with persons who have mental illness than outside-directed violence. This section authorizes the NIMH to conduct "research on the determinants of self- and other directed-violence in mental illness, including studies directed at reducing the risk of self harm, suicide, and interpersonal violence."

TITLE VII—COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT REFORM

Sec. 701. Administration of block grants by Assistant Secretary

This section removes the responsibility for administration of the Community Mental Health Services Block Grant from the SAMHSA and gives it to the Assistant Secretary of Mental Health.

Sec. 702. Additional program requirements

This sections adds "integration" of primary and behavioral healthcare to the list of activities the Community Mental Health Services Block Grant can be used for.

Sec. 703. Period for expenditure of grant funds

This section allows Community Mental Health Centers to carry over 20% of their money they receive through the Community Mental Health Services Block Grant from year to year as long as they use that money for services.

Sec. 704. Treatment standard under State law

This section requires a state to have a "need for treatment standard" law in order to be eligible to receive funds through the Community Mental Health Services Block Grant. Judges, mental health professionals, and family members have had trouble getting a loved one with a mental illness because 23 states use an unworkable standard requiring a person to be "imminently dangerous" before they can receive inpatient medical care. This standard allows the illness to run the treatment, and even the severely mentally ill are able to present a brief façade of normality to avoid commitment. Furthermore, nearly half of persons with schizophrenia or bipolar disorder are unaware they're even ill and will not voluntarily get help.

Sec. 705. Assisted outpatient treatment under State law
This section requires a state to have an assisted outpatient treatment law in order to be eligible to receive funds through the Community Mental Health Services Block Grant. See sec. 103 summary for more information on AOT.

Sec. 706. Best available science and models of care
Under this section the Assistant Secretary for Mental Health will obligate 5 percent of the Community Mental Health Services Block Grant for a fiscal year through the National Mental Health Policy Laboratory (NMHPL) created under this Act. These funds will be used to translate evidence-based medicine and best available science into systems of care that can be applied by community mental health centers. These models may include the Recovery After an Initial Schizophrenia Episode research project of the National Institute of Mental Health and the North American Prodrome Longitudinal Study, both of which have been shown to improve outcomes for the seriously mentally ill.

Sec. 707. Paperwork reduction study
Social workers and CMHC counselors must spend a significant amount of time completing forms and paperwork that hinder their ability to provide wrap-around care for the mentally ill. Under this section, HHS would seek an Institute of Medicine report detailing the cost of paperwork barriers faced by community behavioral health facilities. An action plan for reduction must be submitted to Congress within a year of enactment.

TITLE VIII—BEHAVIORAL HEALTH AWARENESS PROGRAM

Sec. 801. Reducing the stigma of serious mental illness
The Department of Education would work with social media companies and stakeholders in an effort to not only reduce the stigma associated with serious mental illness, but also to help individuals recognize the signs of SMI and help a person who is demonstrating the warning signs of a first episode of psychosis. The program would also seek to de-stigmatize seeking professional medical help from a psychiatrist, clinical psychologist or licensed mental health professional for a mental illness.

The Secretary of Education would report back to Congress on whether the program carried out under sec. 801 improved public health outcomes.

TITLE IX—BEHAVIORAL HEALTH INFORMATION TECHNOLOGY

What we learned:

- Federal law already provides a mechanism for hospitals and clinicians to invest in electronic health records.

- Expanding the application of electronic medical records to the mental health community will produce better outcomes for persons with mental illness and reduce overall healthcare spending by integrating care.
- Untreated mental illness is a significant cost driver for persons with physical ailments. Untreated depression doubles health care costs by complicating symptoms and treatment adherence for back pain, headache and heart disease. The Archives of Internal Medicine found that diabetics with untreated severe depression had 86% higher healthcare costs.
- A January 2013 study by Johns Hopkins University found that hospitals readmission rates for the mentally ill fell by 39% when other mental health professionals like psychologists were given electronic access to inpatient psychiatric records.

Sec. 901. Extension of health information technology assistance for mental health
This section is similar to the Behavioral Health Information Technology Act (H.R. 2957) introduced by Congressman Murphy. This section would:

- Clarify the definition "health care provider" throughout the HITECH Act to include behavioral and mental health professionals, substance abuse professionals, psychiatric hospitals, behavioral and mental health clinics, and substance use treatment facilities.
- Make behavioral health providers eligible for HITECH Act technical assistance which will enhance HIT infrastructure, facilitate medical staff training, and improve the exchange of health information between mental health providers and other health care providers.
- Extend Medicare and Medicaid reimbursement for meaningful use of EHRs to psychologists and mental health professionals who provide clinical care at psychiatric hospitals, mental health treatment facilities, and substance abuse treatment facilities.

TITLE X—EXPANDING ACCESS TO CARE THROUGH HEALTH CARE PROFESSIONAL VOLUNTEERISM

What we learned:
- Mental health and clinical professionals want to volunteer to help community health centers and community mental health centers fill a critical shortage of doctors, but federal law and high medical malpractice costs makes that exceedingly difficult to do so according to the Government Accountability Office.
- A March 2006 study in the Journal of the American Medical Association found CHCs had a 13% vacancy rate for family physicians and a 22% vacancy rate for psychiatrists.
- Doctors who volunteer at community health centers are required to pay for their liability coverage while those who volunteer at free clinics are not. Since medical malpractice insurance is so costly, CHCs saw only 126 full-time equivalent volunteers.
- If doctors were allowed to volunteer, like they can at free clinics, billions in free care would be provided. For example, Florida provides certain med-mal coverage to medical professionals. Nearly 10,000 health professionals volunteered through this low-cost mal program, providing $41.15 million worth of services.

Sec. 1001. Liability protections for physician volunteers community health clinics
This section is similar to the Family Health Care Accessibility Act (H.R. 2703) introduced by Congressman Murphy. This section would enable medical and mental health professionals to receive Federal Tort Claims Act malpractice insurance if they volunteer at a community health center and at community behavioral health centers.

TITLE XI—SAMSHA REAUTHORIZATION AND REFORMS

What we learned:
- The Substance Abuse and Mental Health Services Administration does not promote or disseminate the best practices in medical care.
- Only two of the agency's 530+ employees are actual medical professionals.
- While some SAMHSA programs related to child traumatic stresses, primary care and mental health integration, and other behavioral health needs have proven to be successful, SAMHSA has not always focused on the highest acuity patients: the seriously mentally ill.
- In fact, not once in its 41,000 word strategic plan does SAMHSA mention schizophrenia.
- Over the past twenty years of SAMHSA's existence, substance abuse has increased, homelessness has increased, the number persons with SMI who are violent has not declined, and the number of persons in the corrections system with mental illness has increased to between 20 and 50% of the prison population.
- Money is spent on programs of limited known value or impact. Grants are not required to be evidence-based or proven to be effective using the scientific method.
- Some dollars go to programs that are actually harmful. For example, one of SAMHSA's annual conferences includes seminars teaching persons with SMI to reject physician-prescribed medication.
- The Protection and Advocacy for Individuals with Mental Illness (PAIMI) program funds attorneys who actively interfere with physician-prescribed treatments and the desires of parents to get help for sons or daughters with serious mental illness. PAIMI has gone beyond it original statutory authority to lobby against assisted outpatient treatment laws (in violation of federal law) and promote closure of psychiatric hospitals, which has exacerbated a shortage of inpatient psychiatric beds.

Subtitle A—Organization and General Authorities

Sec. 1101 – In General
With several exceptions, transfers all responsibilities for oversight of mental health policy from SAMHSA to the Assistant Secretary for Mental Health.

Sec. 1102 – Advisory Councils
Requires 50% of all membership on SAMHSA advisory councils or peer review group to have a medical degree, or an equivalent doctoral degree in psychology.

Sec. 1103 – Peer Review
Requires all grants to be evidence-based and reviewed by persons with clinical experience in mental health treatment. Grants must also be reported to the House and Senate committees of jurisdiction.

Sec. 1104 – Data Collection
All data collection on grant outcomes is transferred to the National Mental Health Policy Laboratory to ensure tax dollars are being spent effectively on treating serious mental illness, reducing hospitalizations, reducing incarceration, and reducing mortality rates for persons with SMI.

Subtitle B—Center for Mental Health Services

Sec. 1111 – Centers for Mental Health Services
Places CMHS under authority of the Assistant Secretary for Mental Health.

Sec. 1112 – Reauthorization of Regional and National Significance Program.
Requires RNSP grantees to be authorized by Congress. Grants must be reported to committees of jurisdiction. Reauthorizes at $150M annually until 2018.

Sec. 1113 - Garrett Lee Smith Reauthorization
Ensures grantees receive appropriate information, training, and technical assistance on:

- Developing and implementing cost-effective early intervention programs;
- Identifying and understanding the causes and associated risk factors for suicide;
- Surveying suicidal behavior and nonfatal suicide attempts; and
- Evaluating and disseminating outcomes and best practices of mental health and substance use disorder services.

Extends the current $5 million authorization through fiscal year (FY) 2016.

Provides States, Tribes/Tribal organizations the authorization to develop and implement:

- Early intervention, assessment, and treatment services;
- Information and awareness campaigns;
- Tools to evaluate intervention and prevention practices and strategies;
- Training programs for providers and child care professionals;

The reauthorization would increase the authorization from $30 million to $32 million annually through FY16.

Enables colleges and universities to prevent youth suicide by authorizing:

- Educational and outreach activities on suicide prevention;
- The development and implementation of evidence-based and emerging best practices;
- The provision of mental health and substance use disorder services, including prevention, promotion of mental health, and voluntary screening; and
- The employment and training of personnel.

Increases the authorization from $5 million to $7 million annually through FY16.

Subtitle C—Children with Serious Emotional Disturbances

Sec. 1121 and 1122.

Reauthorizes children mental health services grants up to $130M annually through 2019. Before the Assistant Secretary for Mental Health awards a grant, they shall first consult with NIMH to ensure that the grant recipient will use evidence-based practices.

Subtitle D—Projects for Children and Violence

Sec. 1132. National Child Traumatic Stress Network

This section reauthorizes the National Child Traumatic Stress Network at $50 million annually through 2017. The $5 million annual increase in funding comes from a reduction of PAIMI (below).

Subtitle E—Protection and Advocacy for Individuals With Mental Illness

Sec. 1141 – Protection and Advocacy for Individuals With Mental Illness (PAIMI)

"Disability rights" groups receive nearly all of their funding from the federal government. Some of their money comes through the SAMHSA PAIMI program, but more than 80% comes through other government grants such as the developmental disabilities program, Help America Vote Act, Traumatic Brain Injury program, Social Security Administration, Assistive Technology program, and the work incentives program. While PAIMI recipients are not supposed to lobby, they have actively fought against inpatient medical treatment and against assisted outpatient treatment laws.

This section prohibits any organization receiving funds through the Protection and Advocacy for Individuals With Mental Illness program from engaging in any form of lobbying. PAIMI attorneys could not actively fight against the efforts of a caregiver or parent to get treatment for a mentally ill loved one.

PAIMI would be reauthorized at $5 million annually through 2017.

Subtitle F—Limitations on Authority

Sec. 1151 – Promotion of best practices in medicine

Requires that SAMHSA notify the House Energy and Commerce Committee and Senate Health, Education, Labor, and Pension Committee 90 days prior to sponsoring or hosting any conference.

Prohibits SAMHSA from providing any financial assistance for any program relating to mental health or substance use diagnosis or treatment, unless such diagnosis and treatment relies on evidence-based practices.

Sec. 1152 – Restriction on activities not authorized by Congress

Prohibits SAMHSA from establishing any program or project that is not explicitly authorized or required by statute.

By the end of fiscal year 2014, any SAMHSA program or project that is not explicitly authorized or required by statute will need to receive congressional approval to continue. The Assistant Secretary for Mental Health may obtain an Institute of Medicine study on the value of these programs.