MENTAL HEALTH WEEKLY
Essential information for decision-makers

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Mental health advocates are encouraged about the FY 2014 spending bill that provides important funding increases for the Substance Abuse and Mental Health Services Administration (SAMHSA). The legislation, which includes $1.1 billion for mental health programs and services, offers some relief from the across-the-board spending cuts implemented under last year's sequester. The budget agreement also provides $1 billion for the Prevention and Public Health Fund. . . . *See top story, this page*

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## *Federal Budget Watch*

# FY 2014 spending bill includes SAMHSA, MH block grant increases

**Bottom Line...**
*Advocacy groups, encouraged about the funding increases, intend to keep an eye on 2014 elections that they believe could affect future mental health investments.*

President Obama signed into law Jan. 17 a $1 trillion omnibus spending package that will fund the federal government through fiscal year 2014 and, in the process, provide important funding increases for the Substance Abuse and Mental Health Services Administration (SAMHSA). The new spending plan provides the first meaningful increase in funding for SAMHSA's Center for Mental Health Services (CMHS) in more than a decade, say advocates.

The House overwhelmingly approved the budget bill (359–67) Jan. 15, and the Senate approved the bill Jan. 16 by a vote of 72–26. The budget agreement offers relief from the across-the-board spending cuts that had been implemented last year under sequestration.

The government had been operating without a budget for FY 2013, which commenced October 2012. Instead, a continuing resolution (CR), or rather, a series of CRs, kept the government funded through 2013 (see *MHW*, Feb. 14, 2013).

According to the FY 2014 bud-

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# Peer support services care guidelines important for securing reimbursement

**Bottom Line...**
*Provider organizations should review level-of-care guidelines for peer support services and hold discussions with MCOs about appropriate reimbursements.*

As provider organizations work to move consumers with mental illness toward recovery and decrease hospitalizations and overall behavioral health costs, the need for peer support services to be included as part of their business operations becomes even more apparent, along with standardized criteria to ensure managed care coverage and reimbursement.

According to an article about the best way to provide peer support services in collaboration with managed care organizations (MCOs), a lack of guidelines for how and when peer support services should be delivered can make it difficult for such services to be reimbursed.

The article, "Level-of-Care Criteria for Peer Support Services: A Best-Practice Guide," written by Optum Behavioral Health staff and a healthcare consultant, was published in the December 2013 issue of *Psychiatric Services*.

States, counties, employers and health plans are increasingly covering peer support services (PSSs) in benefit plans. Medicaid and states have not developed level-of-care or

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get agreement (H.R. 3547), SAMHSA will receive a $144 million increase over FY 2013 levels, for a total budget of $3.6 billion. The legislation includes $1.1 billion for mental health programs, which is $136 million more than the 2013 enacted level.

The SAMHSA budget will include $15 million in new funding for a nationwide demonstration program designed to provide Mental Health First Aid training to police officers, first responders, primary care professionals, social workers and college and university staff, among others, according to the National Council for Behavioral Health (National Council).

"What's exciting about what's in the SAMHSA budget is that a number of programs were level-funded or actively received increases in this year's budget," Rebecca Farley, director of policy and advocacy for the National Council, told *MHW*. "We were concerned that the programs were at risk. SAMHSA fared quite well comparatively."

Farley said that all national groups whose members received funding through SAMHSA initiatives have been actively pushing for increased levels in program appropriations.

"Over the last year and a half, Congress has been focused on mental health and addiction treatment in a way we had not seen in recent years," Farley said, adding that in 2013, a few legislative committees held hearings on mental health–related issues.

The omnibus bill provides $1 billion for the Prevention and Public Health Fund carried over from the Affordable Care Act (ACA), said Farley. "This bucket of money pulled from the ACA will support suicide prevention programs, such as the Garrett Lee Smith Memorial Act, among others," added Farley. Of the $1 billion, $831 million will be available to the Centers for Disease Control and Prevention (CDC), $62 million will go to SAMHSA, and $35 million will be directed elsewhere at the U.S. Department of Health and Human Services (HHS).

## Funding support

The FY 2014 spending bill provides $484 million for the Mental Health Block Grant, 5 percent of which will be used to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.

Highlights of SAMHSA's CMHS programs include:

- $35 million for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health);
- $40 million for Project AWARE (Advancing Wellness and Resilience in Education, Now is the Time) state grants (the project will provide 20 grants to state education authorities for comprehensive programs in 1,000–1,500 schools to get students with mental health issues referred to needed services);
- $50 million for Primary and Behavioral Health Integration, which supports the co-location of services in behavioral health and primary care settings;
- $46 million for the National Child Traumatic Stress initiative;
- $2 million for the Consumer and Consumer Support T.A. Centers; and
- $5 million for Consumer and Family Network Grants.

The spending bill allocates $29.9 billion to the National Institutes of Health (NIH), some of which will support the president's BRAIN (Brain Research through Application of Innovative Neurotechnologies) initiative, a multiagency effort to map the human brain.

The new budget bill represents the first time in several years that Congress has been able to reach an agreement on all the line-item ap-

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**Copy Editor** James Sigman
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propriations that make up the annual budget. "I'm not surprised by what they put into the budget," said Farley. "We're excited they're able to find consensus in all these really important programs."

### National debate, coalition building

"The prolonged, sustained national debate on behavioral health in 2013 helped provide some traction to mental health [issues] in a way not seen in the 13 years I've been with MHA," Julio Abreu, senior director of public policy and advocacy at Mental Health America (MHA), told *MHW*. Those discussions helped pave the way for the kind of investments included in the federal spending bill, he said.

Additionally, the support from mental health and disability groups, including the Mental Health Liaison Group, the Coalition of Whole Health and the Coalition of Health Funding, to save nondefense discretionary (NDD) program funding helped in pushing for the FY 2014 budget bill, said Abreu. "We have banded together to make as compelling a case as we can for discretionary health funding," he said.

The sequestration cuts are not as deep as they otherwise would have been if lawmakers had not reached an agreement on the Bipartisan Budget Act of 2013 on Dec. 10, said Abreu. The agreement would provide $63 billion in sequester relief over two years.

Abreu added, "It's encouraging that Congress decided to allow investments in some discretionary programs like SAMHSA and, in particular, funding for [the president's plan] 'Now is the Time.'"

Will new funding increases bode well for next year's budget? "We certainly hope so," said the National Council's Farley. "It's hard to know from one year to the next. We're keeping an eye on the 2014 elections. Election-year politics are going to influence the 2015 [budget] rollout. We're going to be working very hard to [ensure] Congress continues these investments into the future." •

**'I'm not surprised by what they put into the budget. We're excited they're able to find consensus in all these really important programs.'**

Rebecca Farley

MHA is very encouraged about the "robust increases" in the FY 2014 spending bill, particularly for programs important to the advocacy group, such as the $2 million provided for the Consumer and Consumer Support TA (Technical Assistance) Centers, said Abreu.

# Clinical data-sharing effort to bridge BH, physical care gap

A new initiative that will allow for the exchange and coordination of clinical data between physical and behavioral health providers aims to treat the "whole person" and address the early deaths attributable to untreated co-occurring physical health issues in consumers with a serious mental illness, Netsmart officials announced Jan. 14.

Netsmart, a leading software vendor for the behavioral health field, and Epic (Electronic Privacy Information Center), an electronic medical records organization, are collaborating to accelerate clinical information interoperability — the ability to exchange and use information — and improve coordination across all modalities of care for people with mental illness, said officials.

***Bottom Line...***

*Providers coordinating care through this information exchange initiative can expect to reduce the labor-intensive, time-consuming process of dealing with multiple faxes, paperwork and phone calls.*

The collaboration, officials said, aims to use existing national interoperability standards, such as the Continuity of Care Document (CCD), including summary behavioral health data, and the IHE (Integrating the Healthcare Enterprise) and the XDR (external data representation), the latter a standard for the description and encoding of data, to demonstrate a working model for exchanging information for behavioral use cases, with patient consent.

The exchange of clinical information will protect patient privacy and provide clinicians with appropriate access to critically needed information. One goal of the collaboration is to reduce the cost of care by providing clinicians ready access to data that enables them to identify and treat co-morbidities at an earlier stage, said officials.

"The overarching goal is to better coordinate between people with mental illness and physical diagnoses," Kevin Scalia, executive vice president of corporate development at Netsmart, told *MHW*. Physical care for consumers with mental illness is not addressed routinely, he said, contributing to consumers' in-

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creased risk of having co-occurring chronic medical conditions and dying on average 25 years earlier than the general population.

Hospitals have estimated savings in the millions of dollars annually that can be realized by not keeping patients waiting for care for 24 hours or longer. The initiative will allow information about a patient's medication and diagnosis to be electronically transmitted to a mental health agency or facility, he said.

Additionally, the initiative aims to not only improve care coordination for patients but to also save significant time for staff, said Scalia. Currently, the referral process can take a significant amount of time, including the time it takes to fax several pages of documentation over to the other provider, he said. The new initiative aims to automate that process as well. "There will be no paper records floating around," said Scalia, adding that it will improve privacy and security issues as well.

One focus of the initiative involves shared data moving back and forth between a hospital emergency room and a mental health facility, noted Scalia. The records for a patient in an ER waiting room can be transferred electronically to a mental health agency. "This is considered transformational in the way behavioral health services are delivered," he said.

## Pilot projects

Netsmart currently has three active pilot projects and is in discussion with bringing a fourth one on board, said officials. The first project is expected to go live in February.

Henderson Behavioral Health, a not-for-profit agency in South Florida, and Memorial Healthcare System, in Hollywood, Fla. considered the second-largest public healthcare system in the country, are two pilot participants.

The initial focus on clinical operability between Henderson and Memorial involves bidirectional communication to facilitate efficient transition of care for referrals and discharges. Testing of the interoperability system between the two organizations commenced in December, Steve Ronik, Ph.D., CEO of Henderson Behavioral Health, told *MHW*.

**'This is considered transformational in the way behavioral health services are delivered.'**

Kevin Scalia

Memorial is a very large urban hospital system with multiple hospitals in Florida, he said. Although Henderson already provides some primary care services on site, many of its consumers with mental illness and co-occurring physical illnesses show up at the hospital or in the emergency room, he said.

When a patient arrives at a Memorial Hospital ER, that hospital can transmit and share information about that patient to Henderson. Typically, referrals go back and forth through faxing, phone calls and follow-up to obtain additional information, he said. "It's a labor-intensive, time-consuming process," he said. The initiative helps to establish direct communication between Memorial and Henderson, said Ronik. "Rather than [involving] a huge multi-tiered exchange, this involves a direct connection and allows us a much greater confidence related to privacy issues," said Ronik.

Ronik added, "We're the only two organizations sharing this information. We don't have to worry about a third or fourth party." Ronik said that it's too early to cite outcomes. The ability for information to be digitally transmitted between the two organizations will generate huge savings, improve integrated care efforts and ensure better outcomes for patients, he believes. "We hope to be operational in March," said Ronik. •

# Legislation supports coordinated care for Medicare patients

Citing a goal to provide better care at lower cost for Medicare beneficiaries with multiple chronic conditions, congressional lawmakers introduced legislation Jan. 15 that would expand the use of multidisciplinary health teams to keep patients as healthy as possible in their homes and communities.

The Better Care, Lower Cost Act, introduced by U.S. Sens. Ron Wyden (D-Ore.) and Johnny Isakson (R-Ga.) and Reps. Erik Paulsen (R-Minn.) and Peter Welch (D-Vt.), seeks to improve care coordination for beneficiaries with multiple chronic conditions, considered the most expensive and fastest-growing portion of the Medicare population.

According to the Centers for Medicare & Medicaid Services (CMS), 68 percent of Medicare enrollees have multiple chronic conditions and account for 93 percent of Medicare spending. Additionally, 98 percent of costly hospital readmissions involved beneficiaries with multiple chronic conditions.

The legislation creates the "Better Care Program," allowing health plans and groups of providers to form "Better Care Plans" or "Better Care Practices," respectively. This program would be voluntary and open to Medicare enrollees with chronic illnesses. Participating plans and practices would receive newly calculated risk-adjusted, capitated payments rewarding better health outcomes for enrolled beneficiaries.

BCPs would be allowed to focus and specialize in chronic care deliv-

ery and management. Under current law, the so-called "attribution rule" strictly limits the ability of provider-led organizations to reach out to sicker patients and provide them with the highest-quality, integrated chronic care services.

"This legislation is encouraging mental health professionals to participate as part of the Better Care program," Ken Willis, spokesperson for Wyden, told *MHW*. "When trying to ensure patients are getting the full range of services, mental health is a part of that."

The legislation also supports team-based care for Medicare patients that would include social workers and other mental health providers, he said. "Team-based care means you're covering the full spectrum of care," said Willis, adding that the bill encourages a more holistic approach to patient care.

Willis noted that many providers already receive reimbursement for Medicare patients. "This legislation wouldn't change that," he said.

**'This legislation is encouraging mental health professionals to participate as part of the Better Care program.'**

Ken Willis

### Integrated care delivery

Existing integrated care delivery models are largely limited to the Pacific Northwest, Midwest and Northeast, leaving millions of Medicare enrollees without access to this more effective and cost-efficient model of care, officials said in a statement. In these areas, the legislation provides opportunities to go further, they said.

Additionally, the bill would encourage medical schools to focus on team-based care as well as geriatrics and chronic disease management.

"We need to modernize Medicare to drive quality and lower costs," Paulsen said in a statement. "Focusing reform on chronic care management will not only improve the overall health of our seniors, it will decrease costs and help to ensure long-term solvency of the Medicare program."

Paulsen added, "By taking advantage of technology, such as telehealth, to break down geographic barriers that currently plague the system, we can bring the chronic care management skills and experience of providers like Minnesota's Mayo Clinic in the most rural parts of the country." •

For more information, visit www.wyden.senate.gov/chroniccare.

# Foundations aim to promote health, safety of college students

The Jed Foundation, an organization to promote emotional health and prevent suicide among college students, and Clinton Health Matters Initiative (CHMI) officials announced a partnership Jan. 14 to help prevent the leading causes of death in young adults — unintentional injuries, including those caused by prescription drug overdoses or alcohol poisoning, and suicide.

The Jed and Clinton Foundation Health Matters Campus Program (Campus Program) aims to help colleges and universities create healthier and safer campus environments, officials announced at CHMI's third annual Health Matters conference Jan. 13-15 in La Quinta, Calif.

The Campus Program is designed to help colleges and universities promote emotional well-being and mental health programming, reduce substance abuse, and prevent suicide among 18-to-26 year-olds. The Campus Program expands upon The Jed Foundation's JedCampus program, a self-assessment and feedback program that helps colleges create more comprehensive solutions to support their students.

According to the most recent data available, there are about 21 million people enrolled in post-secondary institutions in the U.S., said officials. In 2013, the American College Health Association–National College Health Assessment found that more than half of college students experienced "overwhelming anxiety" at some point in the past year and about 32 percent reported feeling "so depressed that it was difficult to function" and 8 percent reported seriously considering suicide.

To participate in the Campus Program, schools take a confidential, online self-assessment about their current mental health, suicide prevention, and substance abuse programming. Upon completion, the school's responses are compared to recommended practices developed by national experts in college mental health and substance abuse prevention. Then, The Jed Foundation and CHMI provide a confidential feedback report and phone consultation with practical recommendations for enhancement.

Schools that demonstrate comprehensive programming are recognized with a Jed and Clinton Foundation Health Matters Campus Program seal. The seal represents a school's commitment to student mental health and substance abuse prevention and showcases that the school employs a comprehensive, campus-wide approach to mental health, substance abuse and suicide

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prevention programming. Schools that do not receive the seal will not be identified. In the future, through the Campus Program, experts will be available to offer temporary, on-the-ground support and technical assistance to colleges and universities.

During the conference, officials also announced that mtvU's "Half of Us" campaign, an initiative to connect students to appropriate resources to get help, and Facebook will partner with The Jed Foundation and the Clinton Foundation to help prevent prescription drug misuse among college students (mtvU) and to help college students identify potential warning signs that a friend is in emotional distress and may need help (Facebook). •

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medical necessity criteria for PSSs, even though these criteria are standards for determining coverage and reimbursement, according to the article.

The authors pointed to research that shows that PSSs promote empowerment and self-esteem, self-management, engagement and social inclusion and improve the social networks of consumers who receive these services. Studies of clinical outcomes of PSSs have also shown that involvement of a peer mentor (peer bridger services) results in fewer readmissions and overall hospital days, they noted.

**'The world is changing, and PSSs are understood to be important within the framework of recovery and resiliency.'**

Susan Bergeson

Peer bridger services complement the member's behavioral health treatment services and may be delivered while the member is receiving behavioral health treatment in order to facilitate engagement in care, according to the article. The services vary in intensity, frequency and duration in order to support the member's ability to utilize behavioral health services, manage psychosocial challenges and realize broader recovery goals.

Managed care companies cannot pay for PSSs unless the provider organization has level-of-care guidelines that make it possible for this service, Susan Bergeson, vice president of consumer and family affairs at Optum and co-author of the article, told *MHW*. "Having a peer support services program is more important, especially in avoiding hospitalizations and staying on the job," she said. "It is a service important to people on Medicaid and Medicare and people who have insurance through their employer."

## Peer program initiative

In December 2009 Optum partnered with Grassroots Empowerment Project Inc. (GEP), a statewide consumer-run non-profit organization in Wisconsin, on a peer support initiative based on an adaptation of the New York Association of Psychiatric Rehabilitation Services (NYARPS) peer bridger model, Bergeson said.

Data from the organization's programs in New York and Wisconsin reveal a significant decrease in the number of behavioral health hospital admissions and decreases in total behavioral health costs, she said.

Preliminary results of a peer program evaluation report revealed that in New York consumers who received peer bridger services saw a 47.9 percent decrease in inpatient services over six months. In Wisconsin, comparable data revealed a 38.6 percent decrease in inpatient services.

"If we're going to remain clear about the recovery model, we need to see peer support as important and part of any person-centered treatment plan," said Bergeson. Optum may be the only MCO with established level-of-care guidelines for peer services, she said. "Our peer [MCOs] need to be doing this," she said.

"CMS says these services are reimbursable; now we have to figure out how to do it," she said. Currently, 27 states are reimbursing peer services under Medicaid. "But if a managed care company is overseeing the Medicaid benefit, you have to have a way to optimize that," she said. "Creating level-of-care guidelines is one of the steps to getting it done."

## Developing level-of-care guidelines

To create level-of-care criteria for PSSs, an Optum workgroup comprising clinical professionals and consumer representatives reviewed available research findings and guidance on best practices from governmental sources. The group was also responsible for synthesizing evidence-based findings into level-of-care criteria and providing a consensus opinion when the evidence base was lacking.

Four level-of-care criteria sets have been established by Optum and include guidelines for peer-to-peer services and supports, peer bridger services, family-to-family support services and family peer bridger and navigator services. These level-of-care criteria include a review of the scientific and other evidence, a review of governmental services, and indications for coverage, applicable procedure codes

 

and references.

According to the article, in each state, Optum works within the state's established guidelines for training and certification in the development of peer provider networks. Guidelines for PSSs reflect the intent to improve the experiences of people receiving care for mental health and substance use conditions through the development of tools and resources to support well-being, community living and recovery, the article stated.

These evidence-based tools help determine when PSSs are the appropriate services — that is, in line with a person's needs, preferences, and broader recovery and resiliency goals. Although the door is open for organizations to include peer programs, MCOs will make the decision about whether someone is eligible for reimbursement based on the level-of-care guidelines.

## Indications for coverage

To qualify for PSS coverage, the member must have a severe and persistent behavioral health condition, according to the article, and certain other criteria must be met. Following are two examples:

- The member has significant difficulty consistently and independently accessing or utilizing ambulatory behavioral health care or medical care. For example, the member relies primarily on emergency room services or has had two or more inpatient admissions in the last year.
- The member has significant difficulty consistently and independently managing age-appropriate activities of daily living, including finances, hygiene, nutrition and meal preparation, home maintenance, child care, legal services, housing, transportation and other community service needs.

The peer begins the process of contacting the member before the member's discharge from a hospital or other facility-based program or within 24 hours of referral to peer bridger services. The peer also confirms that the member wants peer bridger services, and they both complete an initial needs assessment.

Peer specialists can meet with a consumer in his or her home or at a local McDonald's or Starbucks, said Bergeson. "We'll use tools like symptom tracking or teach self-management skills like yoga and help them prepare for a doctor's services," she said.

## MCO network partners

Provider organizations need to talk to MCOs' network partners and express an interest in receiving reimbursement for peer-related services, said Bergeson. Providers may run into MCOs that may be willing to reimburse these important services but have their hands tied because they may be in one of 23 states that do not reimburse PSSs under Medicaid.

If that is the situation, providers can work with state officials to advocate for reimbursement of peer support services through Medicaid, said Bergeson. Another option is to incorporate these services by linking their clients with free support groups through the Depression and Bipolar Support Alliance (DBSA), Mental Health America (MHA) and the National Alliance on Mental Illness (NAMI), she said.

Level-of-care guidelines open the door, but there has to be a lot more conversation, said Bergeson. The bottom line is that providers have to take a look at level-of-care guidelines and have a conversation with the MCO about the possibility of reimbursement for peer services.

"The world is changing, and PSSs are understood to be important within the framework of recovery and resiliency," said Bergeson. "Providers have to look into bringing PSSs into their mix [of business]."

Transparency in the development and dissemination of these guidelines will help to ensure the ongoing best-practice deployment of PSSs across mental health, addictions and integrated care, the authors concluded. •

To view peer and family level-of-care guidelines, visit http://ubhweb.uhc.com/ubh/clinical_policy_standards/gls/coverageprotocols.html.

## Briefly Noted

### HHS seeks members for new advisory committee

The needs of children in disasters will be the focus of an advisory committee of the U.S. Department of Health and Human Services, HHS officials announced Jan. 22. The National Advisory Committee on Children and Disasters will provide expert advice and consultation to the HHS Secretary on comprehensive planning and policies to meet the needs of children before, during, and after a disaster or other public health emergency. The department is seeking nominations for committee members from the scientific, public health, and medical fields. The National Advisory Committee on Children and Disasters was established under the authority of the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013. Nominations are being accepted from non-federal health care professionals and representatives from state, tribal, territorial or local health care offices. Deadline for submission is Feb. 14, 2014. For more information or to be considered for committee membership, visit www.phe.gov/naccd.



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## State News

### Eastern Washington mental health care options increase

Walla Walla, Washington has historically had a dearth of mental health care professionals, with at most two psychiatrists in residence. Individuals seeking mental health care have had to rely on primary care providers for medication management, although such professionals often lack experience and training in diagnosing mental disorders. *Union-Bulletin* reported on Jan.18 that Walla Walla County awarded Comprehensive Mental Health, a non-profit agency, and three local behavioral health providers grant money from the county's mental-health coffers to provide care to people needing mental health services. This expansion is funded by one-tenth of 1 percent of sales taxes. The county has further been seeking an avenue to turn over its mental health services to contractors who will bear the costs and complexities of providing care for Walla Walla County residents.

### UVa students draft bipartisan mental health bill

Thirteen University of Virginia students have written proposed legislation that would require Virginia's public universities to create and feature a webpage dedicated solely to mental heath resources available to students at each institution. *The Daily Progress* reported on Jan. 19 that students noticed a lack of mental health awareness and drafted a proposal that would provide students, faculty, and staff with life-saving information. The bill would also require incoming students to complete an online learning module and assessment to test their understanding of the content. The students contend that colleges and universities are the ideal place to apply such preventative services, and argue that the proposed legislation is a bipartisan solution to a truly nonpartisan issue.

### Vermont lawmakers debate psychiatric med requirements

Two Vermont Senate committees heard from hospitals and mental health officials Jan. 22 that the state needs to speed up its legal process for requiring some mental health patients to take psychiatric medications against their will, the *Ledger-Enquirer* reported. Vermont currently has stricter protections for patients who do not wish to take psychiatric drugs than many other states do, with the result that mental health caregivers are placed at risk and patients suffer from their illness longer, officials testified. Legislation under review by the Senate Judiciary Committee and the Health and Welfare Committee would allow for a combined request to a court to hospitalize a patient against his or her wishes and to force the person to take medication. They currently require separate hearings, the first of which often doesn't happen until 40 days or longer after the patient is hospitalized. Most of the cases in which the state Department of Mental Health seeks involuntary medication are settled before they go to a court hearing, officials said. Either the patient gets better or agrees to treatment and medication.

## Coming up...

**The Department of Child and Family Studies at the University of South Florida** will host its 27th Annual Children's Mental Health Research & Policy Conference **March 2–5** in **Tampa Fla.** For more information, visit **http://cmhconference.com**.

The **National Association of County Behavioral Health & Developmental Disability Directors (NACBHDD)** will host its 2014 Legislative and Policy Conference **March 3–5** in **Washington, D.C.** Visit **www.nacbhdd.org** for more information.

The **Anxiety and Depression Association of America** will be holding its Anxiety and Depression Conference 2014, "Personalized Treatments for Anxiety and Mood Disorders," **March 27–30** in **Chicago**. Visit **www.adaa.org/conference** for more information.

## In case you haven't heard...

People feel worse when they tell only part of the truth about a transgression compared to people who come completely clean, according to new research published by the American Psychological Association. Cheaters who confessed just part of their wrongdoing were also judged more harshly by others than cheaters who didn't confess at all, according to five experiments involving 4,167 people from all over the U.S. The article appears in the February issue of APA's *Journal of Personality and Social Psychology*. "Confessing to only part of one's transgressions is attractive to a lot of people because they expect the confession to be more believable and guilt-relieving than not confessing," said lead author Eyal Pe'er, Ph.D., who ran the studies at Carnegie Mellon University. "But our findings show just the opposite is true." Confessing to some bad behavior was more common than making a full confession among those who cheated as much as possible in the study. But only telling part of the truth, as opposed to not confessing at all, was more likely to lead to increased feelings of guilt, shame and anxiety, the research found. In other words, it's best to commit to an all-or-nothing approach when it comes to confessing, said Pe'er.