



AMERICAN MENTALTM WELLNESS ASSOCIATION

April 2020 **Rapid Response Plan for America's Broken Mental Health System**
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Our Vision –

We envision a world that through public education values prevention, early intervention, scientific research, and cures of mental health problems which includes substance use disorders for the holistic health of the individual and society.

Our Mission –

We are building healthier lives free of mental health problems through educational outreach.

This white paper uses the Commonwealth of PA as an example, but it should be read as an example of what has been similarly occurring over the years in other States throughout the country, and what needs to improve now.

Executive Summary:

Even though we have known for decades that prevention and early intervention of mental health conditions works, America continues the same old terminology, public policies and funding streams created back in the early 1970s. We know that 50% of mental health conditions surface by the age of 14, and that 75% of mental health conditions are present by age 24, but the mental health system has failed to keep our youth safe. The suicide rate for children ages 10 to 14 has nearly tripled, with rates among older teenagers increasing by 76% from 2007 to 2017. We know that in 83% of addictions, a mental health problem preceded the substance use disorder by about three years; but mental health continues to compete with substance abuse for every available grant dollar while we fail to treat underlying mental health conditions before full blown addictions occur. We need new responses to this broken system now!

With the coronavirus pandemic occurring, we must immediately make major changes to effectively address the mental health needs of all Americans, especially our children and youth.

This paper shows how the current programming has not been working and demonstrates what needs to be done immediately to improve the health and safety of all Americans.

At all levels of government, the structure and names of Departments, Bureaus, and Centers must be updated to reflect 2020 brain science realities. Taxpayer dollars have been spent supporting outdated policies, programs, funding, and terminology for too long. It is ironic that much taxpayer money is spent trying to eliminate the “stigma” surrounding mental illness, by government institutions who perpetuate this stigma through outdated policies, programs, terminology, and funding.

Currently under the Department of Health, and Human Services, the US Substance Abuse and Mental Health Services Administration (SAMHSA) was created by Congress in 1992 right after the Eli Lilly Corporation started manufacturing FDA approved Prozac, the first Selective Serotonin Reuptake Inhibitor (SSRI). Now in 2020 we are at a tipping point for SAMHSA and other institutions and organizations to recreate themselves based on new scientific research findings for the holistic health of the individual and society. The SAMHSA Office of Behavior Health Equity (OBHE) was established in accordance with Section 10334(b) of the Patient Protection and Affordable Care Act (ACA) of 2010 (PDF | 2.2 MB). The law requires six agencies within the Department of Health and Human Services to establish offices of minority health. OBHE's efforts are focused on the promotion of *behavioral* health equity for

underserved racial and ethnic minorities, as well as lesbian, gay, bisexual, and transgender (LGBT) populations. It is discriminating and stigmatizing to call the office *Behavior* Health Equity. Rather it should be called SAMHSA Office of *Physical Mental* Health Equity.

The majority of Americans believe mental health (with addictions included in this definition) is just as important as physical health. And they are correct. Science has proven mental health conditions are physical medical conditions with cognitive and emotional symptoms and in most cases precede a substance use disorder by about 3 years. *Behaviors are symptoms of physical mental health problems.* Scientific research shows most mental health issues can be prevented and the earlier these physical mental conditions are treated the quicker the person can get well. “Early intervention is the deciding factor in how much a person will suffer, how long the person with mental illness will live, how productive and successful a person will be, and how costly the ripple effects of unaddressed mental health concerns will be across many sectors of a community. Mental disorders are the single most expensive category of health costs for many employers across all industries and sizes. According to Aetna, the direct costs totaling \$6,000 per employee per year, is only the tip of the iceberg. The indirect costs, including things like absenteeism, presenteeism, turnover, temporary staffing, etc., are twice as costly as the direct costs” (*futuresTHRIVE* 2/13/2019 <https://www.futuresthive.com/>– Source: Steinburg Institute).

In 2008 the United States Mental Health Parity and Addiction Equity Act (MHPAEA or Parity Law) required all insurers to cover mental health and substance use disorder care on par with physical health coverage that was provided in their policies. Yet, today mental health parity is not a reality. Insurers are not following the letter of the law. Many Americans are denied care when they need it the most. This is unconscionable. Enforcement of the 2008 law must happen immediately. Also, it is pointed out to the reader, the 2008 law is NOT called the United States **Behavioral Health** Act. So, we do not need a new law to change the outdated term “behavioral health.” It should have already been done with this new law being implemented.

More people suffer from mental health problems than those who suffer from cancer, lung disease, and heart disease combined. The Coronavirus pandemic has put tremendous emotional triggers at the forefront of many children, youth, adults, and older adults living with physical mental health conditions, as well as those living with the genetic predisposition for developing these conditions. Trauma is a risk factor for a person with a genetic predisposition for a mental health problem. Requiring schools to teach brain health, to teach the early signs and symptoms of a brain problem, and the importance of immediately seeing a primary care provider is needed as soon as possible because of the coronavirus pandemic hardships. Physical exams and the most current and effective mental health screenings from pediatric physicians, primary care physicians through geriatricians needs to occur now. Once diagnosed as having a mental health problem, specialists and therapists are a key element in recovery. Early detection is NOT waiting 2 weeks after symptoms show up before seeking treatment which is what is currently promoted by insurers and providers. Early detection means knowing the 1st and 2nd stage signs and symptoms of a mental health problem and seeing a Physician, Certified Registered Nurse Practitioner, or Physician Assistant immediately as they are able to diagnose and, if needed, prescribe medicines.

Restructuring of government departments at the federal, state, and local levels to blend Mental Health and Substance Abuse Prevention departments/bureaus/agencies etc., programming, funding, treatment, and services needs to occur immediately to end frivolous spending of taxpayer dollars and to improve the health and safety of all American communities.

The wisest public policy to mitigate high spending on many of society’s ills which will help alleviate burdens on our health care workers, law enforcement, government programming, communities, and families is to fund a highly focused and sustained public education campaign for prevention, early detection (knowing the first signs and symptoms of a mental health problem), and early intervention for physical mental health conditions. Let’s call it “Prevention and Early Intervention of Physical Mental Health Challenges.”

This reincarnation can be done without new tax dollars. Redirection of current funds will suffice.

Rapid Responses Needed are listed at the conclusion of this document on pages 19 through 21.

The American Mental Wellness Association was founded in 2016 because of the huge gap for 50 years in public education for prevention and early intervention (includes early detection) of mental health problems, which includes substance use disorders, for the holistic health of the individual and society.

For the past 50 years, federal, state and local governments, along with non-profit and for-profit organizations, insurers, health care institutions, *behavioral health* providers, schools, and colleges have focused on prevention of alcoholism, drug addictions, and suicides. Yet, science has shown these are symptoms of the underlying core problem of not educating the public on prevention of mental health problems, the first stage signs and symptoms of a developing physical mental health challenge and obtaining early treatment intervention. “Early intervention is the deciding factor in how much a person will suffer, how long the person with mental illness will live, how productive and successful a person will be and how costly the ripple effect of unaddressed mental health concerns will have across many sectors of a community” (*futuresThrive* 2/13/2019 <https://www.futuresthive.com/>, *Steinburg Institute*). Accordingly, research by the national Academies of Sciences, Engineering and Medicine reports that for every \$1 invested in prevention and early intervention for mental illness and addiction programs a \$10 in savings in health costs, criminal and juvenile justice costs and low productivity can be expected (*Steinberg Institute*, August 22, 2017, <https://steinberginstitute.org/press-release/fact-sheet-cost-benefits-early-intervention-mental-illness/>).

Kara Bagot, M.D., a Child and Adolescent Psychiatrist and an Assistant Professor in the University of California, San Diego Department Of Psychiatry writes “Indeed it has been shown that up to 83% of adolescents entering treatment for an Opiate Use Disorder (OUD) have a least one comorbid psychiatric illness, with greater than 50% having two or more psychiatric diagnoses...Psychiatric symptoms may precede, exacerbate or follow substance use; in particular , it is likely that Major Depressive Disorder precedes Opiate Use Disorder by about three years.” (*www.healingmagazine.org*. 2016 Vol. 21, No 2. *Opiate Use Among Youth with Psychiatric Illness: Tackling Treatment Challenges*). Michael Berk, PhD., at Deakin University School of Medicine and the 2015 recipient of the Colvin Prize for Outstanding Achievement in Mood Disorders Research says prevention of depression works, but the message isn’t getting out to the public.

Neuroscience has proven that serious psychological distress is a medical condition, not a character or personality issue. Neuropsychiatric disorders are often linked to genetic conditions that they can be successfully treated, and just like other physical illnesses, combinations of DNA variations – cumulatively occurring in as many as 1,000 of our 21,000 genes – contribute to risk, when viewed at the level of the entire human population...Everyone one of us, on the basis of our unique gene sequence alone, carries some measurable risk of psychiatric illness, just as we do for cancer and other illnesses...” (Science in Progress Part 1 and Part 2, *Brain and Behavior Magazine*, March 2020, pp 4-9).

Some folks think trauma informed care is the same thing as prevention of mental health problems. Nothing can be farther from the truth. Trauma is an environmental trigger for people whose gene DNA predisposes them to develop a mental health condition - just like smoking is an environmental trigger for someone with the genetic predisposition for lung cancer, or sugar for a person with a family history of type II diabetes. Not every person who smokes will get lung cancer. Some nonsmokers will get lung cancer. And stopping smoking will not cure a person’s cancer.

We have been missing the mark on early diagnosis and treatment of mental illnesses for years and trauma informed care will simply perpetuate that misdirection unless we add to it public education programs for prevention, recognition of the early signs and symptoms of these physical mental health problems, and encouragement to see a primary care provider right away. Then we can begin to comprehensively reduce the social ills throughout our country – even poverty. Integrating this care immediately will enable proper diagnosis. Blood work and other screenings by the primary care provider needs to rule out other physical conditions that can present as a mental health condition.

The federal government is a major funding stream for mental health services: Medicare, Veterans Affairs, Medicaid, Children’s Health Insurance Program, Mental Health Block Grant Funding, Judicial Systems. Additionally, they fund mental health research for treatments and recovery (National Institute of Mental Health) with little to no funding for prevention or early detection of mental health concerns. The federal government is a major funder for Substance Abuse Disorders (SUDs) which includes a lot of taxpayer dollars for prevention of SUDs.

Organizations, including federal, state, and local governments, who should have been doing public education for prevention, early detection, and early intervention have solely focused on treatment of mental health problems. Thus,

over the past 50 years the statistics for alcoholism, drug addictions, and suicides have gone up, not down. Prevention of Substance Abuse and Prevention of Suicide funding and promotional programs are NOT educating for prevention, early detection, and early intervention of mental health problems. Substance Abuse and Suicide are the fourth stage of a physical mental health condition, not the first stage of a new problem. It is precarious to precede these terms with the words “Prevention of.” It would be like trying to prevent cancer after the tumor has metastasized. No wonder policies have failed to reduce the numbers of substance abuse disorders and suicides and that America’s jails and prisons are full of individuals with mental health conditions who should be in a hospital or receiving outpatient services.

America’s drug addiction problem costs the nation approximately one trillion dollars per year; and suicides and suicide attempts cost the nation an estimated \$93.5 billion per year. And the numbers keep rising year after year. People are suffering. People are dying. Families are being destroyed. Inhumanity is prevalent.

Now that we will be adding costs arising from the coronavirus pandemic, we cannot afford to wait to treat mental illnesses until they are far advanced and the most difficult and expensive to treat.

At the Federal, State and Local government levels, over the past decades, significant public dollars have been spent on treatments for drug and alcohol disorders and suicide, rather than on education and awareness of the early signs and symptoms of developing mental health problems, and the need for prompt proper medical care. In fact, there are very few dollars being effectively spent on prevention and early intervention education for mental health issues. Funding streams and outdated government departments/bureaus have and are still supporting and promoting the 50 years of omission to targeting the core problem for success in significantly reducing the numbers of people living and dying with/from alcoholism, drug addiction, suicides and many other social ills such as poverty, domestic violence, incarcerations, etc.

Did you know in the organizational structure of SAMHSA there is a specific Center for Substance Abuse Prevention? There is no center for prevention of mental health issues, but there is a Center for Mental Health Services. Also there is the SAMHSA Office of *Behavior* Health Equity (OBHE) established in accordance with Section 10334(b) of the Patient Protection and Affordable Care Act (ACA) of 2010 (PDF | 2.2 MB). The law requires six agencies within the Department of Health and Human Services to establish offices of minority health. OBHE’s efforts are focused on the promotion of behavioral health equity for underserved racial and ethnic minority, as well as lesbian, gay, bisexual, and transgender (LGBT) populations (See Appendix 1). Using the term “*Behavior*” in this day and age is discriminating when science has proven mental health issues are physical medical conditions with cognitive and emotional symptoms. Call it the “Office of Physical Mental Health Equity.”

According to SAMHSA, “prevention of mental and/or substance use disorders and related problems in children, adolescents, and young adults is critical to America’s behavioral and physical health. Behaviors and symptoms that signal the development of a behavioral disorder often manifest 2 to 4 years before a disorder is present. People with a mental health issue are more likely to use alcohol and drugs than those not affected by a mental health problem.” The Institute of Medicine and National Research reports that a \$1 investment in early treatment and prevention programs yields \$2 to \$10 worth of savings in health costs, criminal and juvenile justice costs, education costs, and lost productivity.

Yet, knowing all this, just recently the White House Office of National Drug Control Policy (ONDCP) announced nearly \$25 million is available in fiscal year 2020 to Substance Use Prevention Coalitions in a New Partnership Between ONDCP and the CDC. This money will be appropriated to community coalitions focused on prevention of youth substance use for up to 200 new communities to prevent illicit drug use and save lives. The White House is not solely to blame for this erroneous allocation of funds; rather, the government institutions serving the Presidency should be getting the message out that in order to prevent addiction, focus must be placed on prevention, early detection and early intervention of the mental health problems that lead to addiction. *Perhaps the White House could amend the funding protocols to reflect the need for a portion of the \$25 million to go to public education of mental health prevention, early detection, and proper intervention.*

Without education on prevention and the early signs and symptoms (1st and 2nd stages) of a mental health problem, many people will continue to get sicker and sicker, with many self-medicating on alcohol and drugs, and/or harming themselves or others. The economic burden of serious mental illness (depressive disorder, bipolar disorder,

schizophrenia) in adults in the United States in 2015 is estimated to be at least 125 billion dollars for each serious mental illness (Source: MacEwanJP, Seabury S, et al. *Pharmaceutical innovation in the treatment of schizophrenia and mental disorders compared with other diseases. InnovClinNeurosci.* 2016 Aug 1;13(7-8):17-25). People who experienced Serious Psychological Distress in the past 12 months are more likely to abuse or be dependent on alcohol or illicit drugs during that same time period (*National Survey on Drug Use and Health (2015)*). People who experienced Serious Psychological Distress (SPD) are more likely to have been arrested or be on parole or probation in the past year. A large percentage of the U.S. adult prison and jail inmate population currently experiences Serious Psychological Distress compared to the non-institutionalized population. Additionally, these mental health issues are observed at higher rates in local jails than in prisons.

People living with physical mental health conditions should not be arrested and incarcerated. They should be assisted in being hospitalized just like someone having a heart attack, a stroke, in diabetic shock, etc. The American Civil Liberties Union of Pennsylvania has been suing the PA Department of Human Services for the past three years to reduce the time people with severe psychiatric disabilities spend waiting in jail for treatment beds. These are people whose mental disabilities are so severe that under the Constitution the individual cannot be prosecuted nor punished, which means that they should not be housed in prisons or jails. The ACLU's recent third injection requested the court order PA DHS to transfer these patients within 7 days (required by 2 federal courts) by September 1 (Walezak, Witold, "Pennsylvania is Jailing Mentally Ill People Who Belong in Treatment", American Civil Liberties Union <https://www.aclu.org> 3/29/19).

In the U.S., the average hospital stay duration for adult patients with serious mental illness is high compared to all hospital stays, especially for patients diagnosed with schizophrenia. The total time spent in the hospital by adults with a primary diagnosis of schizophrenia, bipolar disorder or major depressive disorder exceeds seven million dollars each year in the U.S. In contrast to adults, "psychotic disorder, not otherwise specified (NOS)" is diagnosed more often than schizophrenia in the younger population (1-17 years) during hospitalizations, possibly to prevent stigmatization. When schizophrenia is the primary reason for a hospitalization, the average length of stay for younger people is one week longer than in adults, illustrating the challenges in treating and establishing an environment with appropriate follow-up care for this especially vulnerable population. (*Healthcare Cost and Utilization Project (HCUPnet) 2014*)

Knowing this, public policies need to change immediately to responsibly address the social problems associated with mental illnesses: addiction, incarceration, suicide, violence, deaths, etc. If this is done properly, there will be tremendous savings of taxpayer dollars, and the people in our country, especially our youth, will live healthier happier lives.

It is widely accepted that out of every bad thing, something good can also come. Well there is a good already occurring with the Coronavirus pandemic -- the organizations/governments that have been ignoring the core issue for mental wellness in our country are finally doing what they should have done for decades -- educating the public on prevention. There has been a Coronavirus stimulus package for mental health organizations to provide telehealth treatment; and perhaps some funding streams temporarily created to assist with prevention and hopefully early intervention education of mental health conditions caused by the pandemic.

The Coronavirus pandemic has put tremendous emotional triggers at the forefront of the minds of many people living with physical mental health conditions, as well as those with a genetic DNA predisposition for developing such conditions. Many of the above-mentioned groups are predicting a 2nd pandemic which will be mental illnesses in the USA and around the world; and they are anticipating a need to provide many more people with mental health treatment and services.

So, now more than ever, transformation of the outdated mental health and substance abuse disorder public policies, funding streams, and structures needs to occur. We cannot keep making the same mistakes. People need to know how to recognize the first and second stage signs and symptoms of a developing physical mental health problem in themselves and their loved ones, and to seek prompt help, beginning with their primary care physician, before the condition reaches a crisis stage.

Without prevention and early intervention public education on these physical mental health problems it is impossible to significantly reduce the number of people living with/dying from addictions and/or the number of people

succumbing to suicide: and even the number of people living in poverty. We do need to help our extremely sick: but not educating for prevention and early intervention of physical mental health conditions will continue to keep our country in poor health and throw money to the wind.

The wisest public policy to mitigate high spending on many of society's ills, to prevent and reduce pain and suffering is to fund a sustaining highly focused public education campaign for prevention, early detection, and early intervention for mental health problems.

New tax dollars are NOT needed to quickly move forward with long overdue public policy improvements. There are dollars currently available that need to be redirected to benefit the health and welfare of the people. This should be done immediately - end spending on programs that made sense decades ago, but which advances in understanding of the science of mental illness indicate will be better spent on prevention and early intervention of mental health problems. Strong, courageous leadership at all levels of government is needed today to do this. It is poor public policy to appropriate funds into a broken mental health system especially when an epidemic is predicted. We have seen huge improvements in many systems throughout our country because of immediate policy changes due to COVID-19. Recovering from the Coronavirus pandemic creates the opportunity to re-apportion limited financial resources to improve the health, safety, and wellbeing of all Americans. The time is now, and it is ripe to do so.

To demonstrate what needs to be improved a focus on Pennsylvania will be illustrated here:

For several decades there has been a need to revamp the way Pennsylvania has been providing drug and alcohol treatment and mental health services. Many know this, but little has occurred, as entrenched organizations/practices and a focus on the opioid epidemic have made real change nearly impossible. Now we must move quickly and wisely to free up money currently being wasted on ineffective treatments and public policies, to ensure these dollars are available to effectively provide for the health and financial wellbeing of all citizens of Pennsylvania.

Because of the politics of local and state governments, federal block grant dollars must have specific directions for a large portion to be directly spent on public education campaigns for prevention and early intervention (1st & 2nd stages) of physical mental health problems. This will take the pressure off of local and state elected and appointed officials to continue entrenched ineffective services and treatments that some of their voters may want them to keep.

Let us look at what is there now and how specific public policy changes can improve the health and wellbeing of people living in counties in Pennsylvania.

Beginning over 50 years ago, several groups have been involved in prevention of substance misuse in PA which are intertwined financially, program wise, etc. There is great interest in reducing substance abuse, both for humanitarian and economic reasons. Substance abuse costs society lives and money, and considerable resources are spent every year to try and mitigate those losses. However, very few of these resources are directed towards intervening at the earliest stage of the process when the emotional pain of an emerging mental illness drives many individuals to self-medicate with drugs or alcohol.

Here is a list of Government Agencies and Nonprofit organizations involved in prevention of substance abuse in PA, with a short explanation of their connections/funding sources:

1. USA Government – Substance Abuse and Mental Health Services Administration SAMHSA - Lots of dollars for prevention of SA and suicide, little MH prevention/early intervention dollars. The National Institute of Mental Health – little to no dollars for research on prevention, early detection, and early intervention of mental health problems. They do have Early Intervention for Psychosis, yet if an individual becomes psychotic, in most cases, they are already in 3rd stage or 4th stage of a physical mental health condition. Also, the US Department of Justice spends lots of taxpayer dollars on diversion, incarceration, and reentry programs for people with mental health problems but no dollars on public education for prevention, early detection, and early intervention.
2. PA Commission on Crime and Delinquency PCCD – Lots of Prevention Dollars for Substance Abuse and Law Enforcement Issues. In fact, the foundation of PCCD's delinquency prevention strategy is based on the Communities That Care (CTC) model (see #8 below) They know MH problems precede SA but have no dollars to address education on prevention/early intervention of MH issues. Recently lots of State school safety dollars

were funneled through PCCD to school districts for implementation of new safety measures. Unfortunately, these valuable school safety dollars are not going to educate students about brain health, early detection of mental health problem, and to see a physician promptly for proper medical screenings and diagnosis.

3. PA Dept. of Drugs and Alcohol Programs DDAP - Lots of dollars going to this Department some significant dollars are appropriated for Prevention of Substance Abuse.
4. PA Office of Mental Health and Substance Abuse Services OMHSAS - Little to no dollars for Prevention and Early Intervention Public Education Campaign for Mental Wellness/Mental Health Early Intervention
5. PA Single County Authorities SCA (drug & alcohol dept. at county level – receive state and federal dollars through contracts with the PA DDAP– have some significant SA prevention dollars – supports Preventionist Specialists (Commonwealth Prevention Alliance people) and their training which is specifically for SA. SCAs also receive funding for treatment services from the PA Department of Human Services’s Office of Mental Health and Substance Abuse Services (OMHSAS). These DOHS dollars target individuals in non-hospital residential care who are eligible for Medical Assistance or to a continuum of treatment services for those individuals no longer eligible as a result of welfare reforms. See # 9 and # 10 below for additional information on CPAs and CCAP. SCAs have a reputation for not accepting the new science that shows mental health problems precede a substance use disorder by 3 years in 83% of addictions.
6. PA Mental Health & Intellectually Developmentally Delayed (MH/IDD) County departments - no prevention dollars for MH, no blending of prevention dollars from SCA, little co-occurring dollars from OMHSAS nor DDAP Mental Health Conditions do not cause Intellectual Developmental Disabilities, especially when early medical treatment is administered. Mental Health should no longer be under a MH/IDD County Department. Pairing Mental Health with SUDs is a recommendation since co-occurring illness has proven to be the expectation here, rather than the exception. Montgomery County may be the only county in PA doing this.
7. The Pennsylvania Student Assistance Program (SAP) is a systematic team process used to mobilize school resources to remove barriers to learning. SAP is designed to assist in identifying issues including alcohol, tobacco, other drugs, and mental health issues which pose a barrier to a student's success. The primary goal of the Student Assistance Program is to help students overcome these barriers so that they may achieve, advance, and remain in school. While Student Assistance Programs exist in other areas of the country, the structure and operation of the program in Pennsylvania is a unique expression of an integrated model serving the needs of Pennsylvania families and students. PA SAP is overseen by the PA Network for Student Assistance Services (PNSAS) Interagency, Statewide Staff and Regional Coordinators' team; comprised of representation from the PA Departments of Education (Safe Schools Office), Drug and Alcohol Programs (Division of Prevention and Intervention) and Human Services (Office of Mental Health and Substance Abuse Services). SAP is based upon state guidelines, professional standards, and policies and procedures adopted by the local school board of directors. Professional training conducted by a PA Approved SAP Training Provider (PASTP) is required for team members to ensure the appropriateness of the recommended services, effective interagency collaboration and compliance with state and federal laws protecting the privacy rights of parents and students. Guidelines for the SAP K-12 training system in Pennsylvania contain training standards and competencies to ensure SAP team professionals receive up-to-date professional training consistent with accountable standards and appropriate procedures. It is questionable whether the current training is up to date and reflects the reality that mental health problems are physical medical conditions that precede in 83% of cases a substance abuse disorders. Hopefully trauma informed care is NOT being held out as a prevention for physical mental health problems and is not being used as a substitute for actually obtaining proper diagnoses and treatment of an underlying physical mental health conditions. Trauma is a risk factor for developing symptoms, not the core of the problem. Also, are they trained in knowing the earliest signs and symptoms of a mental health problem? Do they make sure there is a physician to evaluate, diagnose, and provide medical care immediately for the student? Answers are needed. School SAP providers are affiliated with the CTCs and CPAs – see #8, #9 & #10 below.
8. PA Communities That Care CTC (school district level) -focus mainly on SA. Incredibly old program (1970s) and in many school districts and communities across the country-reducing trauma (risk reduction) but **does not go to core/cause of a physical mental health predisposition & educating for earliest detection and treatment**. This program needs upgraded to address public education for prevention and early intervention of mental health problems as soon as possible.
9. Commonwealth Prevention Alliance CPA – Since 1976. Non-profit. Member-driven, grassroots organization-supports Certified Prevention Specialists in eliminating Substance Abuse and risk-related behaviors. Represented on: Drug & Alcohol Service Providers Board, on State Initiative Grant (SIG) Advisory Board, on Bureau of Drugs & Alcohol Programs Prevention Workgroup in 2004 (now DDAP). Members: SCAs, Higher

Education, Prevention Coalitions (CTCs, Drug Free Communities, Tobacco Control, Overdose Prevention, etc.) Please note, they hold themselves out as Prevention Specialists (they are trained and certified as SUDS prevention specialists) but they are no longer as effective because science has proven prevention of the core problem now should be of mental health problems. And they are wrong to believe they are preventing mental health problems by focusing a bit of their attention on social determinants. Addressing social determinants including trauma informed care does not prevent mental health problems. Accepting that mental health problems are genetic (DNA) physical conditions and that children and adults need to know the early signs and symptoms of a mental health problem so they can get prompt appropriate medical care from a physician and subsequent mental health care providers is true prevention which will reduce the number of people self-medicating on alcohol, drugs, gambling, pornography, etc.

10. County Commissioners Association of PA CCAP – helps fund PA Association of County Drug and Alcohol Administrators (PACDAA-trade association for SCAs) and Commonwealth Prevention Alliance’s (CPAs) annual conference (400 people at State College, CPAs, PA-SCA administrators, CTC people, PCCD people, Prevention (University) Researchers for Substance Abuse attend) A portion of these dollars should be spent on mental health prevention/early intervention public education and be implemented as soon as possible.
11. County Commissioners –Pennsylvania has 67 individual governmental units designated as counties. Counties are distinguished into different classes based on their population, ranging from the 1st class county of Philadelphia to 8th class counties like Cameron, Forest, Fulton, Montour, Potter and Sullivan. Unlike most other states, Pennsylvania's counties geographically overlap municipalities such as boroughs, townships and cities, but they provide a different set of services. Therefore, every Pennsylvanian is both a resident of their county and their city, borough or township at the same time. Most counties are governed by a board of three county commissioners elected every four years by the voters who live there. The board of commissioners oversees the entire operation of the county and represents the best interests of the citizens. Other officials are also elected to perform certain functions: the controller, the treasurer, the coroner, the recorder of deeds, the prothonotary, the clerk of courts, the register of wills/clerk of the orphans' court, the sheriff, the district attorney and jury commissioners. Under the direction of these officers, the county maintains important legal records such as real estate deeds, marriage licenses, adoption papers and court records. Different counties have different elected officials, depending on their class. Other counties have adopted a "home rule" form of county government. They may have an elected county executive and an elected county council. These counties are Allegheny, Delaware, Erie, Lackawanna, Lehigh, Luzerne, Northampton and Philadelphia. They also have other elected county officials to help perform important duties.

Counties are required by law to provide certain services to their citizens. Each county performs a wide range of different functions: Community Development and Environmental Planning, Elections, Human Services, Judicial Administration, Corrections and Justice Related Activities, Public Health and Safety, Real Estate Assessment. In PA the County Commissioners in County Groups oversee Behavioral HealthChoices which is mental health and drug and alcohol services provided via the HealthChoices program. It differs from the physical health component of the HealthChoices program. For mental health and drug and alcohol services, each county contracts with a Managed Care Organization (MCO). Once you are enrolled with the MCO, you continue to have choices as to who provides your services. The MCO will send you a handbook outlining how to access services and outlining the benefits available to you. If a practitioner is a HealthChoices participating provider, and is accepting new clients, you have the right to see that doctor. Under the behavioral health component of the HealthChoices program, counties are required to ensure high quality care and timely access to appropriate mental health and drug and alcohol services, and to facilitate effective coordination with other needed services. Each HealthChoices consumer is assigned a Behavioral Health Managed Care Organization (BH-MCO) based on his or her county of residence. Members, then, have a choice of Behavioral Health Care providers within the BH-MCO's network. You can use the following chart to determine the BH-MCO that operates in your county, and click the corresponding link provided to access their webpage.

So, County Commissioners in PA serve the local people at the grassroots. Here are some interesting facts that relate to their service to the people: In PA in 2015 the estimated number of people living in serious psychological distress was more than one million adults per year. In 2013, Pennsylvania had more mental health primary care physicians and psychiatric hospital beds per resident, compared to the U.S. average. And the same is such for psychiatrists and psychologists. (Note: *Only physicians, Physician Assistants and Certified Registered Nurse Practitioners can prescribe medications in PA. Psychologists and mental health therapists are not physicians*). People living with mental illness are more likely to encounter the criminal justice system and to be arrested. In most cases state and federal prisons have resources to provide mental health care to prisoners, but

local jails have a difficult time meeting the health care needs of people with mental illness. The overall cost of incarceration of the 12,000+ prisoners with serious mental illness in the state of Pennsylvania is almost half a billion U.S. dollars per year. The economic burden of each serious mental illness in adults is estimated to be at least 5 billion dollars for Pennsylvania per year. Nationally the total figure per year is 125 billion dollars for each serious mental illness. (Hanke Heun-Johnson, Michael Menchine, Dana Goldman, Seth Seabury, February 2017, *The Cost of Mental Illness: Pennsylvania Facts and Figures*, USC Schaeffer - Leonard D. Schaeffer Center for Health Policy and Economics, http://healthpolicy.usc.edu/Keck_Schaeffer_Initiative.aspx). Note: Each Serious Mental Illness is Major depressive disorder, Bipolar disorder, Schizophrenia. Single County Authority Administrators and Mental Health/Intellectual and Developmental Disabilities administrators are hired by the county commissioners and overseen by the county commissioners. A few counties may contract out to non-profit agencies. They are in most cases residents of the county where they work, and they have strong ties in the voting community of the county. Thus, politics may have been one of the reasons why necessary improvements for mental health has not occurred for decades.

Highlighting federal funding for your attention:

Substance Abuse and Mental Health Services Administration (SAMHSA) – “Performance Budget Overview – The need to face mental health and substance abuse is critical to the nation’s future. Prevention, treatment and support to help people recover from mental and/or substance use disorders are essential strategies for the health and prosperity of individual, families, communities, and the country. Unfortunately, the majority of those who need treatment do not receive it. Only 43.1 percent of the 44.7 million adults with diagnosable mental health problems received treatment in the past year. The unmet treatment need for those who needed substance use treatment (19.9 million adults) is even greater with only 1 in 9 individuals receiving specialty treatment in the past year. The nation can do better. SAMHSA has a unique responsibility to focus on these preventable and treatable problems, which if unaddressed, lead to significant individual, society, and economic consequences. **SAMSHA’s mission** is to reduce the impact of substance abuse and mental illness on America’s communities. SAMHSA accomplishes this mission through providing leadership and devoting its resources, including programs, policies, information and data, contracts, and grants to help demonstrate that: *Behavioral Health is essential to health *Prevention works *Treatment is effective *People recover from mental and substance use disorders.” What’s wrong with this? LOTS. Please see Addendum #1 for the Organizational Structure of SAMHSA. There is a center for Substance Abuse Prevention. There is a Center for Mental Health Services. There is also a Center for Substance Abuse Treatment. THERE SHOULD BE A CENTER FOR MENTAL ILLNESS AND SUBSTANCE ABUSE PREVENTION. Also, mental health conditions (includes SUDs) are physical medical conditions with cognitive and emotional symptoms therefore they should no longer be categorized as Behavior Health. THEY SHOULD BE CALLED PHYSICAL MENTAL HEALTH. In SAMHSA’s organizational chart directly answering to Dr. Elinore Katz is the “Office of Behavioral Health Equity.” The title of this office needs to be improved to read “Office of Physical Mental Health Equity.” which will still enable equity for those with the most serious physical mental health conditions and also it will include those with the most serious mental health conditions that have a co-occurring substance use disorder. Only through strong Presidential leadership and strong congressional courage can this be done; but IT NEEDS TO BE DONE NOW for the holistic health of this country. Substance abuse should no longer be separate from mental health problems and vice a versa. In most cases substance abuse is secondary to untreated or improperly treated mental health problems. The statistics prove this when the data is provided appropriately and analyzed appropriately. The COVID-19 pandemic creates the opportune time to make these improvements and thus save pain, suffering, reduce deaths, and stop wasting inappropriately spent taxpayer dollars.

A significant amount of federal dollars goes to the National Council for Behavioral Health NCBH. They are a trade association for community mental health providers who were created by federal law with enactment of President John F. Kennedy’s Community Mental Health Act. The NCBH provides this history on their website: “On October 31, 1963, President John F. Kennedy signed into law the Community Mental Health Act (also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963), which drastically altered the delivery of mental health services and inspired a new era of optimism in mental health care. This law led to establishment of comprehensive community mental health centers throughout the country. It helped people with mental illnesses who were “warehoused” in hospitals and institutions move back into their communities. At the same time, more effective psychotropic medications and new approaches to psychotherapy made community-based care for people with mental illnesses a feasible solution. A growing body of evidence demonstrated that mental illnesses could be treated with

better outcomes and more cost-effectively in community settings than in traditional psychiatric hospitals. As services offered to people with mental illnesses became more diverse and comprehensive, it also became clear that helping people function at optimal levels required addition of treatment services for substance use disorders. This coordinated brand of service was labeled as “behavioral health care” with a goal of providing comprehensive services addressing mental health and substance use disorders in community-based behavioral health organizations. This comprehensive approach continues to be a more effective option than institutionalization in terms of access to quality health care and cost to the taxpayer and private payer. However, the organizations delivering this care have evolved far beyond the original community mental health centers. Community-based behavioral health care is delivered by a combination of government and county-operated organizations, as well as private nonprofit and for-profit organizations. These mental health and addiction services are funded by diverse sources, including Medicaid; Medicare; county, state and federal programs; private insurance and self-pays.” NCBH on their website define themselves as “the unifying voice of America’s health care organizations that deliver mental health and addictions treatment and services. Together with our 3,326 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council introduced Mental Health First Aid USA and more than 2 million Americans have been trained. A not-for-profit 501(c)(3) association, the National Council for Behavioral Health’s mission is to advance our members’ ability to deliver integrated health care.

Premier Behavioral Health Association

The National Council is a 501(c)(3) association that advocates for policies that ensure people who have mental health and substance abuse disorders have access to comprehensive, evidence-based health care services. We also offer state-of-the-science education and practice improvement consulting and resources to ensure services are efficient and effective. We achieve this through several ways:

- Mental Health First Aid USA – 2 million people have learned the skills to identify and respond to signs of mental health and substance abuse challenges.
- SAMHSA-HRSA Center for Integrated Health Solutions – Nationwide technical assistance on integrating primary and behavioral health care.
- Advocacy on Capitol Hill – Work towards policies that ensure people living with mental illness and addiction can access comprehensive health care services.
- Consulting – Leading state-of-the-science education and practice improvement to drive integrated care and ensure services are efficient and effective.
- National Council Conference – The best in leadership, organization development and excellence in mental health and addictions practice.
- National Council Webinars – Meet experts on key mental health and addictions topics online.
- Journal of Behavioral Health Services and Research – Examines the organization, financing, delivery and outcomes of behavioral health services.” See Appendix #2 for more information from the NCBH.

Congress looks to NCBH as a key source for information on developing public policies and funding for mental health and substance abuse disorder services. Yet, they are a public health organization representing and serving mental health and substance use disorder treatment providers who in the majority of cases service individuals on Medical Assistance, Medicare, and other government programs. They do not represent the majority of citizens living and working well, managing their mental health problems. Nor do they represent a majority of the private health care providers who treat people with physical mental health conditions. Their wording is a bit misleading and is not up to date either. They still refer to mental health conditions (definition includes substance use disorders) as “behavioral health issues.” They say they are committed to reducing the stigma placed on mental illness. Scientific research has proven mental health problems are physical medical conditions with cognitive and emotional symptoms and are very treatable especially in the early stages (just like many other physical medical conditions). Behavior issues are a symptom of a physical mental health condition. The words “behavioral health” should be buried. It is time to call these issues physical mental health conditions. WORDS MATTER. The way that a condition is described and defined affects the way people think about it. This gets to the core of ending discrimination, stigma, and false characterization of medical conditions. There is a lot of money going to NCBH. A portion of that money would be better spent on a loud consistent educational message to the whole population, from children to older adults, that mental health issues are physical mental health conditions, that can in many cases be prevented (like diabetes) and, furthermore, with early

detection and early treatment most people no longer will become addicted, suicidal, incarcerated, or dead. Some of these dollars could also be redirected to early screenings at a physician's office where individuals with early signs and symptoms of mental illnesses often first seek help for other conditions. And a physician or another professional who is legally able to write prescriptions should always see an individual as early as possible to determine if medications need to be prescribed. After all, these are physical medical mental health issues. Also, in order to be clear to the public, NCBH should always hold themselves out as the trade association of community mental health providers created under federal law to treat those receiving care through taxpayer funded programs.

USA Government Spending – SAMHSA- 2018 Budget Numbers (Dollars in Millions)

Mental Health:

Community MH Service Block Grant.....	\$ 416
Programs of Regional and National Significance.....	277
Suicide Prevention Programs (non-add)	60
Children's Mental Health Services.....	119
Projects for Assistance in Transition from Homelessness.....	65
Protection & Advocacy for Individuals with Mental Illness.....	36

TOTAL, Mental Health..... \$ 973

Substance Abuse:

Prevention (Programs of Regional & National Significance)	\$ 150
*Substance Abuse Prevention & Treatment Block Grant.....	1,855
*State Targeted Response to the opioid Crisis Grants.....	500
*Programs of Regional & National Significance.....	342

TOTAL, Substance Abuse (*treatment)\$2,847

TOTAL Public Awareness & Support (mental health & substance abuse).....\$ 12.....\$ 12

Highlighting Pennsylvania funding for your attention:

“The PA Department of Human Services (DHS) budget is a mixture of both state and federal funding. Each year the department is involved in the state budget process. Annual funding for the Department's programs and services are determined by June 30 of each year. Act 80 of 2012 established a Human Services Block Grant Program for the purpose of allocating funds to select county governments to provide locally identified county-based human services to meet the service needs of county residents. There are 67 counties in PA. This act originally allowed for 20 counties to participate, but as Act 153 of 2016 amended the Human Services Code removing the cap on the number of counties that may participate. The total now stands at 38 counties. The line items within the Block Grant contain a small but significant portion of the total funds allocated to counties for the delivery of human services. The funds within the Block Grant include:

*Mental Health Community Base Funded Services *Behavioral Health Services Initiative *Intellectual Disabilities Community Base Funded Services *Act 152 Drug and Alcohol Services * Homeless Assistance Program Funding *Human Services Development Funds. (Note: The Behavioral Health Choice Program is not included in the Block Grant Funding). Counties who have opted into the Human Services Block Grant are allowed to move funds between allocations to meet the needs of their county. Counties must submit County Human Services Plans to DHS for approval. Funds included in this plan are a small but significant portion of the total funds allocated to counties for the delivery of human services.

PA Behavioral Health Services:

Program Statement - The Department of Health and Human Services (DHHS) *sic* provide funding for drug and alcohol treatment services, as well as mental health treatment services, through the Behavior Health Services appropriation. This appropriation was created in response to ACT 35 of 1996, which revised eligibility criteria for General Assistance Medically Needy Only (GA-MNO) benefits under the Medical Assistance (MA) Program and let to approximately 18,800 individuals in need of drug and alcohol treatment services or mental health treatment services losing GA-MNO eligibility. The Behavior Health Services appropriation ensured that these non-MA eligible continued to receive necessary mental health and drug and alcohol treatment services.

Centers of Excellence – In Fiscal Year 2016-2017, 20 Centers of Excellence (COEs) for persons living with substance use disorder (SUD) were implemented in the commonwealth. This program funded the expansion of

narcotic treatment programs to include Suboxone treatment at facilities and increased the capacity to care for those seeking treatment for SUD, as well as increasing the quality of care. The Office of Mental Health & Substance Abuse Services worked with the Single County Authorities (SCAs handle SUDs prevention and treatment dollars- NOT mental health prevention and treatment dollars) to establish this initial phase using Behavior Health Services funding. The Governor's Executive Budget for Fiscal Year 2018-2019 included on-going funding to the initial 20 COEs as well as funding to cover medical costs for individuals not eligible under the Medical Assistance program.

Human Services Block Grant – In Fiscal Year 2012-2013, a Human Services Block Grant program was implemented to provide local governments with increased flexibility to address local needs. Under the program, funding for the following six programs was combined at the local level into a flexible Human Services Block Grant: Human Services Development Fund, Community Mental Health Services, Behavior Health Services, Intellectual Disability Community Based Services, Homeless Assistance Program, and Act 152 Drug and Alcohol Services. Participation in the Human Services Block Grant is on a voluntary basis. In Fiscal Year 2017-2018 six additional counties opted into the program, bringing the total number of Block Grant counties to 36.” (SCA Administrators & Staff and Mental Health/IDD Administrators and Staff are appointed by the county commissioners. Some counties contract with non-profits but most counties employ them directly. Local level county politics has kept many county commissioners from optimally appropriating block grant funds for co-occurring (MH & SUDs) treatment. This is the norm, not the exception. Prevention dollars are rarely allocated for targeted MH purposes, which scientific research has proven can significantly reduce self-medication with alcohol, drugs, and other addictive behaviors. SCA administrators are very protective of their funds, and have been for decades, even though they will agree with the scientific statement that “in 83% of SUDs cases a mental health problem precedes the SUDs by about 3 years.” Currently, it appears, there is one county blending funds for co-occurring treatment and prevention of MH problems – Montgomery County.) An Assisted Outpatient Law was enacted in PA two years ago and not one county has implemented it. The law allows (entrenched mental health organizations lobbied against enactment so to get it passed the language makes it voluntary) counties to opt into providing mandatory medication treatment for severely mentally ill individuals in an outpatient setting. CCAP reasons the counties do not have the money to implement it. Yet, this is a very humane public policy and will help save pain, suffering, incarcerations, domestic violence issues, etc. And it works in other states. This policy needs implemented in all counties asap to end the inhumanity. Also, on February 11, 2020 a letter sent to all commissioners throughout the country from Elinore R. McCance-Katz, M.D. Ph.D. Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services, SAMHSA clarified that Community Mental Health Services Block Grant funds can be used in the care and treatment of individuals with serious mental illness who have interactions with the criminal justice system including incarceration or who have a criminal case pending. The letter served to clarify that treatment during incarceration is an allowable use of the MHBG, provided that the treatment services as well as provider of such services meets the statutory requirements of the MHBG. Perhaps a standardized list to help busy County Commissioners and their Staff to know how to optimally help these people should be developed immediately. Have a group of experts from the federal, state, and local level, along with some family members develop a comprehensive list that is reviewed quarterly each year.

PA Department of Drug and Alcohol Programs Budget – “As of July 2012, the Department of Drug and Alcohol Programs (DDAP), formerly under the Department of Health, became a department. DDAP is a cabinet-level agency in the Government of Pennsylvania under Governor Tom Wolf. The objective of this department is to manage and distribute state and federal funds used to oversee alcohol and drug prevention, intervention and treatment services. DDAPs mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to **prevent and reduce drug, alcohol and gambling addiction and abuse**; and to promote recovery, thereby reducing the human and economic impact of the disease.

The Pennsylvania Department of Drug and Alcohol Programs provides 42 Alcoholics Anonymous sites spanning most counties. A desire to stop drinking is the only requirement to becoming a member. There are no dues or fees for A.A. membership; they are self-supporting through their own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution and neither endorses nor opposes any causes. Their main focus is for its members to stay sober and help other alcoholics to achieve sobriety as well. For more information and locations go to the link provided in references.

They also provide 44 Narcotics Anonymous sites to assist in drug addictions as well. For more information on locations and procedures follow the link provided in references. Both organizations utilize a 12-step program which has been proven successful to those trying to remedy their addictions. DDAP provides access to programs such as: the

prescription drug take back program, overdose awareness, and information on rehab centers. One of their main projects, is to spread the knowledge and availability of Naloxone, which is a medication that can reverse an overdose caused by an Opioid drug overdose. They have made progress on this front by enacting ACT 139, which gives first responders, friends, and families access to the opioid overdose reversal medicine, this way more lives can be saved by a quicker treatment response.

Within the United States, Pennsylvania snatched third place on the most use of heroin and is in seventh place for the most deaths due to heroin overdose. It may be that the state is not at the top of the list, but the state government is concerned that the deemed heroin epidemic is killing more and more people and consumes a large sum of government finances with regards of first responders and overdose calls. This kind of state problem requires immediate attention, since the heroin epidemic not only affects the users themselves, but also babies conceived by heroin-addicted mothers. To reduce the death toll, the Pennsylvania Department of Drug and Alcohol Programs, under the supervision of Governor Tom Wolf, arranged for emergency responders to provide naloxone to victims of opioid or heroin overdose. Naloxone is a medication which blocks of opioid receptors and rapidly reverses the effects of an opioid/heroin overdose. Naloxone can be acquired by friends or families of users and can be administered without prescription so that ordinary citizens can take immediate action to save a life. This declaration under ACT 139 also known as David's Law aims to decrease the death rates in Pennsylvania related to opioid/heroin overdose.

DDAP has a July 2015 to June 30, 2020 Fiscal Manual. For brevity purposes here is a link to the manual which purpose is to provide Single County Authority (SCA) fiscal personnel with a central source of information to assist in fiscal operations and outline necessary requirements as set forth by the Commonwealth of Pennsylvania. This Manual also includes overview sections describing funding sources, the budget process and invoicing instructions, as well as reporting and record keeping requirements. Because all aspects of the SCA's agreement with DDAP are not included in the Fiscal Manual, it is not intended to be an all-inclusive resource guide. Unless DDAP instructions are specific to providers of services or otherwise prohibit application to service providers, SCAs may choose to adapt certain parts of the Manual to the provider level in accordance with the SCA's operational requirements. The requirements, policies, procedures, and instructions in this Manual are official and are to be adhered to by the SCAs. If there are conflicts within this Manual shall be regarded as guidelines. Questions from SCAs regarding applicability of specific parts of this Manual may be directed to their respective Program Representative (Project Officer). Any additions or updates to the Fiscal Manual will be sent through Policy Bulletin or Management Directive to the SCA Administrator, as well as the fiscal contact assigned by the SCA and provided to DDAP. In addition, it may be necessary to issue temporary instructions, which will take precedence over material in this Manual. When this is done, the temporary instructions will clarify other documents, the SCA Grant Agreement generally takes precedence over the Prevention, Treatment, Fiscal and Operations Manuals issued by DDAP. However, certain exceptions to the order of precedence may occur. For instance, travel rates for lodging, as set forth by the Commonwealth's Management Directive 230.10, Rev. 1/21/09 would take precedence over the Commonwealth Travel and Subsistence Rates, Rev. 4/12, incorporated into the SCA Grant Agreement. Since no instruction system can anticipate every conceivable situation, the principles and procedures state the exception and include an expiration date."

<http://www.wc-hs.org/Regulations/2015-20%20DDAP%20Fiscal%20Manual%202.PDF>

The 2018/19 budget maintains the prior funding increase requested by Gov. Wolf for assistance to drug and alcohol programs, which provides grants to single county authorities across the state to implement programs to prevent and address substance abuse. Outside of the department, the budget includes \$4.5 million in new funding to provide home visiting services to approximately 800 families affected by substance use disorder. Inclusive of this budget, Gov. Wolf has secured more than \$100 million in new state funding to address the heroin and opioid epidemic over the past four years.

Here are just the State General Funds Committed to Heroin and Opioid Initiatives in the 2018-2019 enacted budget. Please realize that Alcohol and substance are not part of these numbers. In Millions.

Dept. of Drug and Alcohol Programs (SCAs)*.....	3,500
Dept. of Human Services (COEs, CBFC Home Visit).....	23,532
Dept. of Health (ABC-MAP Registry).....	3,077
Dept. of Corrections (MAT Pilot Program)*.....	1,500
Pennsylvania Commission on Crime & Delinquency.....	2,000
Office of Attorney General.....	1,758
TOTAL BUDGETED FUNDS.....	35,367

*Gov. Wolf request \$5 million in additional funding for the SCAs in 2015/16, the General Assembly split this amount

with 1.5 M to DOC for the medically-assisted treatment pilot program.

Source: *House Appropriations Committee (D) 717-783-1540* www.hacd.net *oHDAPPROPS@hacd.net*
2018/19 Budget In Depth: Budget Briefing July 10, 2018

Highlighting County funding for your attention:

From the County Commissioners Association of PA - FY 2018-2019 Budget Signed Into Law – Gov. Wolf signed HB 2121, the commonwealth appropriations bill for FY 2018-2019, into law on June 22, following the Senate’s approval by a 47-2 vote earlier that day and a 189-9 vote by the House two days earlier. The legislation spends about \$32.7 billion in state funds, representing an increase of about \$560 million over FY 2017- 2018 spending, less than the \$32.9 billion budget proposed by the Governor in February. Much of the increase in HB 2121 is directed to educational line items, with an additional \$100 million for basic education, and another \$70 million for school safety. In addition, half of a projected FY 2017-2018 surplus - some \$74.5 million - will go into the Rainy Day Fund, the first time money has been added since FY 2006-2007. For counties, the FY 2018-2019 budget represents largely flat funding in most lines that impact them, with some small increases for home and community-based long-term care services, autism services and the Medical Assistance Transportation Program. It also includes funding to serve 965 more individuals with intellectual disabilities currently on the waiting list, and to give 800 more families affected by opioids access to evidenced-based home visit services. House Bill 2121 contains appropriations to the Department of Corrections and the Board of Probation and Parole as a unified Department of Criminal Justice, pursuant to a memorandum of understanding signed by the agencies in October 2017. However, another proposal to merge the state’s Health and Human Services agencies was not included in the FY 2018-2019 budget. Highlights of the budget’s impact on counties follows. Comparisons are to funding levels available in FY 2017-2018. For analysis of more county line items, check CCAP’s commonwealth budget page at www.pacounties.org.

Human Services Block Grant. In November 2016, counties achieved the expansion of the Human Services Block Grant to any willing and capable county through Act 153, allowing participating counties to allocate a portion of certain human services funds across program areas and thereby increasing their ability to match available dollars to local needs. While HB 2121 does not include restoration of the 10 percent cut to these lines that occurred in FY 2012- 2013 (which has not been restored since), these lines, which impact funding for all 67 counties, are largely flat funded.

* * *

The appropriation for family centers includes a \$4.5 million initiative to provide home visiting services to approximately 800 families affected by substance abuse disorders. The Homeless Assistance Program is part of the Human Services Block Grant for those counties participating. It provides funding to provide temporary shelter to homeless individuals and rental assistance to those in danger of becoming homeless. HB 2121 provides level funding for this line at \$18.5 million. The Human Services Development Fund. HSDF, is another line incorporated into the Human Services Block Grant and is funded at \$13.46 million under HB 2121, the same level as in FY 2017- 2018. This funding allows counties to use dollars not only where they are most needed, but where they can best reduce costs to human services programs in the long run.

* * *

The FY 2018-2019 budget contains \$75 million in state funds for the Medical Assistance Transportation Program (MATP), which represents an increase of \$13.5 million, as well as a \$3 million in federal funds. Omnibus amendments to the Human Services Code in HB 1677 also require the Department of Human Services to request authority from the federal government to move MATP to a statewide or regional full-risk brokerage model; CCAP is seeking details about how such a transition would be implemented and the impacts to counties.

Mental Health - State funds for mental health base services increased by approximately \$15 million for FY 2018-2019, offset by a decrease in federal funding of approximately \$4 million... State funding for behavioral health services is flat at \$57 million... Substance Abuse Treatment and Prevention - The state match provided in FY 2018-2019 for federal block grant dollars is consistent with FY 2017-2018 levels and there is also a slight increase in federal Substance Abuse Prevention and Treatment Block Grant funding. Intermediate punishment funding is also flat funded at \$18.2 million. Continued funding for specialized projects including Naloxone for first responders and Vivitrol for county jails is anticipated, although details were not immediately available. Funding for the Centers of Excellence appears to be included in Behavioral Health Services Initiative line. In addition, the administration anticipates continuation of federal funds for opioid initiatives. Single County Authorities will continue to receive additional federal funding for (SUDs) treatment for the uninsured and underinsured over the next two federal fiscal years, through the federal Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Opioid State Targeted

Response. Funding levels for Act 152 services are contained in the outpatient Medical Assistance line item, but the specific allocations out of the line are not yet available...Judiciary Courts - The final FY 2018-2019 budget largely provides level funding to counties in this area, and continues to provide \$2 million in grants via the Pennsylvania Commission on Crime and Delinquency to establish or expand drug courts. Criminal Justice - Funding for adult probation services and intermediate punishment has been provided at the same levels as in FY 2017-2018. Juvenile Justice. For FY 2018-2019, juvenile probation services will be level funded.

More on county funding:

Building on several years' priority work, CCAP's Comprehensive Behavioral Health Task Force released its findings and recommendations in August 2016:

- Encourage counties to employ successful strategies to control the need for incarceration
- Expand training, education and awareness efforts to improve public perception and understanding
- Provide effective supports and services to reduce entry into the criminal justice system and to improve outcomes for re-entry
- Understand special populations and unique circumstances
- Address the needs of returning veterans
- Research larger policy issues and develop longer range policy strategies to assist county efforts

All of these goals will require the engagement of various communities, including lawmakers, local staff, citizens, judges, local partners and others to assure local buy-in and collaboration.

County Facts - Counties nationwide spend nearly \$100 billion annually on health care for inmates. Average annual cost of incarceration in a county jail for one inmate - \$40,000. Inmates experience behavioral health disorders about three times more frequently than the general population. Studies have shown that jails spend two to three times more money on inmates with mental illnesses that require intervention than on others in custody. More than a decade of declining state and federal financial support has severely strained the ability to maintain behavioral health services and treatment within the community. Other unique circumstances can compound the problem - such as juvenile offenders.

As many as 65 percent of all county jail inmates in Pennsylvania have a substance abuse disorder, 10 to 30 percent have a mental illness, and as many as 14 percent have a serious mental illness. Across the country, county jails house more individuals with mental illness than psychiatric hospitals. Untreated and unaddressed substance abuse and mental health needs are often the catalyst to entry into the criminal justice system - and the reason individuals continue to cycle back through the system. By treating the reasons behind criminal behavior, we can break the cycle of admissions and readmissions to county jails.

According to a survey by the National Association of Counties, reducing the number of people with mental illness in jails is of the highest priority for county jails.

Goal - Research larger policy issues and develop longer range policy strategies to assist county efforts. The task force discussed larger societal issues that may increase the potential for criminal behavior, or increase the risk of behavioral health issues, including poverty, support and funding for basic education and identification and treatment of learning differences, reduction of trauma and domestic violence, and the need to engage schools more effectively on the county level. These matters are related. However, they are outside the scope of the Task Force as identified through the CCAP member priority. Funding for state and federal human services programs has been on the decline for well over a decade, and the ability of counties to provide services to everyone who needs them is severely challenged. While Medicaid expansion is having some impact on improving access, there are few, if any options for prevention as a focus, particularly for families and children. Additional mandates keep coming, with counties expected to step into ever increasing roles to address family issues without any increase in resources or support.

Objective - Fully explore the benefits of prevention and the extent to which funding challenges have forced counties to focus on immediate needs rather than invest in prevention

- Consider the use, evidence based and promising prevention practices for models to consider whether Justice Reinvestment, II or other options create new opportunities to find dollars for prevention and treatment.
- County commissioners should become familiar with the PAYS survey and develop strategies to discuss incorporating the survey into local criminal justice planning strategies.

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PA Communities That Care CTC funding for your attention (School District Level) : CTCs focus on substance use and delinquency NOT mental health prevention and early intervention. Wikipedia writes: "Communities that Care is a

program of the *Center for Substance Abuse Prevention* (CSAP) in the office of the United States Government's *Substance Abuse and Mental Health Services Administration* (SAMHSA). CTC is a coalition-based prevention operating system that uses a public health approach to prevent youth problem behaviors such as violence, delinquency, school dropout and substance abuse. Using strategic consultation, training, and research-based tools, CTC is designed to help community stakeholders and decision makers understand and apply information about risk and protective factors, and programs that are proven to make a difference in promoting healthy youth development, in order to most effectively address the specific issues facing their community's youth.

Developed by Drs. *J. David Hawkins* and *Richard Catalano* at the University of Washington's *Social Development Research Group* (SDRG), CTC's principal strategy, the *Social Development Strategy* (right), focuses on strengthening protective factors that can buffer young people from problem behaviors and promote positive youth development.^[5]

CTC is grounded in rigorous research from social work, public health, psychology, education, medicine, criminology, and organizational development. It engages all community members who have a stake in healthy futures for young people and sets priorities for action based on community challenges and strengths. Clear, measurable outcomes are tracked over time to show progress and ensure accountability.

Public health understanding of risk and protective factors - The field of public health has developed a systematic methodology for understanding and effectively preventing health problems. Through rigorous research, the etiology of diseases has been documented, and the factors contributing to those diseases have been identified. Once these contributing factors are understood, careful study and application of approaches to amend those factors have demonstrated reductions in the disease burden. For example, heart disease has been one of the primary causes of death among American adults. Research shows, however, that adequate exercise, a healthy diet, and avoidance of smoking can help to prevent heart disease. These behaviors are considered protective factors, just as smoking, high blood pressure, and a family history of heart disease are considered risk factors for poor heart health.

Since the late 1970s, researchers in a variety of disciplines (for example, criminology, sociology, social work, psychology, community psychology, education) have been applying this public health approach to the study of the healthy development of young people. This work has created a field called prevention science, which identifies the factors that contribute to the healthy development of children and youth (protective factors) and the factors that impede that development (risk factors)."

Funding information is difficult to find but a 2004 study on CTC cost data for an entire 5-year intervention in discounted 2004 dollar shows an average of \$637,014 was spent in each of 12 communities over 5 years of the intervention, approximately \$127,403 per year. Total expenditures ranged from \$592,666 to \$714,067 across the 12 communities, but two thirds of CTC communities spent within 6% of the average cost. Just over one third of these funds went to program coordinators, another third to intervention programs, and approximately one quarter to training, technical assistance, and implementation monitoring. Other costs represented just under 5% of the total, but they grew steadily from 0% to 13% over the 5 years of the intervention as communities took increasingly greater responsibility for generating funding for CTC. *Prev Sci. Author manuscript; available in PMC 2013 Apr 1. Published in final edited form as: Prev Sci. 2012 Apr; 13(2): 150–161.doi: 10.1007/s11121-011-0259-9*

A Recent Penn State News article "Communities that Care prevention system helps to protect youth; study finds" was funded by the National Institute on Drug Abuse and they state that the study is the largest to-date to examine the effectiveness of Pennsylvania CTC coalitions. The study purports CTC school districts in PA show reduced substance use and delinquency <https://news.psu.edu/story/587912/2019/09/12/research/communities-care-prevention-system-helps-protect-youth-study-finds>. National Institute on Drug Addiction reports the Communities That Care program shows success in reducing substance use and behavioral issues in adolescents <https://www.drugabuse.gov/news-events/latest-science/communities-care-program-shows-success-in-reducing-substance-use-behavioral-issues-in-adolescents>

Studies such as these need to be analyzed for their funders, assumptions going into the study, and their subsequent outcomes. What would the results be if physical mental health prevention, early detection, and early interventions were part of School Districts' and Communities' prevention practices? There is no education on prevention, early detection, and early intervention for mental health conditions in the CTC program. This may be because of the lack of neuroscience knowledge that over the past 20 years shows mental health problems are physical medical conditions with cognitive and emotional symptoms. The money going into this program should be used in part for public education on prevention, early detection, and early intervention of mental health problems. Educating the student and parent on how

the brain works, how to keep it healthy and what to look for if a medical problem arises (early 1st & 2nd stage signs and symptoms of a mental health problem) will make the program more successful at helping students soar.

Commonwealth Prevention Alliance (CPA) funding for your attention:

Since 1976. Non-profit. Member-driven, grassroots organization-supports Certified Prevention Specialists in eliminating Substance Abuse and Risk Related Behaviors. Represented on: Drug & Alcohol Service Providers Board, on State Initiative Grant (SIG) Advisory Board, on Bureau of Drugs & Alcohol Programs Prevention Workgroup in 2004 (now DDAP). Members: SCAs, Higher Education, Prevention Coalitions (CTCs, Drug Free Communities, Tobacco Control, Overdose Prevention, etc.) Here is CPA's history as provided on their webpage:

"CPA is a member-driven, grassroots organization whose mission is to support prevention professionals in eliminating substance abuse. We are a non-profit, 501(c)3 organization. Since 1976, CPA has kept the needs and concerns of the prevention professional and the field of substance abuse prevention as its key focus, and today it continues to be the foremost voice for prevention in Pennsylvania.

History of CPA

1976

CPA is founded by a small group of dedicated and progressive thinking Prevention Specialists. 8 initial members

1977-1980

Organizational structure was developed by creating by-laws, a vision statement and a process for electing a board of directors.

1980

Update Newsletter is created to share information and encourage attendance at professional trainings and support members.

1982-1983

CPA Board begins to have regular monthly meetings in State College at Southridge Motor Inn.

1984

CPA adopted its logo and began co-sponsorship of the Wellness Institute with Wyoming Seminary.

1988

First Prevention Orientation Workshop presented at the Spring Office of Drug and Alcohol (ODAP) Conference.

1988-1989

CPA and Prevention Directors task force worked with consultants from PA Addictions Board to develop Prevention Specialist certification.

1989

Grandfathering process results in 233 Certified Prevention Specialists.

1989

CPA, represented on Drug and Alcohol Services Providers of PA (DASPOP) Board becomes more proactive legislatively.

1990

A CPA Field Issues Forum focused on informing the newly formed PA Student Assistance Program (PASAP) about prevention services.

1990

CPA assists PASAP development by providing CPA's by-laws and organizational structure.

1991

CPA holds its first independent conference in Lancaster, with support from the Governor's Drug Policy Council. 242 members

1991-2000

CPA membership increases. Annual conference coordinated and regional meetings and trainings are scheduled.

1998

CPA leads the campaign to generate over 8,000 letters to Senators Arlen Specter and Rick Santorum, which resulted in re-instatement of block grant funding.

1999

Harrisburg Legislative testimony regarding the need to reduce the use of tobacco products. Little funding was designated for prevention.

2002

CPA president joins State Initiative Grant (SIG) Advisory Board. CPA Web site is established to promote communication with the field. 271 members

2004

CPA is represented on Bureau of Drug & Alcohol Programs (BDAP) Prevention Workgroup.

2005

CPA president joins Performance Based Prevention System (PBPS) Workgroup. 265 members

2005-2006

CPA Board creates a Strategic Plan that includes steps to initiate and fund full time staff. CPA Board begins to meet at (smoke free) Hoss's in State College.

2006

CPA celebrates its 30th anniversary at the Annual Prevention Conference. CPA president joins Strategic Prevention Framework (SPF SIG) Advisory Board. 235 members

2006-2007

CPA Board explores avenues for creating full time staff positions with the creation of budgets and job descriptions at strategic planning session.

2008

CPA begins development of a legislative initiative to bring the importance of prevention work to State lawmakers. 216 members

2009-2010

CPA begins the process of updating and revamping the CPA website. 175 members

2009

Revised Board of Directors to include State-wide Representatives as well as Regional Representatives.

2010

A legislative advocacy breakfast was held at our state Capitol. 192 members

2013

CPA Annual Conference enters the social media age with plenary sessions livestreamed and questions were tweeted. 153 members

2014

CPA membership vote to change bylaws to include "preventing risk-related behaviors". CPA awarded a PCCD SAEDR grant to develop consistent statewide prevention messages regarding opiate abuse

2016

CPA Celebrated our 40th Birthday with a dinner at our annual conference. Our conference was the largest our 26 years of offering a conference.

Funding & other supports for CPA: The Department of Drug and Alcohol Programs (DDAP) is responsible for the development, oversight, and management of substance misuse prevention and intervention services throughout Pennsylvania. DDAP strives to increase the implementation of prevention programs, age-appropriate strategies, policies and practices that are based on research proving effectiveness and/or best practices within the substance abuse field. The agency's major focus is to reduce risk factors associated with substance use and promote the development of healthy lifestyles that positively impact individuals across the lifespan, in their communities, families, and schools. They provide a Prevention Staff Handbook as a tool for outlining information, resources, documents, tasks, related to Prevention Specialists and others who can customize the handbook to make their own handbook.

CPA receives a lot of money from federal and state dollars (SAMHSA, DDAP and the Pennsylvania Commission on Crime and Delinquency). Some Single County Authorities help fund them and many administrators of SCAs and their staff are members and attend the CPA annual conference. Many CTC people are members of CPA and work in tandem with CPA. CPA just hired their first Executive Director. Funds going to this organization need to be redirected/designated for public education of prevention, early detection, and early treatment of mental health problems at the school and community level immediately. The Prevention Specialists should not be doing the training but should be receiving the education/training. The AMWA could provide this training as it has been doing this kind of education in schools and communities for years, for students and adults, on brain health, detection of an early mental

health concerns, and where to go for prompt appropriate early treatment. Note: Early detection is NOT waiting 2 weeks after symptoms show up before seeking treatment which is what is currently recommended by many organizations. Early detection is seeing a physician, Certified Registered Nurse Practitioner, or physician assistant at first signs and/or symptoms.

Rapid Responses Needed

New tax dollars are NOT needed

- A. Enforcement of the 2008 United States Mental Health Parity and Addiction Equity Act (MHPAEA or Parity Law) must happen now. State Insurance Department must immediately do market conduct studies to determine what insurers are breaking the law and those who are should be fined. The 2008 law requires all insurers to cover mental health and substance use disorder care on par with physical health coverage provided in their policies. Yet, today mental health parity is not a reality. Insurers are not following the letter of the law. Many Americans are denied care when they need it the most. This is unconscionable.
- B. Immediate initiation of a properly funded sustaining highly focused public education campaign for prevention, early detection, and early intervention of mental health problems called “Prevention, Early Detection, and Early Intervention of Physical Mental Health Challenges” need to occur. No one should be directed to wait 2 weeks after symptoms arise to seek medical care. We do need to help our extremely sick: but not educating for prevention and early intervention of physical mental health conditions will continue to keep our country in poor health and throw money to the wind.
- C. Restructure government departments at the federal, local, and state levels to blend Mental Health and Substance Abuse Prevention programming, treatment. Public policies need to change immediately to responsibly address the social problems associated with mental illnesses: addiction, incarceration, suicide, violence, deaths, etc. If this is done properly, there will be tremendous savings of taxpayer dollars. For instance SAMHSA should have the CENTER FOR MENTAL ILLNESS AND SUBSTANCE ABUSE PREVENTION, State organizations should be called Physical Mental Health Departments and/or Bureaus (name includes SUDS), County departments should be blended to share Mental Health and Substance Abuse dollars and renamed to be the County Physical Mental Health Department (name includes SUDS).
- D. Renaming organizations using “Behavioral Health” to Physical Mental Health” is needed to end stigma. The words “behavioral health” should be buried. Mental health problems are physical medical conditions with cognitive and emotional symptoms. The undesirable behaviors are symptoms of physical mental health problems, not something that sufferers can simply choose to stop.
- E. Appropriations for the National Council for Behavioral Health should be adjusted so a portion of that money is better spent on a loud sustaining educational message to the whole population, from children to older adults, that mental health issues are physical mental health conditions that can be prevented, in many cases, and with early detection and early treatment most people will get well rather quickly (just like people with diabetes). Some of these dollars could also be redirected to early screenings at a physician’s office where individuals with early signs and symptoms of mental illnesses often first seek help for other conditions. A physician or another professional who is legally able to write prescriptions should always see an individual as early as possible to determine if medications need to be prescribed. Therapists are secondary to a physician’s care when it comes to physical medical conditions.
- F. The National Council for Behavioral Health NCBH should always hold themselves out as the trade association of mental health providers created under federal law to treat those receiving care through taxpayer funded programs.
- G. A reasonable amount of dollars currently going to the PA Commission on Crime and Delinquency PCCD for Prevention of Substance Abuse and Law Enforcement Issues need to be immediately redirected to public education for prevention, early detection, and early intervention of mental health problems. This is only reasonable and wise public policy knowing that mental health problems precede a substance abuse problem in most cases by about three years.

- H. County Department names need to be updated. For instance, in Pennsylvania the Mental Health & Intellectually Developmentally Delayed (MH/IDD) County departments should be separated immediately. The Single County Authority name at the county level and State level should be removed. Mental Health and Substance Abuse departments should be blended and named County Physical Mental Health Department (name includes SUDS). Pairing Mental Health with SUDs is recommended since co-occurring illness has proven to be the expectation rather than the exception.
- I. Federal block grant dollars must have specific directions for a large portion to be directly spent on public education campaigns for prevention, early detection, and early intervention of physical mental health problems. Because of the politics of local and state governments, this will take the pressure off of local and state elected/appointed officials to continue entrenched ineffective services and treatments that some of their voters may want to keep.
- J. A standardized list for busy County Commissioners and their Staff must be developed so everyone knows how best to provide programming for people who have physical mental health concerns (definition includes SUDs) Have a group of experts from the federal, state, and local level, along with some family members develop the comprehensive list that is reviewed quarterly each year.
- K. All counties in PA must immediately implement the PA Assisted Outpatient Law. The law allows counties to opt into providing mandatory medication treatment for severely mental ill individuals in an outpatient setting.
- L. A portion of the dollars from the County Commissioners Association PA (CCAP) that helps fund PA Association of County Drug and Alcohol Administrators (PACDAA-represents SCAs) and Commonwealth Prevention Alliance's (CPAs) annual conference (400 people at State College, CPAs, PA-SCA administrators, CTC people, PCCD people, Prevention (University) Researchers for Substance Abuse attend) should be spent on mental health prevention/early intervention public education and be implemented as soon as possible.
- M. School Districts need to provide education programs for prevention and recognition of the early signs and symptoms of physical mental health problems. Educating both the student and the faculty and staff should occur for best results. Having trauma informed care programming as well, provides a comprehensive approach to wellness.
- N. Communication with School Districts in PA must make it clear that School Safety Dollars are permitted to be used for education on prevention, early detection, and early intervention of mental health problems
- O. The SAP trade association and all School SAP advisers need up to date training to reflect the reality that mental health problems are physical medical conditions that precede in 83% of cases a substance abuse disorders. Knowing the earliest signs and symptoms of a mental health problem is essential for them to be optimally effective for all students needing their services. Trauma informed care training is not enough.
- P. PA Communities That Care CTC dollars should be used in part for public education on prevention, early detection and early intervention of mental health problems. CTC people should be educated on how the brain works, how to keep it healthy and what to look for if a medical problem arises will make the program more successful at helping students soar.
- Q. A significant amount of Federal, State, and Local funds going to the Commonwealth Prevention Alliance CPA need to be redirected/designated for public education of prevention, early detection, and early treatment of mental health problems at the school and community level immediately. Also, CPAs hold themselves out as Prevention Specialists without the important explanation that they are certified as Prevention Specialists in substance misuse and risk factors. They are not trained in preventing physical mental health conditions. Mental health prevention and early detection/intervention training needs to be provided by those who are knowledgeable and experienced to effectively provide this education in the schools and communities.

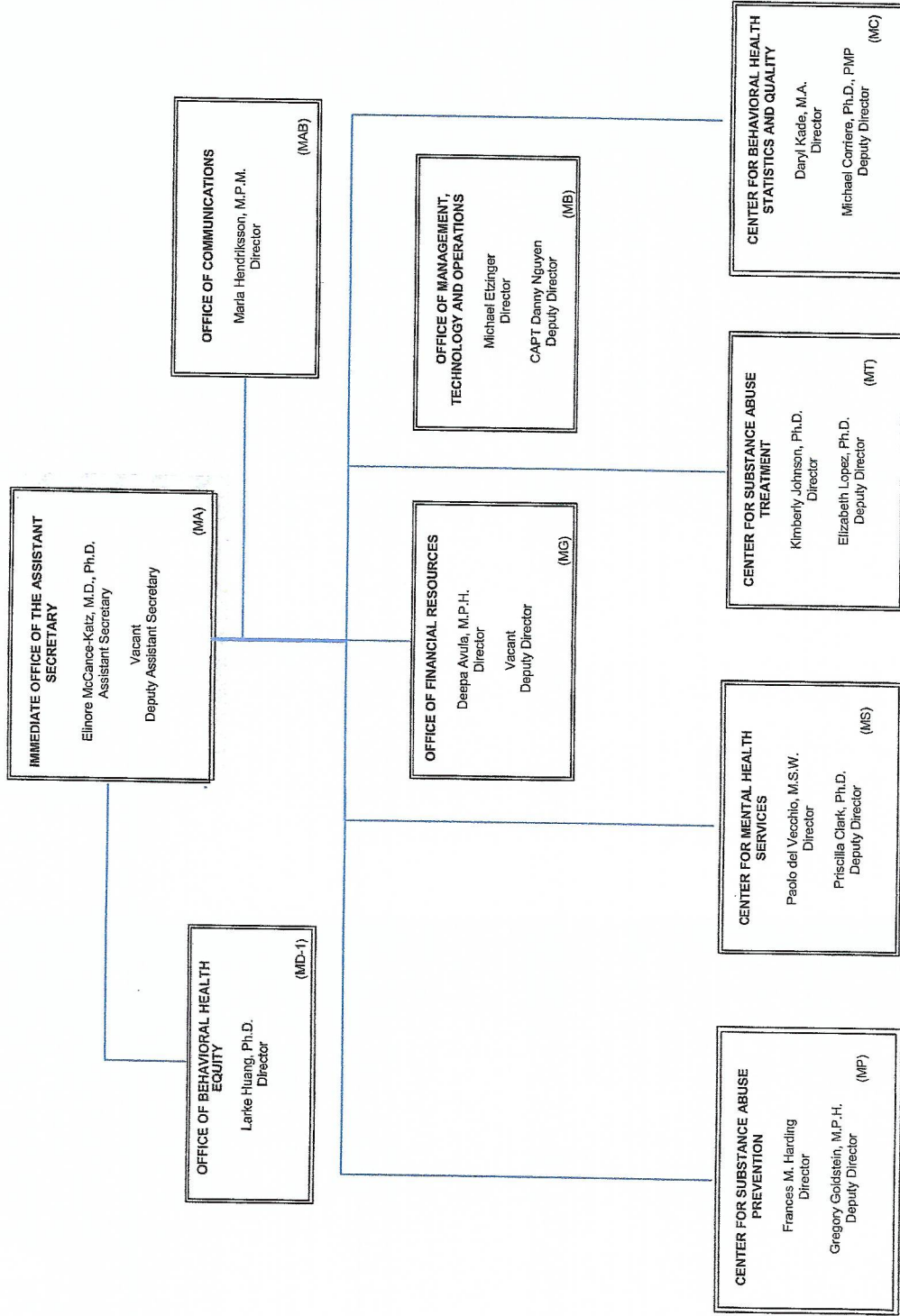
There are dollars currently available that need to be redirected to benefit the health and welfare of the people. This should be done immediately - ending spending on programs that made sense decades ago, but which advances in understanding of the science of mental illness indicate will be better spent on prevention, early detection, and early

intervention of mental health problems. Strong, courageous leadership at all levels of government is needed to do this. It is poor public policy to be appropriating funds to a broken mental health system especially when an epidemic is predicted. We have seen huge improvements in many systems throughout our country because of immediate policy changes due to COVID-19. Recovering from the pandemic creates the opportunity to re-apportion limited financial resources to improve the health, safety, and wellbeing of all Americans. The time is now, and it is ripe to do so.

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APPENDIX I

Organizational Structure: Substance Abuse and Mental Health Services Administration (SAMHSA)



FY 2018 MENTAL HEALTH AND SUBSTANCE USE APPROPRIATIONS

A robust mental health and addiction care system is essential to helping all Americans lead healthy, productive and independent lives. Federal investments in the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH) and other federal agencies support desperately needed mental health and substance use prevention, treatment and recovery services nationwide and foster new research and clinical innovations. In light of the nation's opioid crisis and huge treatment gaps for individuals with mental health and substance use disorders, we call on Congress and the Trump administration to expand funding for behavioral health prevention, treatment and recovery services.

WHY DO WE NEED INCREASED INVESTMENTS IN SUBSTANCE USE AND MENTAL HEALTH PROGRAMS AND RESEARCH?

Cuts in funding for behavioral health programs in FY 2018 would jeopardize the health care services that play a crucial role in both keeping Americans healthy and reducing the spillover costs of untreated mental health and substance use conditions. The President's proposed FY 2018 budget and subsequent proposal from the House of Representatives funds increased defense spending, in part, by making major cuts to non-defense discretionary spending, including federally-funded health care and social service programs. The House's proposed budget would slash non-defense discretionary spending by 17 percent below 2010 funding levels — and \$1.3 trillion below the Budget Control Act caps by 2027 — making it nearly impossible for health care professionals to provide for the critical needs of adults and children with mental illness and substance use disorders. Increases in defense spending should not come at the expense of non-defense programs. Our organizations support maintaining equity between any proposed cuts to non-defense and defense spending.

Among the many important programs that fund mental health and addiction services, the National Council and Hill Day Partners urge lawmakers to support funding of the following:

Comprehensive Addiction and Recovery Act (CARA) (S. 524/H.R. 953)

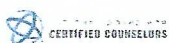
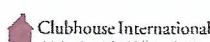
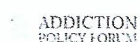
Opioid addiction destroys lives, disrupts families and destabilizes communities. In 2016, Congress passed the Comprehensive Addiction and Recovery Act (S. 524) – a landmark law that authorizes \$181 million for greater federal coordination of addiction resources and support in six key areas: prevention, treatment, recovery, law enforcement, criminal justice reform and overdose reversal. In 2017, CARA's programs received \$153 million in funding, falling \$28 million short of full funding. The House Appropriations Committee proposed funding CARA at \$179.75 million, again

REQUEST

Support funding for:

- 👉 Comprehensive Addiction and Recovery Act (CARA)
- 👉 The 21st Century Cures Act
- 👉 SAMHSA: Primary Care-Behavioral Health Integration and Technical Assistance
- 👉 SAMHSA: Mental Health First Aid
- 👉 SAMHSA: Healthy Transitions
- 👉 SAMHSA: Practice Improvement and Training
- 👉 SAMHSA: Substance Abuse Prevention and Treatment Block Grant
- 👉 SAMHSA: Community Mental Health Services Block Grant
- 👉 NIH: Mental Health and Substance Use Research
- 👉 HHS Administration for Families and Children: Social Services Block Grant
- 👉 HUD: Supportive Housing to Promote Recovery and Integration

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falling short of fully funding CARA's comprehensive strategy for addressing the nation's addiction crisis. The National Council and Hill Day Partners strongly support the full funding of prevention, treatment and recovery activities envisioned in CARA.

- ◆ **Request for FY 2018:** Fully fund the prevention, treatment and recovery initiatives in the Comprehensive Addiction and Recovery Act.

The 21st Century Cures Act (Including State Targeted Response Grants and Other Grant Funding)

Recognizing the urgency of the opioid crisis, Congress authorized additional support to states by adding a \$1 billion fund to the 21st Century Cures Act in December 2016. The fund, known as the State Targeted Response to the Opioid Crisis Grants or "Opioid STR," aims to address the opioid crisis by increasing access to treatment (particularly medication-assisted treatment), reducing unmet treatment need and reducing opioid overdose-related deaths through provision of prevention, treatment and recovery activities for opioid use disorder. In FY 2017, this program was fully funded at \$500 million. The 21st Century Cures Act also authorized a number of other grant-funded mental health and addiction prevention, treatment and recovery activities.

- ◆ **Request for FY 2018:** Fully fund the 21st Century Cures Act grants to improve access to medication-assisted treatment and other mental health and addiction services and supports.

SAMHSA: Primary and Behavioral Health Care Integration (PBHCI) and Technical Assistance (TA)

The PBHCI program supports community behavioral health and primary care organizations in partnering to provide essential primary care services to adults with serious mental illnesses. Because of this program, more than 87,000 people with serious mental health and addiction disorders have been screened and treated for diabetes, heart disease and other common and deadly illnesses at 213 grantee sites in an effort to stem the alarming early death rate from these health conditions in this population. Essential to the success of PBHCI is the technical assistance offered by the Center for Integrated Health Solutions (CIHS), funded by SAMHSA as "Primary and Behavioral Health Care Integration TA." For FY 2018, the President's budget proposes the elimination of PBHCI and PBHCI-TA. However, the House and Senate's proposed budgets would keep these vital programs intact. We thank House and Senate appropriators for their support of this important program.

- ◆ **PBHCI request for FY 2018:** \$50 million (level funding to FY 2017)
- ◆ **PBHCI-TA request for FY 2018:** \$2 million (level funding to FY 2017)

SAMHSA: Mental Health First Aid

Mental Health First Aid is a public education program that helps participants identify, understand, and respond to signs of mental illness and substance abuse. The course teaches a five-step action plan to reach out to a person in crisis and connect them with help. Mental Health First Aid funding appropriated each of the last four years has been used to support training activities for individuals who work with youth, an important audience and one that should be expanded in future years' appropriations. For FY 2018, the President's budget proposes elimination of this important education program. However, the House and Senate's proposed FY 2018 appropriations bills would protect Mental Health First Aid. Additionally, the Senate bill would extend funding to key audiences, such as law enforcement officers and first responders. We thank members of the House and Senate for their support of this important program.

- ◆ **Mental Health First Aid request for FY 2018:** \$15 million (level funding to FY 2017)

SAMHSA: Healthy Transitions

Healthy Transitions connects young adults between ages 16 and 25 who are at the highest risk of disconnection from school and employment because of mental health or substance use conditions to the evidence-based services and supports they need to bend this trajectory. In FY 2016,

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ADDICTION
POLICY FORUM



Clubhouse International



fredla

Hazelden Betty Ford

internationalbipolarfoundation

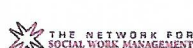
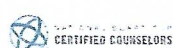
LEGAL
ACTION
CENTER

MIHAZ

NAADAC

NAMI

NASW



Healthy Transitions grantees made substantial improvements in the employment and educational functioning for 32 percent of the people served, improved housing stability for 41 percent and improved social connectedness for 13 percent – remarkable outcomes for a socially and medically complex population. Continued support for Healthy Transitions will build on this success and help keep more of America's most at-risk youth engaged in community life, and further promote the use of evidence-based practices in our nation's health and social services. Congress funded Healthy Transitions at \$19.9 million in FY's 2016 and 2017, and similar levels of funding in 2018 would continue the success of the program.

◆ **Healthy Transitions request for FY 2018: \$19.9 million** (level funding to FY 2017)

SAMHSA: Practice Improvement and Training

The Practice Improvement and Training Grants research and disseminate effective health care practices for transitioning individuals with serious mental health conditions from an expectation of lifelong disability toward productive employment and participation in community life. In particular, these grants seek to reduce the provision of medically unnecessary high-cost, long-term services and supports and focus instead on promoting independent living and competitive employment, with health care services and supports provided only as required to achieve these goals. As America seeks to bend the health care cost curve, dissemination of effective practices for improving outcomes for high-cost populations is crucial. Congress funded the Practice Improvement and Training Grants at \$7.8 million in FYs 2016 and 2017, and similar levels of funding in 2018 would further promote the goals of the program.

◆ **Practice Improvement and Training request for FY 2018: \$7.8 million** (level funding to FY 2017)

SAMHSA: Substance Abuse Prevention and Treatment (SAPT) Block Grant

The SAPT Block Grant remains the foundation of the publicly supported substance use prevention, treatment, and recovery systems. Stronger federal support through the SAPT Block Grant is critically important given that the block grant has lost 29 percent of its purchasing power over the last 10 years by not keeping up with health care inflation. The SAPT Block Grant includes a set-aside amount reserved specifically for prevention services, which makes up 65 percent of primary prevention funding in the states and territories. SAPT Block Grant funding is essential to effectively preventing youth alcohol and drug use, treating addiction and providing recovery supports to help people stay well over their lifetime. Congress funded the SAPT Block Grant at \$1.858 billion in FY 2017 (level funding from FY 2016). The House and Senate Appropriations Committees approved level funding for FY 2018.

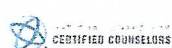
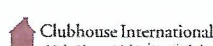
◆ **SAPT Block Grant request for FY 2018: \$1.858 billion** (level funding to FY 2017)

SAMHSA: Community Mental Health Services Block Grant

Services funded by the Block Grant include supported employment, supported housing, rehabilitation, crisis stabilization, case management, family-run programs, peer specialist and consumer-directed care, wrap-around services for children and families, jail diversion programs and services for special populations like people who are homeless, live in rural and frontier areas and military families. The majority of these services are currently not broadly covered under private and public insurance. The Block Grant also includes a 10 percent set-aside to focus on evidence-based practices for early intervention in psychosis, an increase from 5 percent in previous years. For FY 2017, Congress boosted funding for the Mental Health Block Grant by nearly \$30 million, to \$562.6 million. The Senate Appropriations Committee approved level funding for FY 2018. Unfortunately, the House Labor-HHS Appropriations budget bill proposes cutting the block grant by \$141 million. We urge Congress to follow the work of the Senate and maintain Mental Health Block Grant funding.

◆ **Mental Health Block Grant request for FY 2018: \$562.6 million** (level funding to FY 2017)

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NIH: Mental Health and Substance Use Research

Scientific advances have led to astounding discoveries about the nature of the brain and the roots of mental health and substance use disorders. Continued investments in basic scientific and applied research will aid in developing rapid, effective treatments for behavioral health disorders and facilitate early identification and intervention. The National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute of Mental Health (NIMH) have the research tools they need, but NIH must have sufficient funding to realize this ambitious vision of finding cures to these disabling illnesses. In FY 2017, Congress boosted NIH funding to \$34 billion, including increases for NIDA (\$32 million increase) and NIMH (\$80 million increase). Unfortunately, the President's FY 2018 budget proposes cuts for NIAAA (a \$105 million cut), NIDA (a \$210 million cut) and NIMH (a \$301 million cut). The FY 2018 House Labor-HHS Appropriations bill boosts overall NIH funding by \$1.1 billion, or \$35.2 billion. The Senate Appropriations Committee approved a \$2 billion increase for NIH funding in FY 2018. We urge Congress to support a 5 percent increase for the NIH – equal to the cost of biomedical research inflation – to ensure that NIH-funded research can continue to improve our nation's health.

- ◆ **Overall NIH request for FY 2018:** \$36.2 billion (\$2 billion or 5 percent above FY 2017)
- ◆ **President's NIMH request for FY 2018:** \$1.324 billion
- ◆ **President's NIDA request for FY 2018:** \$887 million
- ◆ **President's NIAAA request for FY 2018:** \$362 million

HHS Administration for Families and Children (AFC): Social Services Block Grant (SSBG)

Addiction and mental illness impact the entire family. Often, when parents are unable to care for their children due to an active addiction or serious mental illness, child welfare services are required. The Social Services Block Grant is a flexible funding source through which states fund efforts to support foster care, address family poverty and prevent child abuse and neglect. Both the President's budget request and the House's appropriation bill would end this critical source of support for families. Senate appropriators restored level funding to the program in their bill. We urge Congress to adopt the Senate's proposed funding level in FY 2018.

- ◆ **SSBG request for FY 2018:** \$1.7 billion (level funding to FY 2017)

HUD: Supportive Housing to Promote Recovery and Integration

Access to safe, affordable housing and supportive services is vital for recovery from addiction and mental illness. Department of Housing and Urban Development (HUD) programs such as the Section 811 Project-Based Rental Assistance (PRA) Demonstration and the McKinney-Vento permanent supportive housing programs are proven, effective models that promote recovery and cost savings. For FY 2018, President Trump proposed \$121 million for the Section 811 PRA program, a \$25 million reduction and an amount insufficient to cover the costs to renew project-based operating subsidies for existing 811 housing units. This cut in funding is restored in the House and Senate Transportation-HUD Appropriations bills for FY 2018 (H.R. 3353 & S. 1655). In addition, H.R. 3353 proposes \$30 million in new funding for 811 "mainstream" housing vouchers for FY 2018. For McKinney-Vento Homeless Assistance Grants funding, the President is proposing a \$133 cut for FY 2018, an amount insufficient to renew existing permanent supportive housing units under the program. By contrast, S. 1655 proposes a \$73 million increase for the program. We urge Congress to support new investments in permanent supportive housing (PSH) for people with disabilities through the 811 and McKinney-Vento programs.

- ◆ **Section 811 "Mainstream" vouchers:** \$150 million, with \$30 million for new 811 vouchers
- ◆ **Homeless Assistance Grants request for FY 2018:** \$2.456 billion, with \$73 million to fund new PSH units to end chronic homelessness

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