THIS CONTAINS 3 files on SAMHSA Mental Health Block Grant

1. Summary of problems with SAMHSA Mental Health Block Grant (MHBG) process (prepared 2013)

2. Comments to SAMHSA identifying problems with 2015-1016 proposed Mental Health Block Grant (MHBG) application

3. Comments on problems with 2013 SAMHSA final Mental Health Block Grant application

**How SAMHSA Mental Health Block Grant Guidance and Application Form Encourages States to Not Use Block Grants for the most Seriously ill**
**Draft (2/3/13)- NOT FOR DISTRIBUTION**

## *SUMMARY*

*CAUTION: The following has not yet been checked against Federal legislation to see if any of the problematic SAMHSA activities are related to federal law or guidance from Congress.*

**Background:** The authorizing legislation and implementing regulations governing SAMHSA's Community Mental Health Services Block Grant (MHBG) identifies targeted or priority populations to be served with MHBG funds ($459 million[1]) as adults with a *serious mental illness* and children with a serious emotional disturbance.[2]

**Problem:** SAMHSA's block-grant application process has successfully driven state block grant expenditures away from people with serious mental illness[3] SAMHSA block-grant guidance:

- Directs funds to "mental health promotion" (mission-creep) rather than treating serious mental illness. [4]
- Directs funds to "mental illness prevention[5]" No one knows how to prevent serious mental illness.[6]
- Directs funds to the "Recovery Model" which prevents treatment of seriously mentally ill until after they become 'danger to self or others.[7]
- Directs funds to peer support, which a) prevents treatment of seriously mentally ill until after they become 'danger to self or others'; and b) replaces professionally trained and licensed professionals with individuals who have experience mental illness.[8]
- Ignores and specifically contradicts Congressional direction on how funds are to be used
- Discourages helping those who refuse treatment.

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[1] http://www.thenationalcouncil.org/galleries/policy-file/Making%20Sense%20of%20the%20Presidents%202013%20Budget%202-16-11.pdf

[2] Section 1912 of Title XIX, Part B, Subpart I of the PHS Act (42 USC §300x-2)

[3] According to SAMHSA, "Information gathered from the FY 2011 block grant Addendum and the FY 2012/2013 Block Grant Application indicates that almost all states are using Block Grant funds to purchase services in all categories identified in SAMHSA's Description of a Modern Addictions and Mental Health Service System." See page 33 at http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf. SAMHSA's "Description of a Modern Addictions and Mental Health Service System is at http://prevention.mt.gov/strategicprevention/nov082011meeting/GoodandModernAddictionsandMentalHealthServiceSystem.pdf and includes numerous references to the 'recovery' and 'prevention' programs Mental Illness Policy Org has previously identified as neither facilitation recovery or prevention.

[4] 100% of the population can have their mental health improved. Only 5-9% have serious mental illness. SAMHSA focuses it's efforts on the former, not the later.

[5] In describing their budget, SAMHSA wrote, "SAMHSA's Budget represents a commitment to prevention of substance abuse and mental illness as priority # 1." http://www.samhsa.gov/Budget/FY2012/LeadingChange2012.aspx

[6] In fact, in recognition of the fact that we don't know how to prevent mental illness, SAMHSA's Evidence Based Practices do not include any guidance on how to prevent mental illness http://www.nrepp.samhsa.gov/. Further, SAMHSA acknowledges (page 49 of Block Grant App., that *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities by the Institute of Medicine* articulates the current scientific understanding of the prevention of mental and substance use disorders. *That report does not identify any ways to prevent schizophrenia or bipolar (Available at http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx )*

[7] Congress directed SAMHSA to spend money on "Recovery". But instead of using the commonly understood meaning of 'recovery' (becoming free of an illness), SAMHSA redefined it as "process of change" that is "self-directed'. Because many people with the most serious mental illnesses are incapable of self-directing their care, they must necessarily become 'danger to self or others' before they can be treated.

[8] We have been looking for, but have not yet found more than a single study purporting that peer support helps people with bipolar or schizophrenia ("serious mental illness") achieve reduced arrest, incarceration, hospitalization, homelessness, etc. The studies we have found measure 'hopefulness' and 'empowerment' which are important, but perhaps not the most important. No studies compare Peer Support with other interventions, such as hospitalization, treatment with medication, Assisted Outpatient Treatment, or treatment by educated and licensed social workers, psychologists, psychiatrists, etc.

- Discourages collecting metrics on the most important outcomes (reduced hospitalization, violence, incarceration, homelessness) and instead focuses on, for example, feelings of 'hopefulness' and 'empowerment'.

**Block Grant Solutions:**

- Require X% of block grant funds to be spent on seriously mentally ill as defined by NIMH
- Require NIMH rather than SAMHSA to determine which programs for people with serious mental illness are proven to reduce hospitalization, violence, incarceration, and homelessness (NREEP)
- Add Assisted Outpatient Treatment to the list of services that may be funded with block grants

**Other SAMHSA-related Solutions**

We have previously suggested saving money and improving care for persons with mental illness by:

- Eliminating SAMHSA and moving any useful programs elsewhere;
- Replacing the SAMHSA administrator with someone who will focus on serious mental illness.
- Eliminating Technical Assistance Grants, and Consumer Network Grants (or at least limit to those who recognize mental illness exists and won't use funds to lobby against treatment)
- Eliminating or reforming SAMHSA's Protection and Advocacy for Individuals with Mental Illness (PAIMI, formerly P&A) Program so funds are not used to prevent people with mental illness from receiving care.

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To: SAMHSA (*blockgrants@samhsa.hhs.gov*)
From: DJ Jaffe
Date: 2/25/2015
Re: Comment on SAMHSA's draft application for 2016-2017 Mental Health Block Grant funds.[1]

*Please confirm receipt to office@mentalillnesspolicy.org*

**Summary:** Mental health block grants (MHBG) are legislatively limited to "adults with a serious mental illness" or children with "serious emotional disturbance." Those terms were narrowly and precisely defined in a process established by Congress.[2] SAMHSA's proposed application contains provisions to divert funds from those populations that therefore must be changed. This public comment supplements our comments made 1/8/15. We only address the mental health block grant (MHBG) requirements appertaining to adults (not children), nor do we address the substance abuse block grant provisions.

**Legislative requirements SAMHSA is ignoring:** The mental health block grant legislation specifically provided that "The Secretary may make a grant...**only** [to provide] comprehensive community mental health services to individuals who are either **adults with a serious mental illness or children with a serious emotional disturbance**." (emphasis added) [3] SAMHSA's proposed application ignores that limitation. "Serious mental illness in adults" was narrowly defined by the HHS Secretary pursuant to congressional direction as any illness in DSM that currently or within the last year "resulted in functional impairment which substantially interferes with or limits one or more major life activities." [4] Functional impairment are "difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g. eating, bathing, drinking); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social family, and vocational/educational contests."

Further, when Congress established SAMHSA, it directed it to "to target … mental health services to the people most in need,"[5] as SAMHSA Administrator Pamela Hyde herself recognized in her own

[1] Draft application at http://www.samhsa.gov/sites/default/files/bg_application_fy16-17_12112014_final_draft_clean_rev_r122914d.pdf

[2] See Federal Register 5/20/1993, page 29425 http://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf

[3] Section 1911 of Title XIX, Part B, Subpart I and III of the Public Health Service (PHS) Act. See 300x-1 (b) page 1101 available at http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXVII-partB.pdf

[4] Federal Register Vol. 58. 96. Pg. 292425. May 20, 1993. Available at http://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf

[5] Conference Report on ADAMHA Reorganization Act. (S1306), Congressional Record May 19, 1992. ADAMHA Reorganization Act Public Law 102-321 (1992) Available at http://tie.samhsa.gov/Documents/pdf/Public_Law102-321.pdf

recent testimony to Congress.[6] The proposed Block Grant Application encourages states to divert funds from those 'most in need.'

By way of background, we agree with the statement on page 1, last paragraph of MHBG application that "block grant expenditures should be based on the best possible evidence." However, the proposed MHBG application suggests states use MHBG funds for programs that are not based on evidence. That direction should be removed.

Following are suggested changes.

**1. Remove Reference to 'behavioral health' or define it correctly on page 1, in Footnote 1, and throughout the entire proposed application**

Rather than using the term, "serious mental illness and substance abuse", SAMHSA created the phrase "Behavioral Health" to encompass both and uses that term throughout the application. But SAMHSA defines the mental health component of "Behavioral Health" much more broadly than 'serious mental illness.' For example, the definition of Behavioral health in the application (FN 1) also includes "the promotion of emotional health." This encourages the diversion of funds from people with serious mental illness to those who need their "emotional health" promoted. "Serious mental illness" is only listed as a subset of behavioral health in the application, but is not described as the focus to which MHBG expenditures are to be limited. Further, the definition of "serious mental illnesses" included the application (FN1) limits "serious mental illnesses to those "that people can and do recover from." This prevents funds from reaching the most seriously ill who do not recover. This stands contrary to the legislative requirement to help those "most in need." SAMHSA's definition of 'behavioral health' in FN1 includes "prevention of mental…disorders." There is no way to 'prevent' serious mental illnesses.[7] SAMHSA can replace "Behavioral Health" with the phrase "substance abuse activities and serious mental illness related activities." Changing the language, in and of itself, will help states understand that the MHBG funds are to be spent to improve care for those with "serious mental illness."

**2. Remove most references to "mental health" and "mental illness" and replace with "serious mental illness."**

The report is full of references to funds being used for "mental health" and "mental illness." The MHBGs are legislatively required to be spent on "serious" mental illness not the others. SAMHSA's

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[6] Statement of Pamela S. Hyde in testimony before the The Energy and Commerce Subcommittee on Oversight and Investigations. "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill." May 22, 2013. Available at http://docs.house.gov/meetings/IF/IF02/20130522/100900/HHRG-113-IF02-Wstate-HydeP-20130522.pdf

[7] To support the false idea that serious mental illness can be prevented, SAMHSA quotes a 1994 Institute of Medicine (IOM) report. (Institute of Medicine, 1994) But the report said something different than what SAMHSA claims.

> To date, the definitions [of prevention] have been so broad and flexible that almost everything has been labeled prevention at one time or another. Some have defined prevention as 'increasing the ability to overcome frustration, stress, problems, enhancement of resilience and resourcefulness' versus preventing serious mental illness.
>
> Prevention programs that currently exist are service programs and demonstrations that have not incorporated rigorous research methodologies. Even those that have an evaluation component usually have not used rigorous standards for assessment of effectiveness. *Thus the nation is spending billions of dollars on programs whose effectiveness is not known.* [emphasis added]

own (NSDUH) data shows that 18.5% of adults have 'any' mental illness and only 4.2% had "serious mental illness"[8] MHBGs are required to address the needs of the 4.2%, not the 18.5%.

In order to ensure that states are clear where they are required to spend MHBGs, many more references to 'serious mental illness' should be included.

For example, on page 5 (and throughout the proposed application) SAMHSA directs states to target services to "individuals who experience trauma, increased numbers of individuals diverted or released from correctional facilities, and lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals." MHBGs may not be used for those populations if they do not also have serious mental illness. That should be made explicit in the application.

### 3. Remove suggestions/requirement that states serve people without serious mental illness

Congress established mandatory populations to serve. SAMHSA's proposed application suggests that states use MHBG to serve many populations that are not enumerated thereby encouraging the diversion of funds

- Page 12: Eliminate Bullet one which states "The focus is about everyone, not just those with an illness or disease" The legislation requires a focus on SMI.
- Page 15-16, Eliminate populations that do not have an asterisk (indicating they are required to be served by language in the legislation.
- On page 18, step 3, the proposed application says the plan "must include… 'other priority populations.' That language should be removed especially because SAMHSA's definition of those other priority populations (ex. LGBT) are not required to have serious mental illness.
- Page 44: Make it clear that MHBGs are only to be used to address health disparities in the underserved population that has serious mental illness. The way the section is written now, it reads like MHBGs are supposed to reduce all health disparities that affect all LGBT, all members of tribal nations, all people with HIV, all people of different ethnicities, rather than those with serious mental illness.

### 4. Collect meaningful metrics

In numerous places SAMHSA requires the collection of data that is not specific to the goal of MHBGs and ignores collecting data that is specific. SAMHSA should require states to produce data on success at reducing homelessness, suicide, arrest, incarceration of people with serious mental illness. Instead of collecting those hard numbers that measure *progress,* SAMHSA only requires the provision of numbers on *process* (ex. how much money was spent on an effort).

- On Page 25, Table 1: Reducing incarceration and homelessness among seriously mentally ill should be priority indicators.
- Page 18: Step four should require states to measure rates of arrest, incarceration and homelessness of seriously mentally ill and make it a priority indicator.
- Page 17, Planning Step one and two should require addressing and listing number of people with SMI who are homeless, in jails and prisons, arrested and are otherwise ***not*** in the mental health system. Too many states only advocate and allocate for those in the mental health system and ignore those they offloaded to the shelters, prisons, and jails.
- Page 72. Require states to report number of suicides which is the only way to tell if suicide funds are helping.

[8] Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Available at http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm

SAMHSA requires the collection of information like ethnicity and sexual orientation, but not diagnosis. SAMHSA should also collect information by diagnosis, which will help ensure funds are being spent on people with serious mental illness. SAMHSA does this for first-episode programs on page 50, but should do so for all expenditures.

**5. Eliminate direction to states to use MHBG for Trauma.**

As SAMHSA is aware, trauma is not a mental illness.[9] PTSD is. And even that can run from mild to severe. SAMHSA should not be requiring the diversion of MHSA funds to something that is not a mental illness. (See page 58-59, Page 20, and throughout) This is especially problematic because SAMHSA never exactly defined trauma, but instead declared where it comes from:

*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well being. (SAMHSA, 2012)*

These definitions can therefore include anyone who got divorced, found their spouse was cheating, knows someone who died, was in a storm, or had any event they "experienced as...emotionally harmful" if it affected their "spiritual well-being." For example, it sounds sympathetic when SAMHSA says they want to "reduce the effects of trauma", but the effect of a trauma (like losing a parent), is most likely that you will feel sad. Reducing sadness is not an appropriate use of MHBGs. Using them for that purpose diverts funds that are legislatively intended to help persons with "serious mental illness" or children with "serious emotional disturbance" to other uses.

**6. Eliminate requirement to use recovery model and insert requirement to use medical model.**

The application makes use of the SAMHSA invented Recovery Model "imperative" even though it does not have the proof that the medical model has. (See Page 22, 65-67, and Page 6) [10] However, SAMHSA created it's own 1100 word definition of "recovery" summarized as:

*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*" (SAMHSA, 2013)

SAMHSA's definition does not require an individual have a serious mental illness. It can be and is used to justify spending mental health funds on anything anyone believes will help them "reach their

[9] Trauma is something that happens to everyone who loses a loved one, is in an accident, loses a job, has a house burn down etc. We are aware that SAMHSA has been using its own non block-grant funds to give 'trauma' illness status.

[10] SAMHSA had a meeting of stakeholders and invented a "recovery model' to replace the medical model. Their definition of what recovery is, is not "a return to health" like in the dictionary, it is 1100 words. SAMHSA started their quest for a definition of recovery in August 2010, with a "Dialogue Meeting," a yearlong "Public Engagement Process" followed by four months of internal reviews and then a vote by 8,500 interested parties they had marshaled. After sorting through 259 online comments, 500 ideas from 1,000 participants, and over 1,200 comments, SAMHSA finally issued its definition. And then took four months to revise it. This 16-month process became the "Recovery Model" and the 10 "Guiding Principles of Recovery" designed to foster "physical and emotional wellbeing." By creating their own Alice-in-Wonderland definition of "recovery" (as opposed to using the one John Q. Public uses) they were able to declare "Everyone Recovers" However, that is not true for people with serious mental illness, so states should not be encouraged to use block grants for it. See http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.VNESXXDF9Vo

full potential." The recovery model ignores the fact that some people with schizophrenia and bipolar do not recover.

This recovery model also encourages states to focus on those who can 'self-direct' their recovery thereby leading states to ignore those who are too ill to self-direct. By doing so, it fails to meet the mandate of MHBGs to focus on those 'most in need'. Like much of the proposed MHBG application, it focuses on "behavioral health" which has been defined more broadly than 'serious mental illness." That will lead to diversion of funds.

Most importantly, certain components of the Recovery Model can be dangerous to people with SMI.[11]

We do appreciate, for first time that we are aware of, that SAMHSA makes the claim within this section, that the Recovery model "includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed." This has not previously been recognized by SAMHSA. But referencing the medical model within the SAMHSA invented Recovery model, does not make the recovery model better than the medical model.

There is so much in this section that lacks a scientific basis, it should be removed in its entirety. In it, SAMHSA lists multiple interventions that do not have evidence they help people with serious mental illness.

**7. Eliminate direction that encourages states to use peer specialists in lieu of mental health professionals.**

(See Page 22, third sub-bullet, Pages 65-67 and overall**)** As previously stated by SAMHSA in this proposed application, MHBGs are supposed to be used on 'evidence based practices.' As to peer support, SAMHSA found "The literature (on peer support) that does exist tends to be descriptive and lacks experimental rigor" (SAMHSA-BRSS, 2012). That is to say, it is not evidence-based. SAMHSA's 76-page publication *Consumer-Operated Services: The Evidence* lists multiple studies on what peer support is, its history, its popularity, its importance, how to expand its usage, and what its future will be. (CMHS, 2011) But despite its title, the publication includes no evidence peer support improves meaningful outcomes in people with serious mental illness. That conclusion is supported by numerous other quality studies.[12] There is not evidence that peer support is better than professional support. SAMHSA should remove requirement that it be funded.

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[11] Two examples:

> 1. The Recovery Model requires "self-direction." Some SMI have anosognosia. They can't self direct. So the recovery model, by definition, excludes some of the most seriously ill. John Hinckley was self-directing his 'recovery' when he shot Ronald Reagan to get a date with Jodi Foster.
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> 2. In the recovery model as described in this application, "the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly." If a consumer has an advance directive stating they don't want treatment, and their cognition becomes significantly impaired and can be restored with medications, it would be cruel to the patient and against the interests of taxpayers to make them legally untreatable and not restore their cognition. SAMHSA is supposed to be preventing tragedies, not facilitating them.

[12] The well-respected Cochrane Collaborative reviewed all the high- and low-quality data on peer support and concluded: "Involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services." (Cochrane Collaborative, 2013).

**8. Require planning for medication assisted treatment for people with serious mental illness.**

The proposed application requires planning for medication assisted treatment for substance abuse, but not mental illness. That is absurd. The only mention of medication for mental illness, is a single line in the recovery section. Medication is the sine quo non for many with mental illness. Medications can ameliorate some of the most severe symptoms such as delusions and hallucinations and are the most effective treatments for schizophrenia (Lehman, Lieberman, Dixon, McGlashan, & Miller, 2009) and bipolar disorder (Hirschfeld, Bowden, Gitlin, & Keck, 2009).[13] Medications are very effective at reducing criminal justice involvement and violence. (Robertson, Swanson, & Van Dorn, 2014) [14]

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- The American Psychiatric Association found that "a majority of randomized trials that compare peer-delivered with non–peer-delivered services do not show differences on most outcome measures" and quoted four studies in support of its conclusion. (APA, 2009)

- A recent study of eighteen trials of 5,597 participants found "there is little evidence from current trials about the effects of peer support for people with severe mental illness….(C)urrent evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programs." (Lloyd-Evans, Mayo-Wilson, & Harrison, 2014)

- The Centers for Medicaid and Medicare services found peer support is expensive but doesn't improve outcomes. (Landers & Zhou, 2014)

- Even SAMHSA found "The literature (on peer support) that does exist tends to be descriptive and lacks experimental rigor" (SAMHSA-BRSS, 2012).

[13] As far back as 1959, researchers noted that the hospital discharge rate for patients treated with medications was twice that for those not treated. (Brill and Patton 1959) In 2013, recognizing the importance of antipsychotics in ameliorating symptoms, the National Committee for Quality Assurance (NCQA) added "**Adherence to Antipsychotic Medications for Individuals with Schizophrenia" as a metric to be tracked by health care organizations seeking its seal of approval.**

[14] Following are more studies on the association between medication compliance and violence reduction.

- A study of 82,000 patients compared rates of violent criminality during the time that patients were prescribed medications versus the rate for the same patients while they were not receiving them. "Violent crime fell by 45% in patients receiving antipsychotics…and by 24% in patients prescribed mood stabilizers. (Seena Fazel, 2014)
- One meta-analysis of 10 studies of homicides and psychotic illness reported that 39% of such homicides occur in individuals with psychoses before they have ever been treated and the homicide rate in individuals never treated was 22 times higher than the rate in individuals treated. (Nielssen, 2010)
- Meta-analyses of studies of individuals with serious mental illness who commit acts of violence, including homicides, report that a disproportionate number of these acts occur during the person's first psychotic episode before they have been treated. Large MM, Nielssen O. Violence in first-episode psychosis: a systematic review and meta-analysis. Schizophrenia Research 2010;125:208–220. Nielsson O, Large M. Rates of homicide during the first episode of psychosis and after treatment: a systematic review and meta-analysis, Schizophrenia Bulletin 2010;36:702–712.

- A study in New York assessed 60 severely mentally ill men who had been charged with violent crimes. The author reported that medication noncompliance and lack of awareness of illness both played significant roles in causing the men's violent behavior. Alia-Klein N, O'Rourke TM, Goldstein RZ et al. Insight into illness and adherence to psychotropic medications are separately associated with violence severity in a forensic sample. Aggressive Behavior 2007;33:86–96.

- A study of 907 individuals with severe mental illness reported that those who were violent were "more likely to deny needing psychiatric treatment." The authors concluded "clinical interventions that address a patient's perceived need for psychiatric treatment, such as compliance therapy and motivational interviewing, appear to hold promise as risk management strategies." Elbogen EB, Mustillo S, Van Dorn R et al. The impact of perceived need for treatment on risk of arrest and violence among people with severe mental illness. Criminal Justice and Behavior 2007;34:197–210.

- A study of 1,011 outpatients with severe psychiatric disorders in five states reported that "community violence was inversely related to treatment adherence," i.e., the less medication individuals took, the more likely they were to become

**Following are additional changes**

**Page 3: FN 6: Replace this new definition of serious mental illness with definition of SMI in federal register.**[15] In this footnote, SAMHSA again encourages the broadening of the purpose of MHBGs away from those with serious mental illness by noting, "States may have additional elements that are included in their specific definitions, but the following provides a common baseline definition." States may not have additional elements that broaden the use of funds.

**Page 7-8, 16, and 27: Remove language requiring states to "to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment"** The IOM reported serious mental illness cannot be prevented with universal or selected interventions.[16] We do not yet know how to use "primary prevention" to prevent serious mental illness.[17] As MHBGs are required to target people with SMI or SED, the requirement to use funds for prevention should be eliminated.

**Page 46: Require MHBGs to be used for evidence based programs**. The wording on page 46 allows funds to go to non-evidence based programs "to establish the evidence." That direction from SAMHSA allows/encourages the diversion of funds to anything under the rubric that they are 'establishing evidence.' Research is best done on a coordinated national level, not to have 50 states researching the same thing. States can conduct research with their own funds and SAMHSA has funds with which to conduct research and NIMH conducts research. MHBGs should be limited to programs with evidence, as SAMHSA stated multiple times elsewhere.

**Page 63-64: Remove non-evidence based services from crisis services to be funded.** We are glad to see that SAMHSA is finally focusing on crisis services. SAMHSA should eliminate what they define as pre-crisis and post-crisis services as those are the same programs SAMHSA

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violent." Elbogen EB, Van Dorn RA, Swanson JW et al. Treatment engagement and violence risk in mental disorders. British Journal of Psychiatry 2006;189:354–360.

[15] Federal Register Vol. 58. 96. Pg. 29245. May 20, 1993. Available at http://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf

[16] The 1994 Institute of Medicine report defined "selective" and "universal prevention" activities and advocates often use that as 'proof' we should use them. But the report unequivocally stated that they do not work for serious mental illness. For example, it stated, "universal and selective interventions to prevent the onset of schizophrenia are not warranted at this time. Much more risk factor research is needed." Some argue that that the 2009 IOM update justifies using 'universal prevention' to reduce serious mental illness. But the IOM report focuses only on youth and specifically excludes "some rare but often severe disorders; for example, schizophrenia, bipolar disorders." The report states "Studies to date (on schizophrenia and bipolar) have not been large or numerous enough to capture these rare disorders with any hope of accuracy." What the report did find is that perhaps some issues the industry considers mental "health" problems (ex. failed marriages) could be prevented (ex. by marriage counseling). But MHBGs are not intended to improve marriages. They are to address serious mental illness.

[17] In 2003, the President's New Freedom Commission acknowledged, "Preventing mental illnesses remains a promise of the future." (President's New Freedom Commission on Mental Health, 2003). Further evidence that preventing serious mental illness is impossible, was described in a recently released IOM report on efforts to prevent mental illness in the military. (Institute of Medicine, 2014). *The Wall St. Journal* summed up the IOM's findings: "Study Fails to Find Evidence That Programs for Soldiers and Families Prevent Psychological Disorders" (Wang, 2014). Serious mental illness cannot be predicted or prevented because as National Institute of Health Director Dr. Thomas Insel recently noted, "For mental disorders, we do not know the cause, we lack a biomarker that is 100% accurate for diagnosis" (Insel, Director's Blog, 2014). The North American Prodrome Longitudinal Study (NAPLS) is trying to determine ways to predict who will develop serious mental illness. (Addington & Cadenhead, 2012).

promotes/requires elsewhere in the application and are not crisis services, nor are many evidence-based. This section should focus on hard-core services for those actually in crisis. SAMHSA's proposed MHBG application ignores many crisis intervention services that are helpful and includes many that are non-evidence based and in some cases harmful.

- SAMHSA should add access to doctors, medications, intensive case management, supported housing, assisted outpatient treatment, guardianship and conservatorships to the pre-crisis, crisis, and post crisis services. These are perhaps the most important services and are ignored by SAMHSA.
- There is no evidence WRAP helps people with mental illness or serious mental illness improve a meaningful metric. (Jaffe, 2013) It should be removed from crisis services and other places in the application.
- Advance directives that prohibit medication can compound a crisis so advance directives should be removed from crisis services.
- Remove words "peer operated" and "peer-run" from description of warm lines and respite programs respectively. And remove "peer support-peer bridges". There is not evidence these are more effective than non-peer run warm lines and respite programs or professional support. Further, SAMHSA already suggests they be used elsewhere in the application.
- Remove the "open dialogue" as it is not an evidence based program and the bias against medications in that program can make a crisis more likely
- Mobile Crisis outreach should be a pre-crisis intervention.

**Page 16 (number 5): Remove direction encouraging states to engage in "environmental prevention activities including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement."** We are not sure what SAMHSA means by "environmental prevention activities". Is that poverty elimination, or bad grades elimination? We could find no definition of that term on SAMHSA website. In any event, there was no intent for MHBG to be used to create a fund for political advocacy.

**Page 46. Eliminate or dramatically narrow the suggestion that states invest MHBG funds in programs listed in NREPP**. NREPP programs are not independently proven to improve a meaningful outcome in people with serious mental illness. As the draft block grant application makes clear the NREPP programs are for "mental health promotion and treatment." "Mental health" is not the same as mental illness or serious mental illness. Of the 342 interventions in NREPP less than ten serve people with SMI. Many of those do not have any independent evidence, only evidence from those who sell the largely educational programs. None claim to improve a meaningful outcome like reducing homelessness, arrest, incarceration.[18] Dr. Sally Satel could only find four even remotely targeted to serious mental illness. (Satel, 2013)

**Page 38: Correct section on system integration to focus on treatment for mental illness and lack of access to medications.** This section focuses on non mental-illness related health needs of people with serious mental illness. It correctly notes that people with serious mental illness die younger, but then goes on to encourage states to introduce interventions that don't address that, for instance, by improving heart health programs. But multiples studies, including one recent major study found, "The highest overall mortality [in people with schizophrenia] was observed among patients with

[18] See testimony of Dr. Sally Satel to Oversight Commission available at http://mentalillnesspolicy.org/samhsa/satel.5.22.13.samhsa.testimony.pdf For example, WRAP is not evidence-based but is listed in NREPP. See http://mentalillnesspolicy.org/samhsa/wrapunproven.html MHFA is not evidence based but is listed in NREPP. See http://mentalillnesspolicy.org/samhsa/mental-health-first-aid-fails.html. Kognito at Risk is not Evidence based, but is listed in NREPP http://mentalillnesspolicy.org/samhsa/kognitounproven.html. Teen Screen is not evidence based but until recently was listed in NREPP. See http://mentalillnesspolicy.org/samhsa/teenscreenunproven.html

no antipsychotic exposure." (Torniainen, Mittendorfer-Rutz, & Tanskanen, 2014) Therefore, to reduce mortality, SAMHSA should be encouraging states to ensure access to antipsychotics and medical treatment for the mental illness. For example, without treatment, many seriously mentally ill wind up homeless, which in itself decreases life expectancy. The legislation itself requires mental health plans to describe "case management services and provide for activities leading to reduction of hospitalization." We have trouble understanding how SAMHSA direction to states can ignore the medical needs related to mental illness and only focus on those that are generic to everyone. This section should be rewritten and add programs like ACT, ICM, AOT, medications and others.

**Page 2. Remove reference to SAMHSA *Leading Change Report* (Strategic Direction Report)** The Application suggests MHBGs be used to follow the direction in the SAMHSA Strategic Leading report, which focuses on 'Behavioral health'. That report makes no mention of bipolar disorder. It makes only two mentions of schizophrenia, and those are limited to mentioning that schizophrenia is among the mental illnesses SAMHSA focuses on. Bipolar and schizophrenia are among the few most serious mental illnesses. [19] We note that none of the strategic objectives on page 2 and 3 of proposed MHBG application concerns providing better treatment to people with serious mental illness, except to prevent mental illness. Serious mental illnesses cannot yet be prevented (see above).

**Page 6, 14, and 75-77 Add "police, sheriffs, corrections, prosecutors, district attorneys, state hospital directors, emergency room directors, homeless shelter directors" to the list of "strategic partners" and "planning council" members.** Criminal justice representation is required by the enabling legislation defining composition of the planning councils.[20] These individuals and departments care for more people with serious mental illness than the community mental health system and therefore have more expertise. Criminal justice can explain how policies often endorsed by mental health advocates like closing hospitals, making civil commitment more difficult, diverting funds away from people with serious mental illness often increase incarceration.

**Page 1 and 20: Add direction to section mentioning Olmstead that urges state to consider AOT and other policies for those who have anosognosia or cannot self direct own care.** The application suggests states use MHBG funds for people to further Olmstead implementation for those "needlessly institutionalized or at risk of institutionalization." i.e, to move them to lower levels of care. The block grant applications should specifically mention AOT[21] as a way to accomplish that. Assisted Outpatient Treatment allows eligible individuals to live in less restrictive environments than jails, prisons and involuntary inpatient commitment. It also saves states money. Therefore, it meets both prongs of the Olmstead decision.

**Page 48, Remove section on Prevention and subsume it under following section on early intervention."** As this section properly notes, "MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode" but then suggests going beyond that by stating "states may want to consider using other funds for these emerging

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[19] Support for the fact that Schizophrenia and bipolar disorders are serious mental illnesses comes from the Congressionally established National Advisory Mental Health Council. They defined serious mental illnesses as those 'accompanied by psychotic symptoms--schizophrenia, schizoaffective disorder, bipolar disorder, and autism--and the severe forms of major depression, panic disorder and obsessive compulsive disorder" The Council decided all schizophrenia was serious, but applied severity requirements to the other disorders. (National Advisory Mental Health Council 1993). Since 1993, based on new research and understanding, autism has been reclassified as a developmental disorder, rather than a mental illness.

[20] See page 1104 at http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap6A-subchapXVII-partB.pdf

[21] http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.html

practices." The "emerging practice" that SAMHSA is encouraging is treatment for those with prodromal symptoms. But as the study cited in the application notes, 78% of those with prodromal symptoms do not go on to develop psychosis after one year even with no treatment. Further, treatment will only stop 54% of the remainder from developing psychosis in the one year time frame.[22] That means offering prodromal intervention is 89% waste. Prodromal treatment is promising, but is not ready for rollout. As Dr. Thomas Insel wrote "In most studies, the majority of "high-risk" individuals never go on to develop a psychotic disorder."[23] Most importantly, as noted on the bottom of page 49, there is 5% set aside by Congress for a related program, so any efforts in this area should come out of those funds.

**Page 59**: **In the section on criminal justice, suggest states implement Assisted Outpatient Treatment Programs to divert seriously mentally ill from jails and prisons"** AOT has been declared by DOJ to be an effective jail diversion program. (Department of Justice, 2012) In New York it reduced incarceration and arrest over 70% each.[24]

[22] The longer term results are similar. "Only about one third of patients at high risk for psychosis based on current clinical criteria convert to a psychotic disorder within a 2.5-year follow-up period." Quote from the study, Automatic auditory processing deficits in schizophrenia and clinical high-risk patients: forecasting psychosis risk with mismatch negativity. It quotes two studies. 1. Cannon TD, Cadenhead K, Cornblatt B, Woods SW, Addington J, Walker E, et al. (2008): Prediction of psychosis in youth at high clinical risk: A multisite longitudinal study in North America. Arch Gen Psychiatry 65:28–37. 2. Fusar-Poli P, Bonoldi I, Yung AR, Borgwardt S, Kempton MJ, Valmaggia L, et al. (2012): Predicting psychosis: Meta-analysis of transition outcomes.

[23] http://www.nimh.nih.gov/about/director/2014/can-we-prevent-psychosis.shtml

[24] http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.html

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# Examples of SAMHSA encouraging and requiring states to divert block grant funds away from people with serious mental illnesses.

The following is based on our analysis of the 2013 Block Grant Application.[9]

**Pages 1-27 of the application[10] describe the key issues states must address with block grants**

Below we show that many of the issues SAMHSA identifies as "key" are at best tangential, often false, and frequently inimical to the purpose of Congress which was to help persons with serious mental illness.

SAMHSA block grants were originally without strings, but now SAMHSA ties them to "trauma, justice, parity education…recovery, prevention" "self-direction" and "peer services".

> *(Page 4) (T)**hese grants were originally designed to give states maximum flexibility** in the use of the funds to address the multiple needs of their populations. This flexibility was given in exchange for reductions in the overall amount*
> *… Currently, flexibility is given to allow states to address their unique issues; **however**, health care systems, laws, knowledge, and conditions have changed. The Substance Abuse and Mental Health Services Administration (SAMHSA) now observes a more complex interplay between the Block Grants and other funding streams, such as Medicaid, and increasing knowledge in the behavioral health field about evidence-based practices**, self direction, and peer services that require more consistency and direction** to ensure that the nation's behavioral health system is providing the best and most cost effective care possible. This care is based on the best possible evidence, and tracking the quality and outcome of services enables informative reporting. This leads to improvements, which can be made as science and circumstances change.*

SAMHSA does not even include 'treating mental illness' in the descriptive sections:

> *(Page 4) This Block Grant … sections includes subsections on the following policy topics: health reform, coverage of mental and substance use disorder (M/SUD) services, Affordable Insurance Exchanges, use of evidence in purchasing decisions, program integrity, tribes, quality, trauma, justice, parity education, primary and behavioral health care integration activities, health disparities, recovery, prevention, and children and adolescents behavioral health services.*

(Page 7) SAMHSA encourages states to use funds "for persons **not** identified as needing treatment';"[11]

> *SAMHSA **strongly recommends that Block Grant funds be directed toward** four purposes… (3) to fund primary prevention: universal, selective, and indicated prevention activities and services for **persons <u>not</u> identified as needing treatment.***

SAMHSA encourages states to use their "National Registry of Evidence-Based Programs and Practices" (NREPP[12]) when deciding what programs to implement. We have previously noted that SAMHSA has very few evidence-based programs for people with serious mental illness (ex. Schizophrenia) in their database (most focus on 'mental health'), some programs rely on poor research (ex. WRAP), and while SAMHSA certified programs measure increases in 'hopefulness' and 'empowerment', almost all fail to prove they improve more important measures like suicide rates, hospitalization rates, incarceration rates, homelessness, murder, etc.

> *(Page 10) States and other purchasers are requesting information on evidence-based practices … To respond to these inquiries and recommendations, SAMHSA has … a National Registry of Evidenced-based Programs and Practices (NREPP)…so that they can learn how to implement these approaches in their communities.*

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[9] "SAMHSA seeks to ensure that SMHAs and SSAs are prepared and ready to address the priorities described... These environmental factors are key drivers that will enhance the ability of SMHAs and SSAs to take advantage of many changes that will decrease the prevalence of mental and substance use disorders and/or improve the health of individuals with mental illness and addictions, improve how they experience care, and reduce costs." Page 28 of block grant application at http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf

[10] http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf

[11] They use the term "universal" activities. Those are basically education efforts to the public vs. services for the ill.

[12] http://www.nrepp.samhsa.gov/ViewAll.aspx

SAMHSA directs states to spend mental health block grant money on "prevention" even though no one knows how to prevent serious mental illness. They talk about "community-based risk" but the biggest 'risk' factor for mental illness is having a relative with it. They talk about "promoting emotional health", but that has nothing to do with mental illness. They talk about 'reducing the likelihood of mental illness" but for the most part, that can not be done and in fact none of the SAMHSA certified programs show how to do that.

> *(Page 13) One of SAMHSA's eight strategic initiatives articulated in Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014 is the Prevention of Substance Abuse and Mental Illness: —creating communities where individuals, families, schools, faith-based organizations, and workplaces take* ***action to promote emotional health and reduce the likelihood of mental illness***[13]***,*** *substance abuse including tobacco, and suicide."*

SAMHSA requires states to take a "community-based approach" vs. a medical approach that treats individuals.

> *(Page 13) To support that initiative, SAMHSA promotes the use of its Strategic Prevention Framework (SPF), which uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors. The SPF is built on a community-based risk and protective factors approach to prevention and a series of guiding principles that can be adapted and utilized at the federal, state/tribal, and community levels. The idea behind SPF is to use the findings from public health research along with evidence-based prevention programs to build capacity within states, territories, tribes, and the prevention field.*

SAMHSA specifically tells states **not** to just target those most at risk

> *(Page 13) Implementing evidence-based practices requires cooperation across a variety of community settings****…,*** for all segments of the population ***especially those who are at high risk for mental*** *and substance use disorders… "In implementing the primary prevention comprehensive program, states should use a variety of programs, policies, practices, and strategies that target populations* ***with different levels of risk****."*

SAMHSA tells states **not** to spend money on helping individuals, but changing society

> *(Page 14) The primary prevention of the onset of mental, emotional, behavioral, and substance use related problems may be best achieved by using a combination of universal and selective approaches. (*SAMHSA describes "Universal" strategies, as those directed at the mass media, changing legislation, community-wide interventions, changing in cultural norms, or other types of efforts, can reach broad segments of the population. (Page 14))

SAMHSA specifically tells state to ignore the congressionally approved legislation and instead implement prevention programs for mental health. As SAMHSA acknowledges below, Congress told SAMHSA to prevent substance abuse (which can be done) but did not tell SAMHSA to prevent mental illness. Presumably that is because we don't know how to do that now and didn't know how to do it when Congress created SAMHSA. In the block grant application, SAMHSA specifically directs applicants to ignore Congress and make prevention a "top priority."

> *(Page 14) While the federal statute requires states to spend a portion of the SABG (Substance Abuse Block Grant) on primary* substance abuse *prevention services, the scientific understanding of* mental health *promotion and mental illness prevention (or mitigation) was not well-known or developed when the MHBG was first authorized in the 1980s. Thus, states and communities should take scientific developments of the last 25 years into account as they develop plans to prevent substance use* ***and mental disorders*** *and promote emotional health.* ***States should make general prevention and primary prevention top priorities****.*

SAMHSA oxymoronically told states to use "prevention" funds on people who already have mental illness

> *(Page 14) States may use some of their current MHBG to support services that are preventative in nature for adults with serious mental illness (SMI) and children with serious emotional disorders*

[13] Note some research does seem to indicate that programs that reduce substance abuse may be able to reduce the chance of, or extend the age of onset of serious mental illnesses in those genetically prone to it. But this is still unclear.

SAMHSA claims the President's 2013 budget requires states to focus on prevention, but the 2013 budget was not passed by Congress and is therefore inoperative.

> *(Page 15) The President's budget for FY 2013… proposes…the Mental Health-State Prevention Grant[14] (to) support the development of a mental health promotion/mental illness prevention infrastructure in every state and territory… SAMHSA (is) encouraging states to provide …services and activities for the primary prevention of mental and substance use disorders (including the use of universal, selective, and indicated strategies.)*

SAMHSA encourages mission-creep by telling states extend block grants to accomplish objectives beyond helping people with serious mental illness, and instead to improving mental health.

> *(Page 17) SAMHSA…created the National Behavioral Health Quality Framework… (to)…improve the behavioral health of the U.S. population by supporting proven interventions to address behavioral,* ***social, cultural, and environmental determinants*** *off positive behavioral health[15] …Promote the most effective prevention[16], treatment, and recovery practices[17] for behavioral health disorders… enable healthy living.*

SAMHSA Block Grant encourages states to focus on eliminating trauma. "Trauma" can include losing a parent, child or job, being in an accident or thousands of other events that are a part of everyday living. Trauma is not an illness. PTSD is.

> *(Page 19) "Trauma is a widespread, harmful, and costly public health problem"…" it is critical that public health systems screen for and intervene early with evidence-supported trauma interventions."*

SAMHSA told states implementation of the recovery model is imperative. The 'recovery model' is useful for many, but specifically precludes the treatment of people who are so ill they do not recognize their need for treatment. It requires these people to become danger to self or others before they can receive treatment.[18]

> *(Page 25) The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. SAMHSA has identified recovery support services as one of its strategic initiatives. The urgency of health reform compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.*

SAMHSA directs state block grants away from scientific medical models to social theories

> *(Page 25) Recovery emerges from hope; Recovery is person-driven; Recovery occurs via many pathways; Recovery is holistic; Recovery is supported by peers and allies; Recovery is supported through relationship and social networks; Recovery is culturally-based and influenced; Recovery is supported by addressing trauma; Recovery involves individual, family, community strengths, and responsibility; Recovery is based on respect.*

SAMHSA encourages states to use block grant money to support strategic initiatives do not help people with serious mental illness.

> *(Page 27) SAMHSA has established eight Strategic Initiatives…(E)ach initiative …will be disseminated to states, stakeholder groups, national organizations, and policy makers. With this guidance,* ***states should develop plans and applications with a focus on SAMHSA's Strategic Initiatives****.*

**Pages 28-38 of application[19] describe the impact of key issues on spending of block grant funds**

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[14] Presumably this $90 million prevention (sic) grant (and a similar $50 million for tribal areas) was suggested to the President by SAMHSA as part of their "Leading Change" initiative in spite of the fact we do not know how to prevent serious mental illnesses. http://www.samhsa.gov/Budget/FY2012/LeadingChange2012.aspx

[15] The enabling legislation identifies adults with a serious mental illness and children with a serious emotional disturbance as priority populations, not changing

[16] We do not know how to prevent serious mental illness

[17] SAMHSA has it's own definition of recovery "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." In other words, anything that is a process of change counts as a recovery program. We have analyzed the most popular SAMHSA backed recovery program (WRAP) and found it is not based on evidence.

[18] See Mental Illness Policy Org report on SAMHSA Medical Model vs. Recovery Model and discussion of 'self-directed'

Many of the directions to states (page 28-38) are irrelevant or harmful to persons with mental illness.

SAMHSA encourages states to spend block grant money on increasing public awareness rather than providing services. This is particularly problematic because only the highest functioning are shown in these efforts. The homeless psychotic eating out of dumpsters are not included (for fear of creating 'stigma') thereby preventing the public from understanding an important impact of serious mental illness.

> *(Page 28) Public Awareness and Support: Increasing understanding of mental and substance use disorders to achieve the full potential of prevention,*

SAMHSA encourages states to use block grant money on peer supporters rather than licensed professionals.

> *(Page 30) Individuals that have personal experiences with mental or substance abuse disorders are playing an increasingly important role in the delivery of recovery-oriented systems of care.*

SAMHSA encourages states to use the block grants on 'self-directed' interventions. By definition, these interventions do not help the psychotic or delusional who refuse treatment. Self-directed interventions do not allow certain patients to be treated until after they become 'danger to self or others'.[20] Treatment models should prevent violence, not require it.

> *(Page 31) State authorities should focus more … services and supports (that) foster individual and family capacity for self-directed recovery.*

SAMHSA requires states to use block grants to do outreach to find new people who need treatment (under the guise of preventing mental illness) rather than providing services to those already identified

> *(Page 32) SAMHSA strongly recommends that Block Grant funds be directed …to fund primary prevention: universal, selective, and indicated prevention activities and services* ***for persons not identified as needing treatment***

SAMHSA requires states to use funds on "recovery". This would not be problematic, except that rather than using the dictionary definition of recovery (overcoming illness) SAMHSA has created their own multipage "SAMHSA Definition of Recovery"[21] that allows almost anything that is part of a "process of change" to be funded.

> *(Page 31) State authorities should focus more on recovery from mental health and*

SAMHSA correctly requires states to use evidence, but then refers states to a document that is not evidence based.

> *(A)lmost all states are using Block Grant funds to purchase services in all categories identified in SAMHSA's "Description of a Modern Addictions and Mental Health Service System" (*That document[22] says *The system should be guided by principles and evidence that mental illness… prevention… work(s).* As we have previously shown, this is wishful thinking, not science.) No one knows how to prevent serious mental illness.)

SAMHSA is requiring states to use the block grants to reduce trauma (ex. Loss of a parent or job which is not a mental illness) versus PTSD, which is. They also position treatment in itself as a cause of trauma:

> *State authorities should pay particular attention to trauma. Practitioners and policymakers also need to have a better understanding of how their policies, practices, and behaviors can … be secondarily traumatizing to people. States can better address this issue by screening for trauma, providing trauma-focused treatments, and offering trauma-informed care.*

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[19] http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf
[20] See Mental Illness Policy Org. on how recovery models prevent the treatment of patients with anosognosia until after they become danger to self or others, which many do.
[21] http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/
[22] Draft at http://www.samhsa.gov/Healthreform/docs/AddictionMHSystemBrief.pdf

SAMHSA requires Block Grants to be used to train those in criminal justice but does not require money to be used to reduce the numbers who become criminally involved.

> *(Page 34) Police and other first responders need training and consultation to respond appropriately and safely to people with mental and substance use disorders in crisis. Judges and other court officials need education and support to develop successful specialty court and other diversion programs for people with mental and substance use disorders.*

SAMHSA requires funds to be used for "recovery" which precludes funds from being used for those who do not volunteer for services (since SAMHSA defines recovery as 'self-directed).

> *(Page 37) State authorities are encouraged to implement, track, and monitor recovery oriented…services…Promote recovery-oriented service systems.,,,Engage individuals in recovery and their families in self-directed care..,*

SAMHSA requires block grants to be used on employment programs. That largely exclude people with schizophrenia because few are capable of non-subsidized employment.

> *(Page 37) meaningful daily activities, such as a job, …Increase gainful employment …Increase the proportion of individuals with mental … disorders who are gainfully employed and/or participating in self-directed educational endeavors…Develop employer strategies to address national employment and education disparities among people with identified behavioral health problems…Implement evidence-based practices related to employment and education for individuals with mental and/or substance use disorders.*

SAMHSA requires states to fund peer support services which leaves fewer dollars for care from professionally schooled and licensed mental health providers.

> *(Page 38) … relationships and social networks that provide support, friendship, love, and hope…Promote peer support …Increase the number and quality of consumer/peer recovery support specialists and consumer-operated/peer run recovery support service provider organizations*

**Page 39-40 establish the Goals of Block Grants as defined by SAMHSA**

*(Page 40) These goals are significant drivers in the revised Block Grant application(s… States should use these aims as drivers in developing their application(s).*

Many of the goals SAMHSA has outlined are generic and non-specific to the unique needs of people with serious mental illness, rather they are goals that help everyone in society.

> *(Page 39) Block Grant Programs' Goals a. A physically and emotionally healthy lifestyle (health); b. A stable, safe and supportive place to live (a home); c. Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a purpose); and, d. Relationships and social networks that provide support, friendship, love, and hope (a community).*

Other Goals of the Block Grant specifically exclude people with mental illness:

> *Additional aims of the Block Grant programs:* ***The focus is about everyone, not just those with an illness or disease, but the whole population. The focus is on prevention and wellness activities.***

Some Goals are designed to change the system rather than help people with serious mental illness

> *(Page 39) There is an emphasis on policy impact and support: an analysis of the laws, rules, and infrastructure which informs and supports the work.*

**I have to work on the following section**

**Behavioral Health Assessment and Plan Page 41-90**

The SAMHSA-delineated state mental health block grant planning process is flawed.

(Page 44) It requires input from many, but does not require input from those who are the most seriously mentally ill, i.e., those living in state psychiatric hospitals or who are incarcerated because of mental illness.
(Page 44) It does not identify offspring of persons with mental illness as an at-risk population[23]
(Page 46) Does not include reduction of criminalization as a measurable
(Page 48) requires states to show how they are "improving emotional health" and preventing mental illness. (Improving emotional health is not a function of government and we do not know how to prevent serious mental illness).
(Page 49) Positions trauma as "a central factor in the development of mental…disorders". (Note: everyone experiences trauma (ex. Losing a parent, child, or job) and it rarely results in PTSD.
(Page 49) Forces services to be "self directed" and "participant directed" thereby penalizing states who use funds to help those not well enough to help themselves.
(Page 49 and 51) Require states to develop strategies that "are focused on emotional health and the prevention of mental illnesses. SAMHSA correctly states *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* articulates the current scientific understanding of the prevention of mental and substance use disorders. But SAMHSA also states "It also describes a set of interventions that have proven effective in preventing substance abuse and mental illness" That is not true. While substance abuse can be prevented, there are no preventions for serious mental illness in that report, because none exist.
(Page 51) Requires states to make use of peer support, which is not a evidence based practice.[24]
(Page 56-58) Lists required services (like 'recreational'), but does not list any services to help people who refuse treatment or are not well enough to accept it (like Assisted Outpatient Treatment, Mental Health Courts or Conditional Discharge)
(Page 71) Measures of success do not measure increase/decrease in homelessness, incarceration, arrest, violence, suicide and other important measures. By measuring, for example, employment, it encourages states to serve higher functioning who are capable of employment.
(Page 72) requires states to address Trauma. Trauma is not an illness. There is no way to prevent trauma (ex. Death of a parent, loss of a job, etc.).
(Page 73) Does not require states to provide the most effective criminal justice program, Assisted Outpatient Treatment, which prevents incarcerations, and only focuses on interventions after someone has committed a crime (ex. Mental health courts).
(Page 77) "encourages states to take proactive steps to implement recovery support services." Within SAMHSA, "Recovery" and "Peer-Support" must be "self-directed" and therefore exclude the most seriously ill who are not capable of self-directing their recovery. These provisions require states to "develop a definition of recovery" (rather than use one in the dictionary), document that "persons with mental illness are in leadership roles" (regardless of whether they are the most qualified; use "self-direction and participant-directed care", "meet the holistic needs of those seeking or in recovery" (regardless of whether they are needed", include "peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services" (regardless of whether these services could be more effectively provided by non-peers); "provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers", "have an accreditation program, certification program, or standards for peer-run services" and "describe state's exemplary activities or

[23] The offspring of persons with mental illness are the most at-risk, as there is a large genetic component to bipolar and an important genetic component to schizophrenia.
[24] We have been looking for, but have not yet found more than a single study purporting that peer support helps people with bipolar or schizophrenia ("serious mental illness") achieve reduced arrest, incarceration, hospitalization, homelessness, etc. The studies we have found measure 'hopefulness' and 'empowerment' which are important, but perhaps not the most important. No studies compare Peer Support with other interventions, such as hospitalization, treatment with medication, Assisted Outpatient Treatment, or treatment by educated and licensed social workers, psychologists, psychiatrists, etc.

initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems." (Page 82) requires states to focus on suicide, and submit a plan consistent with SAMHSA direction[25]. That direction fails to call attention to the facts that the people who are most likely to commit suicide are those who have previously attempted suicide; have a first degree relative who has attempted or completed suicide, or have a serious mental illness.

[25] "Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at http://www.samhsa.gov/grants/blockGrant/docs/SAMHSA_State_Suicide_Prevention_Plans_Guide_Final.pdf

**Examples of the 2014 block grant diverting money from seriously ill as taken from comments made about the RFP[26]**

The federal register allowed comments and many complained[27] SAMHSA was directing funds to programs that do not serve seriously mentally ill, and

The priorities listed under the Program Integrity Section do not correspond with the four purposes that SAMHSA proposes grant funds be directed towards." SAMHSA responded: SAMHSA understands that the priorities for Program integrity activities and the purpose of the use of block grant dollars are not identical, but are complementary.

Line 54
Arthur T. Dean, Major General, U.S. Army, Retired, Chairman and CEO, Community Anti- Drug Coalitions of America (CADCA) wrote: The new Uniform Block Grant Application makes the case for and **explicitly includes mental health promotion as a "priority area" for planning and resource allocation purposes, despite the fact that current law for neither the SAPTBG nor the MHBG includes any language to authorize expenditures for this purpose**."
SAMHSA RESPONDED States will be allowed to use some of their current CMHS Block Grant to support mental health promotion and mental illness prevention activities related to adults with serious mental illnesses and children with serious emotional disturbances and their families. (Note: This comment was made by multiple commentators)

line 94
"**The encouragement of including mental health promotion as a priority area when current law does not allow** expenditure of either Mental Health Grant and Substance Abuse Block Grant funds for mental health promotion is puzzling and can place states in a precarious position if they plan and/or spend their block grant funds illegally." SAMHSA responded "States will be allowed to use some of their current CMHS Block Grant to support mental health promotion and mental illness prevention activities related to adults with serious mental illnesses and children with serious emotional disturbances and their families

Line 105 Nebraska said
**In addition to the areas of emphasis being expanded, how the funds from the block grant are to be used is becoming more directed and perhaps less flexible**. This does not allow states to address what they see and have been told are areas of concerns. DBH believes the funds should be used for prevention and non-treatment recovery such as housing, job assistance, and recovery services that are not considered "treatment". **Primary prevention cannot be directed to a population that is already diagnosed. As such, it seems somewhat contradictory to indicate that CMHBG funds may be used for prevention but that prevention must be directed towards adults with SMI and youth with SED**. DBH prefers the original concept of a highly flexible, highly state-defined, block grant program.

[26] http://www.samhsa.gov/grants/blockgrant/docs/BGComment-Question-Log-Continuous.pdf
[27] http://www.samhsa.gov/grants/blockgrant/docs/BGComment-Question-Log-Continuous.pdf