



Behavioral Health Association of Providers

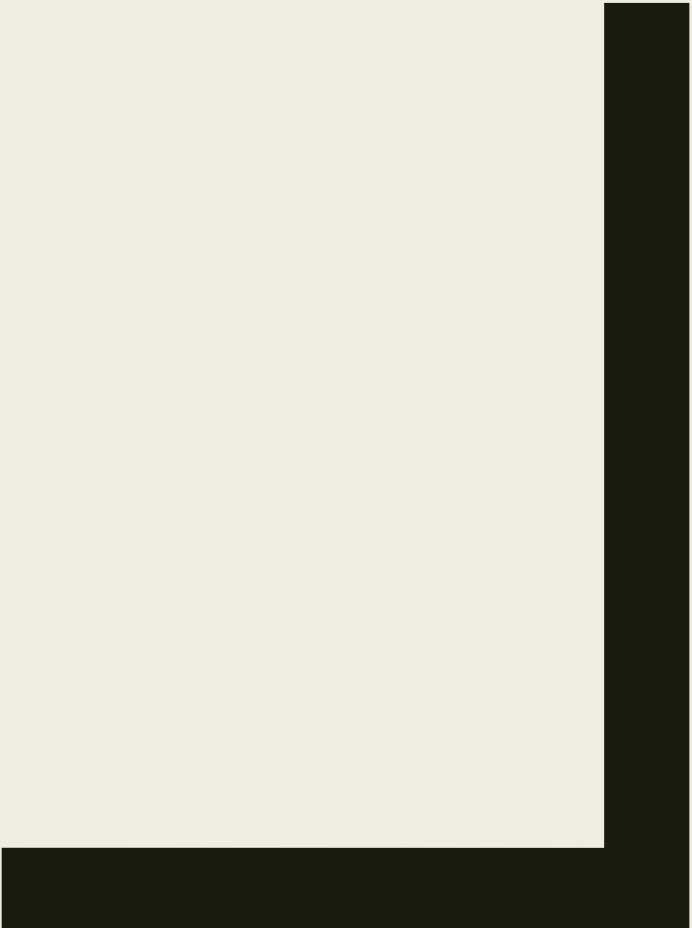
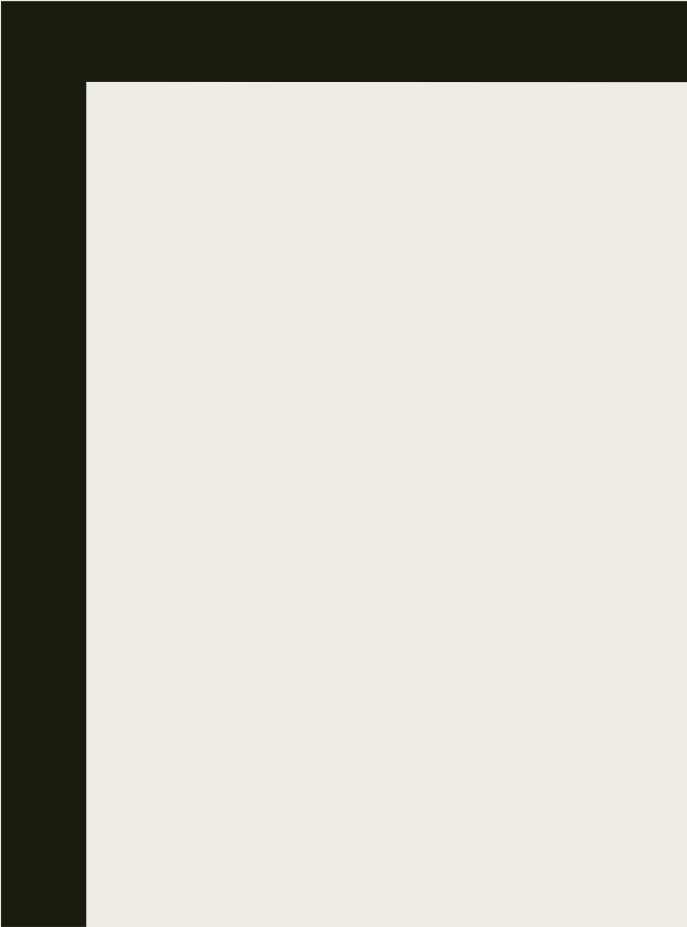
NATIONAL

MEMBERSHIP

EDUCATION

ADVOCACY

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BHAP
June 2021
Slingshot Solutions LLC
Andrew Kessler, JD

Introduction

- Andrew Kessler, JD
- Slingshot Solutions, LLC
- 26 years federal policy experience (20 in behavioral health)
- Clients Include: Faces and Voices of Recovery, IC&RC, Behavioral Health Association of Providers, California Consortium of Addiction Programs & Professionals.

Policy in a Post Covid World

- COVID-19 impact on Behavioral Health was substantial
- Not like we had all the resources we needed beforehand....

Getting back to “Normal?”

- Legislation being introduced
- White House is engaging
- Progress still moderate/slow

The Mountain to Climb

- According to the CDC, 2020 was the worst year on record for overdoses.
- We have eclipsed 90,000 deaths

Overdose

- 2019- already increasing pre pandemic. 72,000 (5% over 2018)
- 2020 provisional data- acceleration- 93,000 deaths. (29.4% increase)
- largest increase in three decades
- 3/4 involved opioid (incl fentanyl) (56k incl fentanyl)
- synthetics/illicit manufactured fentanyl (IMF) is primary driver in deaths. increasing 38% (may to may)
- cocaine increased 26.5% (linked to co use of IMF or laced with IMF)

RTI study

- Treatment initiated by patients is down 28% in California
- Justice involved populations, as well as Medicaid populations, are hit especially hard
- Individuals' reluctance to seek addiction treatment for fear of becoming infected with the virus
- Providers' inability to maintain the same volume of services because of staff shortages stemming from fear of the being infected with the virus, lack of personal protective equipment, lack of funding to implement telemedicine and hire temporary staff, and lack of residential treatment capacity to allow for social distancing.

American Rescue Act (March)

- \$1.5 billion to the SAPT block grant
- When added to the funds from the December 2020 stimulus, states will receive close to TRIPLE their block grant funding in FY 2021.
- States will have two years to spend this money, not one.

ARP Workforce provisions

- **“FUNDING FOR COMMUNITY-BASED/LOCAL BEHAVIORAL HEALTH NEEDS.”**
- \$50,000,000, to remain available until expended
- The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall award grants to State, Tribal, and territorial governments, Tribal organizations, nonprofit community-based entities, and primary and behavioral health organizations to address increased community behavioral health needs worsened by the COVID–19 public health emergency.

American Rescue Plan

- (2) USE OF GRANT FUNDS.—Grant funds awarded under this section to eligible entities may be used for promoting care coordination among local entities; **training the mental and behavioral health workforce**, relevant stakeholders, and community members; expanding evidence-based integrated models of care; **addressing surge capacity for mental and behavioral health needs**; providing mental and behavioral health services to individuals with mental health needs (including co-occurring substance use disorders) as delivered by behavioral and mental health professionals utilizing telehealth services; **and supporting, enhancing, or expanding mental and behavioral health preventive and crisis intervention services.**

American Rescue Plan

- **SEC. 3059B. FUNDING FOR BEHAVIORAL HEALTH WORKFORCE EDUCATION AND TRAINING.**
- In addition to amounts otherwise available, there is appropriated to the Secretary for fiscal year 2021, out of any money in the Treasury not otherwise appropriated, \$100,000,000, to remain available until expended, for carrying out section 756 of the Public Health Service Act (42 U.S.C. 294e-1).
- [\(accredited\)](#) professional training programs that are establishing or expanding internships or other field placement programs in mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing (which may include master's and doctoral level programs), social work, school social work, **substance use disorder prevention and treatment**, marriage and family therapy, occupational therapy, school counseling, or professional counseling, including such programs with a focus on child and adolescent mental health, trauma, and transitional-age youth;)

New Authorizations

- It requires the Secretaries of HHS, Labor, and the Treasury to request comparative analyses of at least 20 plans per year that involve potential violations of mental health parity, complaints regarding noncompliance with mental health parity, and any other instances in which the Secretaries determine appropriate.
- Section 203 requires the Secretaries of HHS, Labor, and the Treasury to publish an annual report with a summary of the comparative analyses.

CARA 3.0

- Follow up to Comprehensive Addiction Recovery Act of 2016
- A little more “comprehensive” in my book...
- Investments in treatment, recovery, prevention, criminal justice system

CARA 3.0

- Workforce
- Authorizes such sums as necessary under the Substance Abuse and Mental Health Services Administration (SAMHSA) to support training and employment opportunities in positions for substance use professionals, including peer recovery specialists.
- Authorizes \$55 million for the Health Resources Services Administration's Mental and Behavioral Health Workforce Education and Training program to retain substance use disorder professionals, with dedicated funding set aside for retention efforts.

CARA 3.0

- Establishes a pilot program through SAMHSA to address substance use disorder prevention workforce challenges. Directs SAMHSA to study existing challenges and barriers and to make recommendations.

CARA 3.0

- Recovery housing
- Requires SAMHSA, along with national accrediting entities and reputable providers of recovery housing services, to develop guidelines for states to promote the availability of high-quality recovery housing. Provides grants to states to implement these guidelines and promote high-quality housing. Requires the National Academy of Sciences to study the current availability of high-quality recovery housing, as well as make recommendations for increasing availability, improving data collection, improving inclusivity for individuals who take MAT, and report on state or local allegations or legal actions regarding the opening and operation of recovery housing.

CARA 3.0

- Creates an interagency working group, chaired by SAMHSA and the Department of Housing and Urban Development, to increase collaboration among federal agencies in promoting the availability of high-quality recovery housing. Authorizes a grant to a single organization to establish standards for recovery housing.

CARA 3.0

- Recovery investment
- Authorizes \$200 million annually to build connections between recovery support services and networks, including treatment programs, mental health providers, treatment systems, and other recovery supports. Funds may also be used on efforts to reduce stigma associated with substance use; to develop recovery wellness plans that address barriers to recovery, including social determinants of health; and to use telehealth to support recovery in rural and underserved areas.

CARA 3.0

- Authorizes \$50 million in grants to peer recovery services to provide continuing care and ongoing community support for individuals to maintain their recovery. These organizations are nonprofits that mobilize resources within and outside the recovery community to increase long-term recovery and that are wholly or principally governed by people in recovery who reflect the community served.

CARA 3.0

- Commissions a GAO study examining the reimbursement parity between substance use disorder services and other health care, and its effect on the substance use disorder workforce.

ONDCP priorities

- Expanding access to evidence-based treatment;
- Advancing racial equity issues in our approach to drug policy;
- Enhancing evidence-based harm reduction efforts;
- Supporting evidence-based prevention efforts to reduce youth substance use;
- Reducing the supply of illicit substances;
- Advancing recovery-ready workplaces and expanding the addiction workforce; and
- Expanding access to recovery support services.

Enhancing evidence-based harm reduction efforts;

- *Integrate and build linkages* between funding streams to support SSPs;
- *Explore opportunities to lift barriers* to federal funding for SSPs;
- *Identify state laws that limit access* to SSPs, naloxone, and other services;
- *Develop and evaluate the impact* of educational materials featuring evidence-based harm reduction approaches that link PWUD with harm reduction, treatment, recovery support, health and social services through a diverse range of community members, including first responders, and train law enforcement officials in evidence-based approaches that address overdose and provide police-assisted recovery;

Harm Reduction

- *Examine naloxone availability* in counties with high rates of overdose and identify opportunities to expand access in targeted areas among pharmacies, clinicians, peer support workers, family and community members, and PWUD;
- *Amplify best practices for FTS services*, standards for FTS kits, and use of FTS as a means of engagement in health care systems

Advancing recovery-ready workplaces and expanding the addiction workforce

- *Identify ways* in which the federal government can remove barriers to employment and create employment programs for people in recovery from addiction;
- *Conduct a landscape review* of existing programs, and subsequently conduct outreach to State and local governments, employers, and members of the workforce. This outreach could include offering grant opportunities that support recovery in the workplace and remove hiring and employment barriers, and providing recommendations to ensure all communities (including rural and underserved areas) have access to the programs;
- *Identify a research agenda* to examine existing recovery-ready workplaces;

- ***Request agencies to support*** training for clinicians in addiction with special emphasis on: community-based services in underserved areas, such as federally qualified health centers
- (FQHCs); the Veterans Health Administration; and the Indian Health Service;
 - o Identify authorized, evidence-based vocational programs that can expand the addiction workforce but that have not yet secured appropriations; and
 - o Explore opportunities for training bilingual immigrants who were addiction professionals in their home countries to become case managers;
- ***Produce guidelines*** for federal managers on hiring and working with people in recovery from a substance use disorder;

Expanding access to recovery support services.

- *Work with federal partners, State and local governments, and recovery housing stakeholders* to begin developing sustainability protocols for recovery housing, including certification, payment models, evidence-based practices, and technical assistance;
- *Develop interagency support* for Recovery Month activities in September; and *Engage persons with “lived experience”* in the development of drug policy.

Harm Reduction

- Rhode island
- Opened nation's first safe injection site
- All eyes on the Department of Justice, which appears to be letting it open...
- Federal funds can now be used to test Fentanyl Test Strips

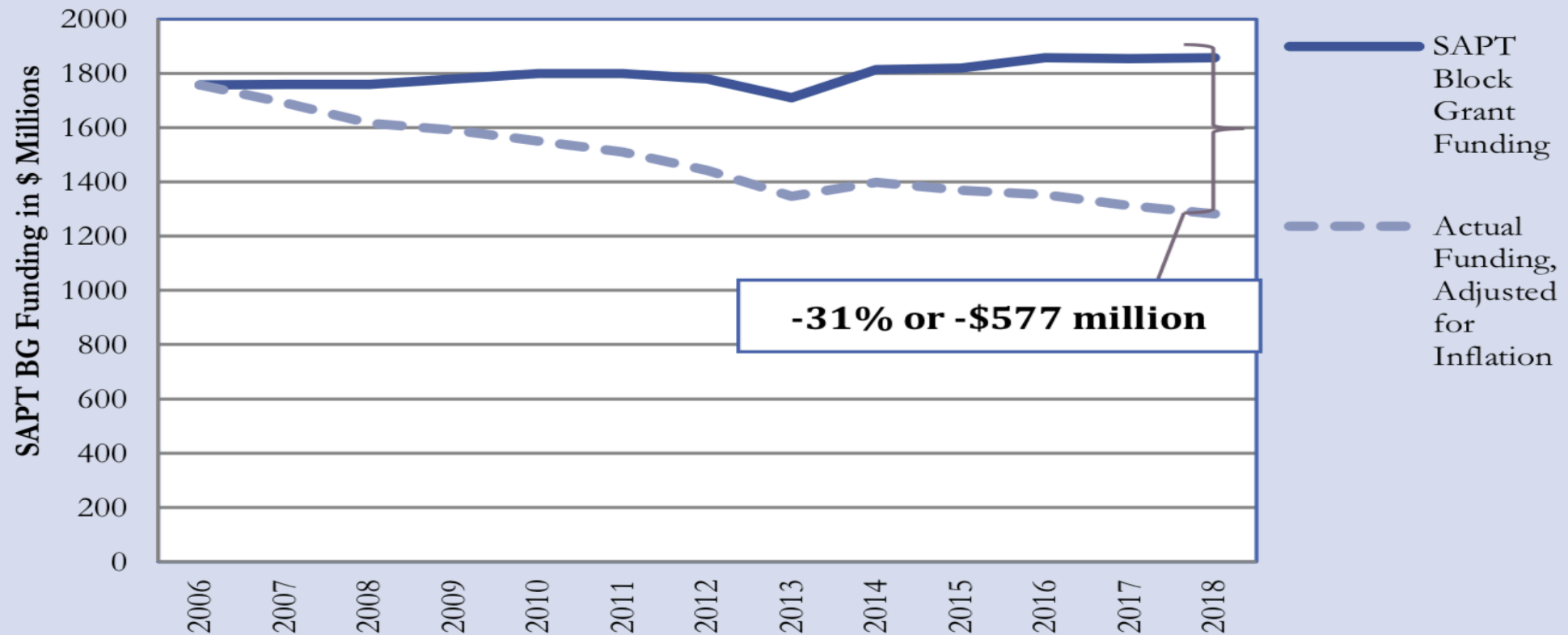
Budget

- SAMHSA
- HRSA
- CDC

FY 2022

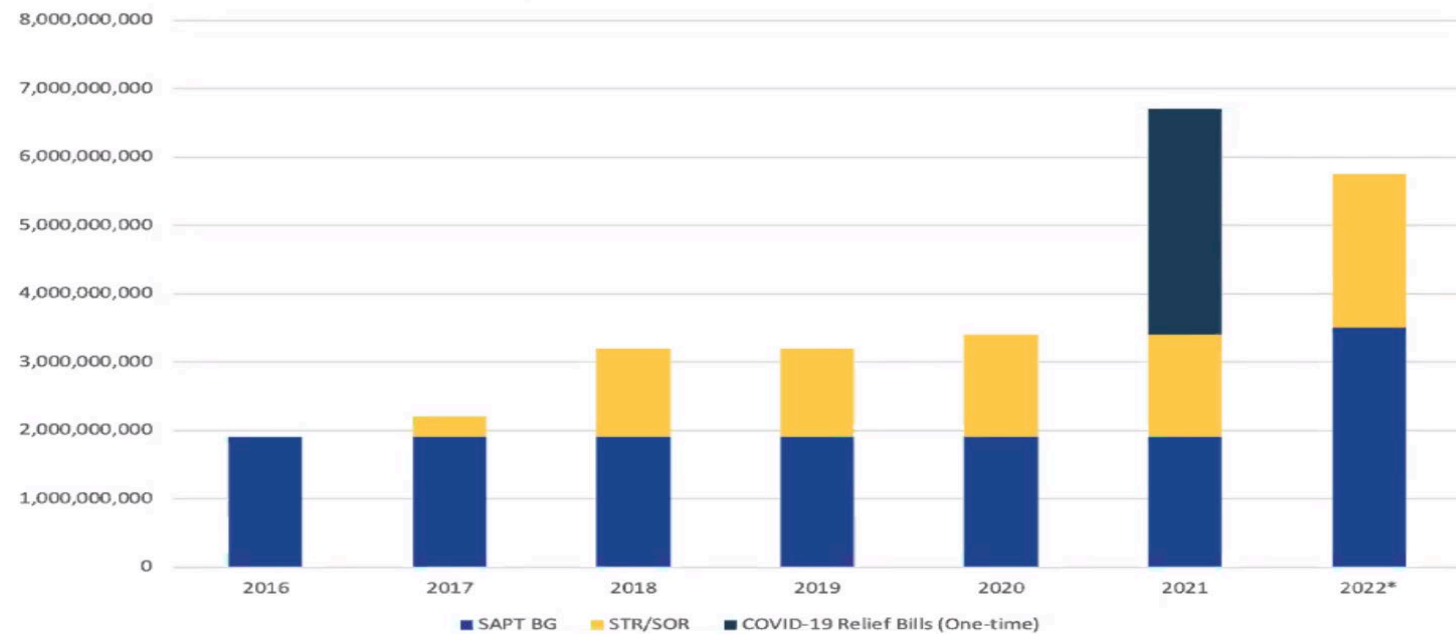
- The President recommended an increase in the SAPT block grant from \$1.8 billion to \$3.5 billion.
- The House of Representatives appropriated a final number of \$2.8 billion
- Would be the first increase in the block grant in 13 years.

SAPT Block Grant Funding: Appropriations vs. Actual, 2006-2017



Substance Use Funding Passed Through To States

SAMHSA's Single State Authority
Federal Substance Use Funding



- The White House recommended a 10% set aside in the block grant for Recovery Support Services
- The House of Representatives agreed and authorized the change
- We now turn to the Senate (this could take a while)

Recovery “Set aside”

- (1) develop local recovery community support institutions including but not limited to recovery community centers, recovery homes, and recovery schools or programs to mobilize resources within and outside of the recovery community, to increase the prevalence and quality of long-term recovery from SUD;
- (2) provide peer-based recovery coaching, individual or group supports, to individuals and families led by those with lived experience with SUD, delivered in person or using technology;
- (3) provide ancillary community-based supports necessary to sustain recovery, including access to transportation, job training, and educational services;
- (4) provide activities to reduce SUD recovery-related stigma and discrimination at the local level;
- (5) provide technical assistance to organizations principally governed by people in recovery from SUD through facilitating financing, business functions and cross-training on evidence informed practices within the recovery community.

- Funds from the recovery set-aside will support operating costs for organizations that provide above services, prioritizing those with leadership, staffing and governance structures that include representation from those identified as in long-term recovery and impacted family members who reflect the community served.

HRSA

- Workforce
- Loan repayment
- \$155 million for NHSC
- \$28 million for all SUD professionals.

Conclusions

- New White House, new priorities?
- Presents us with potential opportunity
- The impact of COVID
- The crystal ball isn't so crystal clear

Questions & Answers



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an email will be sent out in the next
few business days to access the CE quiz
coming from @bhap.us