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DEAN’S EXECUTIVE PROFESSOR
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Conflict of Interest Statement

I have no conflict of interest to disclose and no financial or other interest associated with the this presentation.

H. Westley Clark, MD, JD, MPH
Increased interest in behavioral health

Recovery
## MOST RECENT SAMHSA FUNDING TO CALIFORNIA

<table>
<thead>
<tr>
<th>Substance Abuse Prevention and Treatment Block Grant</th>
<th>$250,323,608</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Services Block Grant</td>
<td>$63,093,869</td>
</tr>
<tr>
<td>Projects for Assistance in Transition from Homelessness (PATH)</td>
<td>$8,809,000</td>
</tr>
<tr>
<td>Protection and Advocacy for Individuals with Mental Illness (PAIMI)</td>
<td>$3,156,787</td>
</tr>
<tr>
<td><strong>Subtotal of Formula Funding</strong></td>
<td><strong>$325,383,264</strong></td>
</tr>
</tbody>
</table>
## MOST RECENT SAMHSA FUNDING TO CALIFORNIA

**Discretionary Funding FY 2015/2016**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>$26,001,940</td>
</tr>
<tr>
<td>Substance Abuse Prevention</td>
<td>$10,705,273</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>$22,953,696</td>
</tr>
<tr>
<td><strong>Subtotal of Discretionary Funding</strong></td>
<td><strong>$59,660,909</strong></td>
</tr>
</tbody>
</table>

**Total Funding FY 2015/2016**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Mental Health</td>
<td>$101,061,596</td>
</tr>
<tr>
<td>Total Substance Abuse Funds</td>
<td>$283,982,577</td>
</tr>
<tr>
<td>Total Funds</td>
<td>$385,044,173</td>
</tr>
</tbody>
</table>
• Schizophrenia
• Paranoid and other psychotic disorders
• Bipolar disorders (hypomanic, manic, depressive, and mixed)
• Major depressive disorders (single episode or recurrent)
• Schizoaffective disorders (bipolar or depressive)
• Pervasive developmental disorders
• Obsessive-compulsive disorders
• Depression in childhood and adolescence
• Panic disorder
• Post traumatic stress disorders (acute, chronic, or with delayed onset)
• Bulimia Nervosa
• Anorexia Nervosa
Pending legislation at the federal level

- Comprehensive Behavioral Health and Recovery Act of 2016
- Helping Families in Mental Health Crisis Act of 2015
- The Mental Health Reform Act of 2015
- The Strengthening Mental Health in Our Communities Act
- Comprehensive Addiction and Recovery Act of 2015
MENTAL HEALTH ON THE MINDS OF CONGRESS

- S.993 - Comprehensive Justice and Mental Health Act of 2015
  - H.R.1854 — Comprehensive Justice and Mental Health Act of 2015
- S.1893 – Mental Health Awareness and Improvement Act of 2015
- S. 2173 – Improving Access to Mental Health Act of 2015
  - H.R.3712 –Improving Access to Mental Health Act
- S.2166 – Timely Mental Health for Foster Youth Act
- S.2002 – Mental Health and Safe Communities Act of 2015
  - H.R. 3722 – Mental Health and Safe Communities Act of 2015
- S.1830 – Seniors Mental Health Access Improvement Act of 2015
- S. 1588 - Mental Health in Schools Act of 2015

- H.R. 4374 - Mental Health on Campus Improvement Act
- H.R. 4277 – Medicare Mental Health Access Act of 2015
- H.R. 4080 – Veterans Mental Health Accessibility Act of 2015
- H.R. 2759 – Mental Health Access Improvement Act of 2015
  - etc-
The agreement includes a $50,000,000 increase over fiscal year 2015 for the Mental Health Block Grant program and increases the set-aside to 10 percent for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. The increase to the set-aside for serious mental illness is fully offset by the additional funds provided to the Mental Health Block Grant program.

After taking into account the offset funds for serious mental illness activities, the balance of the increase to the block grants will provide over $20,000,000 in additional funds to States and territories through their traditional formula grants.

Congress directed SAMHSA to continue its collaboration with NIMH to ensure that funds from the set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode of psychosis.
The Congress provided an additional $10,000,000 under the Project AWARE budget line for discretionary grants to communities that have recently faced civil unrest. These grants should focus on high risk youth and family populations in these communities and surrounding areas that have experienced significant exposure to trauma and can benefit from additional evidence-based violence prevention and community youth engagement programs as well as linkages to trauma-informed behavioral health services.

SAMHSA was directed to prioritize funding grants from communities that have formed partnerships between key stakeholders including State and local governments (including multiple cities and counties if impacted); public or private universities and colleges; and non-profit community- and faith-based organizations.
Assisted Outpatient Treatment in FY 2016

- The FY2016 appropriation included $15,000,000 to implement section 224 of the Protecting Access to Medicare Act of 2014 (Public Law 113-93), the Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness (AOT).

- The Congress wants the AOT program to work with families and courts to allow individuals to obtain treatment while continuing to live in their communities and homes.

- AOT has been proven to reduce the imprisonment, homelessness and emergency room visit rate among this population by 70 percent. The agreement requests a report in the fiscal year 2017 budget request on the planned uses of this $15,000,000.
Congress provided $25,000,000, an increase of $13,000,000, to expand services that address prescription drug abuse and heroin use in high-risk communities. The funding provided will increase the number of States that receive funding from 11 to 22.

SAMHSA was directed to target States with the highest rates of admissions and that have demonstrated a dramatic increase in admissions for the treatment of opioid use disorders.

The Center for Substance Abuse Treatment was directed to include as an allowable use medication-assisted treatment and other clinically appropriate services to achieve and maintain abstinence from all opioids and prioritize treatment regimens that are less susceptible to diversion for illicit purposes.
Centers for Disease Control
FY 2016

Opioid Prescription Drug Overdose...... $70,000,000

Illicit Opioid Use Risk Factors............. $5,579,000

Opioid Prescription Drug Overdose (PDO) Prevention Activity.- The agreement commends CDC for its leadership in expanding efforts combatting prescription and opioid drug overdoses. The agreement directs the CDC Director to implement these activities based on population-adjusted burden of disease criteria, including mortality data (age adjusted rate), as significant criteria when distributing funds for the State POO Prevention activities.
To keep pace with advancements in science and research, Congress directed SAMHSA to update all of its public-facing information and treatment locators such that all evidence-based innovations in:

- counseling,
- recovery support,
- and abstinence-based relapse prevention medication-assisted treatments are fully incorporated.
FY 2016 Congressional Instructions

- SAMHSA was further directed to ensure that all drug treatment court grant recipients work directly with the corresponding State substance abuse agency in the planning, implementation, and evaluation of the grant.
- SAMHSA was also directed to expand training and technical assistance to drug treatment court grant recipients to ensure evidence-based practices are fully implemented.
SAMHSA’S STRATEGIC INITIATIVES for 2015-2018 are Key Issues for the field

1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
5. Health Information Technology
6. Workforce Development

The Other Key Issue for the Field

Treatment Strategies for SMI and SUD
SAMHSA FY 2017 Key Priorities

• Engaging Individuals with Serious Mental Illness in Care
• Addressing the Opioid Public Health Crisis
• Preventing Suicide
• Maintaining the Behavioral Health Safety Net

• But Let’s Not Forget Alcohol, Marijuana, Methamphetamine and Tobacco
<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
<th>Enacted</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2012</td>
<td>$3,347</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2013</td>
<td>$3,210</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2014</td>
<td>$3,426</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2015</td>
<td>$3,439</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2016</td>
<td>$3,584</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY2017</td>
<td>$3,489</td>
<td>$590</td>
<td></td>
</tr>
</tbody>
</table>

**SAMHSA BUDGET FY 2012 – FY 2017**

(in millions of dollars)
## COMPARISON TO FY 2016 ENACTED LEVEL
(Dollars in thousands)

<table>
<thead>
<tr>
<th>Appropriation</th>
<th>Mental Health Services</th>
<th>Substance Abuse Prevention</th>
<th>Substance Abuse Treatment</th>
<th>HSPS (SA &amp; MH)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2016 Enacted Level Total</td>
<td>$1,158,928</td>
<td>$211,148</td>
<td>$2,191,885</td>
<td>$169,475</td>
<td>$3,731,436</td>
</tr>
<tr>
<td>FY 2017 Budget Request Total</td>
<td>1,273,766</td>
<td>211,148</td>
<td>2,661,348</td>
<td>175,386</td>
<td>4,321,648</td>
</tr>
<tr>
<td>FY 2017 Mandatory Funds</td>
<td><strong>115,000</strong></td>
<td><strong>-----</strong></td>
<td><strong>475,000</strong></td>
<td><strong>-----</strong></td>
<td><strong>590,000</strong></td>
</tr>
<tr>
<td>FY 2017 PHS Evaluation Funds</td>
<td>31,039</td>
<td>16,468</td>
<td>109,200</td>
<td>56,8282</td>
<td>213,585</td>
</tr>
<tr>
<td>FY 2017 Prevention &amp; Public Health Fund</td>
<td>$10,000</td>
<td><strong>-----</strong></td>
<td><strong>-----</strong></td>
<td><strong>$17,830</strong></td>
<td><strong>$27,830</strong></td>
</tr>
<tr>
<td>FY 2017 +/- FY 2016</td>
<td>+114,838</td>
<td>$-----</td>
<td>+$469,463</td>
<td>+$5,911</td>
<td>+$590,212</td>
</tr>
<tr>
<td>Activity</td>
<td>FY 2017</td>
<td>FY 2018</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 223 Expansion Centers for Medicare &amp; Medicaid Services</td>
<td>$55</td>
<td>$55</td>
<td>$110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based Early Interventions</td>
<td>115</td>
<td>115</td>
<td>230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide State Pilot Comprehensive Demos Centers for Disease Control and Prevention</td>
<td>30</td>
<td>30</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Health Service Corps Health Resources and Services Administration</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tribal Behavioral Health Indian Health Services</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$250</strong></td>
<td><strong>$250</strong></td>
<td><strong>$500</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence-based Early Interventions

- $230.0 M two-year request in mandatory funding, $115.0 M in FY 2017 and $115.0 M in FY 2018.

- This new formula grant would enable all states to establish early intervention programs, supports and services for SMI and enables states that already have programs to expand their efforts.

- Plans include a minimum of $700,000 to each state.

Part of the Department’s effort to “Engage Individuals with SMI in Care.”
Mental Health Block Grant Set-Aside

- 10% ($50.0 M) of the MH Block Grant funds must be used for evidence-based programs which intervene early in the onset of SMI.

Set-Aside for Youth in the Prodrome Phase

- Establishes a 10% set-aside ($11.9 M) in the CMHI program to focus on youth and young adults who are at clinical high risk for developing a first episode of psychosis.
Crisis Systems: +$10.0 M

• Communities will build sustainable systems to prevent and respond to behavioral health crises and ensure post-crisis follow up services.

Assisted Outpatient Treatment (AOT): $15.0 M

• Communities will test the use of AOT to reduce hospitalization, homelessness, and criminal justice involvement while improving health and social outcomes.
• Will include a robust evaluation.
<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2017</th>
<th>FY 2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Targeted Response Cooperative Agreements SAMHSA</td>
<td>$460</td>
<td>$460</td>
<td>$920</td>
</tr>
<tr>
<td>NHSC –MAT National Health Service Corps</td>
<td>25</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Cohort Monitoring and Evaluation of MAT SAMHSA</td>
<td>15</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$500</strong></td>
<td><strong>$500</strong></td>
<td><strong>$1,000</strong></td>
</tr>
</tbody>
</table>

(Dollars in millions)
State Targeted Response Cooperative Agreements: +$920.0 M

• Two-year request in mandatory funding, $460.0 M in FY 2017 and FY 2018.
• Grants to states to close the treatment gap for opioid use disorder by making medication-assisted treatment (MAT) affordable and available to people who want to achieve recovery.

Cohort Monitoring and Evaluation of MAT: +$30.0 M

• Two-year request in mandatory funding, $15.0 M in FY 2017 and FY 2018.
• Test the effectiveness of MAT programs employing different treatment modalities under real-world conditions.

These initiatives are part of the HHS’s Addressing Opioid Crisis effort.
MAT for Prescription Drug and Opioid Addiction: $50.1 M (+$25.1 M)
• Grants to states to focus on communities with high rates of opioid use disorders.

Buprenorphine-Prescribing Authority Demonstration: +$10.0 M
• A services research demonstration to test the safety and effectiveness of allowing prescribing buprenorphine by non-physician advance practice providers.
Grants to Prevent of Prescription Drug/Opioid Overdose-Related Deaths: $12.0 M

- Grants for states to purchase naloxone, equip first responders in high risk communities with this drug and training on its use.

Strategic Prevention Framework Rx: $10.0 M

- Grants to states to enhance, implement, and evaluate strategies to prevent prescription drug misuse and abuse.
Suicide Deaths

FY 2015 Funding
FY 2016 Funding
FY 2017 Funding

Funding in thousands

ADDRESSING SUICIDE ACROSS THE AGE RANGE

Suicide Deaths by Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Suicide Deaths</th>
<th>FY 2015 Funding</th>
<th>FY 2016 Funding</th>
<th>FY 2017 Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 24</td>
<td>5,511 Suicide Deaths</td>
<td>$46,903</td>
<td>$56,915</td>
<td></td>
</tr>
<tr>
<td>25+</td>
<td>37,262 Suicide Deaths</td>
<td></td>
<td></td>
<td>$30,000</td>
</tr>
</tbody>
</table>

$2,000
National Strategy for Suicide Prevention: $30.0 M (+$28.0 M)

- $30.0 M in FY 2017 to support the National Strategy for Suicide Prevention and create the Zero Suicide program.
- A comprehensive, multi-setting approach to suicide prevention that will improve identification of suicide risk, follow-up, and evidence-based interventions focused specifically on preventing suicide.
- Focuses on prevention within health systems, and among a population at highest risk.
Community Mental Health Services Block Grant (MHBG): $532.6 M

- SAMHSA proposes to maintain the 10 percent set-aside for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.

Substance Abuse Prevention and Treatment Block Grant (SABG): $1.9 B

- SABG funds support services not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance abuse prevention and treatment service systems.
Peer Professional Workforce Development: +$10.0 M

- A new Peer Professional Workforce Development program, providing tuition support and furthering the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs.

Pregnant and Postpartum Women (PPW) Demonstration

- Proposes a new PPW 25% set-aside to explore strategies to serve more women and families in outpatient settings and provide flexibility in services provided.
DOES THE USE OF MANDATORY FUNDING MEAN PLAYING POLITICAL FOOTBALL WITH BEHAVIORAL HEALTH IN THE FY 2017 BUDGET

SHOW US THE MONEY!!!
Youth Violence Prevention: $0.0 M ($-23.1 M)

- Reallocates funding to Project AWARE and continues to bring to scale activities, practices, and lessons learned from Safe Schools/Health Students.

Primary and Behavioral Health Care Integration: $26.0 M ($-23.9 M)

- Continues to support the coordination and integration of primary care services into publicly funded community behavioral health settings and will not result in the termination of any existing grants.
Screening, Brief Intervention and Referral to Treatment (SBIRT): $30.0 M (-$16.9 M)

- Continues to provide grants for alcohol and drug screening and support early intervention to reduce the number of individuals who misuse drugs and alcohol.

Criminal Justice Activities: $61.9 M (-$16.1 M)

- Continues to provide comprehensive treatment and recovery support services for adolescents and adults with substance use disorders who come into contact with the criminal justice system, as well as offenders re-entering the community.

Treatment Systems for Homeless: $36.4 M (-$4.9 M)

- Plans to support annual Cooperative Agreements to Benefit Homeless Individuals for States-Enhancement and Grants for the Benefit of Homeless Individuals. Will not result in termination of any existing grants.
Federal Budget Spending

- Mandatory Programs - 60%
- Discretionary Programs - 33.5%
- Interest on National Debt – 6.5%
WHAT IN THE HECK IS MANDATORY SPENDING?

• Mandatory spending funds U.S. Federal programs that have already been established by Congress under so-called authorization laws. These laws both establish the federal programs, and mandate that Congress must appropriate whatever funds are needed to keep the programs running.

• Congress cannot reduce the funding for these programs without changing the authorization law itself.

• Funding can't be changed without an act of Congress. Some authorization laws provide direct spending to recipients. These include the major entitlement programs, such as Social Security, Medicare and Medicaid. Almost all of them are permanent, but there are exceptions. For example, the Food Stamp program requires periodic renewal.

http://useconomy.about.com/od/glossary/g/mandatory_spend.htm
STILL, WE’RE IN THE GAME
Medicaid Expansion states (as of January 2016)

http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/
Essential Health Benefits & the ACA

• Ambulatory patient services;
• Emergency services;
• Hospitalization;
• Maternity and newborn care;
• Mental health and substance use disorder services, including behavioral health treatment;
• Prescription drugs;
• Rehabilitative and habilitative services and devices;
• Laboratory services;
• Preventive and wellness services and chronic disease management;
• Pediatric services, including oral and vision care.

https://www.healthcare.gov/glossary/essential-health-benefits/
INTEGRATED CARE

SYNERGIES

HEALTH

SMARTCARE

SOCIAL

Wellbeing
treatment
accessing care
Policymakers
vulnerable groups
informal care
fragmentation
linksICT
Active and Healthy Ageing
Electronics health record
closing the gap
nurses
management
savings
rehabilitation
regional systems
individuals
challenges
Response
services
diagnosis
patient needs
illness
E-health
The thrust of the ACA is towards integration of care. By incentivizing such approaches as health homes, patient-centered medical homes and accountable care organizations, the ACA’s emphasis on integration is clear. Increased coordination between primary care and behavioral health treatment providers is implicitly encouraged.

Christina Andrews et al, Health Affairs, 2015
Depression May Increase Risk of Heart Disease, Stroke In Older Adults

http://www.psychiatryadvisor.com/mood-disorders/depression-depressive-symptoms-older-adults-increase-risk-heart-disease-stroke/article/470585/?DCMP=EMC-A_Update&cpn=psych_md&hmSubId=k5_h99F0uHQ1&NID=&&spMailingID=13640659&spUserID=MTY2Nzc0MDI5N%DY0S0&spJobID=720155212&spReportId=NzIwMTU1MjEyS0
The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Commonly used depression screening instruments include the Patient Health Questionnaire (PHQ) in various forms and the Hospital Anxiety and Depression Scales in adults, the Geriatric Depression Scale in older adults, and the Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women. All positive screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems (eg, anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions.
Percent of Women Ages 18 and Older Reporting Fair or Poor Health Status, by Race/Ethnicity, 2012-2014, California

- All Women: 19%
- White: 13%
- Black: 23%
- Hispanic: 31%

Note: "NSD" - not sufficient data.
Source: Kaiser Family Foundation, State Health Facts. Analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System 2012-2014 survey results
Percent of Women Ages 18 and Older Reporting Poor Mental Health Status, by Race/Ethnicity, 2012-2014, California

- All Women: 41%
- White: 42%
- Black: 43%
- Hispanic: 41%

Note: "NSD" - not sufficient data.
Source: Kaiser Family Foundation, State Health Facts. Analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System 2012-2014 survey results
CHANGES TO 42 CFR PART 2 HAVE BEEN PROPOSED BY SAMHSA

Promote Access to Treatment

Reduce Stigma

Confidentiality

Nurture the Doctor-Patient Relationship

Core Values of 42 CFR, Part 2
HHS is proposing to modernize the existing rules because new models are
- built on a foundation of information sharing to support coordination of patient care;
- the development of an electronic infrastructure for managing and exchanging patient data; and
- an increased focus on performance measurement and quality improvement within the health care system.

http://www.hhs.gov/about/news/2016/02/05/hhs-proposes-changes-to-rules-governing-confidentiality-substance-use-disorder-records.html
“The concern is that handing a patient a general consent form would become a de facto standard. These people will be presented this consent form at their weakest, where they're suffering and at their most vulnerable. It's an effort that appears to preserve the patient's right, when in practice, it sets up a process to ignore it.”

Jim Pyles, an expert on 42 CFR Part 2 to Joseph Conn

http://www.modernhealthcare.com/article/20160205/NEWS/160209897
“SAMHSA strives to facilitate information exchange within new health care models while addressing the legitimate privacy concerns of patients seeking treatment for a substance use disorder. These concerns include: The potential for loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration.”

GUN VIOLENCE AND GUN CONTROL: A Behavioral Health Issue

NOT A SECOND AMENDMENT ISSUE
CDC Report on Number of Deaths from Firearms in 2013

<table>
<thead>
<tr>
<th>Cause of Death in 2013</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Discharge of Firearms</td>
<td>505</td>
</tr>
<tr>
<td>Suicide by Firearm</td>
<td>21,175</td>
</tr>
<tr>
<td>Homicide by Firearm</td>
<td>11,208</td>
</tr>
<tr>
<td>Undetermined Intent by Firearm</td>
<td>281</td>
</tr>
<tr>
<td>Total Deaths by Firearm</td>
<td>33,169</td>
</tr>
</tbody>
</table>

- 33.8% of Firearm Deaths in 2013 due to homicide
- 63.8% of Firearm Deaths in 2013 due to Suicide

http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf
Of gun homicide victims are black

Black men are 10 TIMES MORE LIKELY to be shot and killed than white men

Black women are more than 3 TIMES MORE LIKELY to be shot and killed than white women
Of gun suicide victims are white

White men are **3 TIMES MORE LIKELY** to be shoot and kill themselves than black men

White women are more than **4 TIMES MORE LIKELY** to shoot and **kill themselves** than black women
Federal Behavioral Health Categories of Persons Prohibited From Receiving Guns

• An unlawful user and/or an addict of any controlled substance; for example, a person convicted for the use or possession of a controlled substance within the past year; or a person with multiple arrests for the use or possession of a controlled substance within the past five years with the most recent arrest occurring within the past year; or a person found through a drug test to use a controlled substance unlawfully, provided the test was administered within the past year.

https://www.fbi.gov/about-us/cjis/nics/nics
Federal Behavioral Health Categories of Persons Prohibited From Receiving Guns

- A person adjudicated mental defective or involuntarily committed to a mental institution or incompetent to handle own affairs, including dispositions to criminal charges of found not guilty by reason of insanity or found incompetent to stand trial

https://www.fbi.gov/about-us/cjis/nics/nics
New Executive Actions to Reduce Gun Violence

• Keep guns out of the wrong hands through background checks
• Increase the number of ATF agents and investigators to enforce gun laws
• Use the Internet Investigation Center to track illegal online firearm sales
• Increase mental health treatment and reporting to the background check system
• Conduct or sponsor research into gun safety technology

Increase Mental Health Treatment and Reporting to the Background Check System

• Include information from the Social Security Administration in the background check system about beneficiaries who are prohibited from possessing a firearm
  • Approximately 75,000 people receiving disability benefits who have a documented mental health issue and are unable to manage those benefits because of their mental impairment or who have been found by a state or federal court to be legally incompetent will have their records reviewed for transmittal to the Department of Justice NICS

• The Department of Health and Human Services issued a final rule expressly permitting certain HIPAA covered entities to provide to the NICS limited demographic and other necessary information about individuals who are prohibited from possessing or receiving a gun for specific mental health reasons

As sung by Elvis Presley
The public behavioral health system is changing under your stewardship.

Recovery principles and social justice in the access by, and delivering care to, persons experiencing behavioral health issues in California will be influenced by principles of accountability, efficiency and effectiveness.
TOOLS USED TO MANAGE QUALITY AND COST

• Benefit Design
• Provider Networks (credentialing; size of network; control over network vs hospital monopolies
• Tiered Services and “Fail First”
• Prior Authorization vs. Post-Service Determination
• Random and Targeted Audits
• Special Investigation Unit for Fraud, Waste and Abuse (FWA)
• Data Gathering for Quality Metrics

Kelly J. Clark, MD, MBA, “The Card in Your Wallet”
Since 2010, the U.S. Department of Health & Human Services, Office of Inspector General (HHS OIG), the Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Justice (DOJ) have been using powerful, new anti-fraud tools to protect Medicare and Medicaid by shifting beyond a “pay and chase” approach toward fraud prevention.

Through the groundbreaking Healthcare Fraud Prevention Partnership, stronger relationships have been built between the government and private sector to help protect all consumers.

In Fiscal Year (FY) 2014, the government recovered $3.3 billion as a result of health care fraud judgments, settlements and additional administrative impositions in health care fraud cases and proceedings.
Individual and community problems related to behavioral health must be addressed by the whole community, including: people experiencing behavioral health problems, the health care delivery system, family members, public health, community health, the faith community, law enforcement, social services, housing authorities, transportation authorities, child welfare, recreation, employers, advocates and our education systems.
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