Study Finds Naloxone Administration in Emergency Medical Services Increased 75 Percent from 2012 to 2016, Mirroring an 80 Percent Increase in Opioid Overdoses

An analysis published August 9 in the Morbidity and Mortality Weekly Report of the Centers for Disease Control and Prevention (CDC) reveals that naloxone administration in emergency medical services (EMS) increased 75.1 percent per 100,000 EMS events from 2012 to 2016, mirroring an age-adjusted increase in opioid overdose deaths of 79.7 percent over that same time period.

Researcher Rebecca E. Cash, MPH, of the National Registry of Emergency Technicians and colleagues from the National Highway Traffic Safety Administration, the Association of Schools and Programs of Public Health, The Ohio State University Wexner Medical Center, and the CDC compared data from the National Emergency Medical Services Information System (NEMSIS) with data from the National Vital Statistics System’s multiple cause-of-death mortality files. During the 2012–2016 time period, the rate of EMS naloxone administration events increased from 573.6 to 1004.4 administrations per 100,000 EMS events, while there was an increase in opioid overdose mortality from 7.4 deaths per 100,000 persons to 13.3 deaths per 100,000.

The researchers also found the age distribution of patients receiving naloxone from EMS paralleled a similar age distribution of deaths, with persons aged 25 to 34 years and 45 to 54 years most affected. In 2012, a larger proportion of naloxone administration events occurred among persons aged 45 to 54 years (19.8 percent, 18,049) than among persons aged 25 to 34 years (17.2 percent, 15,686). By 2016, this finding had reversed, and a larger proportion of naloxone administration events occurred among persons aged 25 to 34 years (21.2 percent, 35,179) than among persons aged 45 to 54 years (17.7 percent, 29,491). A similar bimodal age distribution was identified in opioid overdose deaths from 2012 to 2016.

Approximately 10,000 EMS agencies and 49 U.S. states and territories contribute data to the NEMSIS Database. EMS naloxone administration events were defined by the researchers as the administration of at least 1 naloxone dose during EMS patient care. EMS events considered in the study included 9-1-1 responses, responses during special event coverage, and provision of care by EMS crew in an ambulance intercept or during mutual aid to another ambulance response. Those events in which opioids were administered by the EMS crew, where no patient was found by the responding EMS crew, or where the event was a medical transport or interfacility transfer were excluded. Because the focus of the study was on rates of naloxone administration events as a proxy to opioid overdoses, rather than severity of overdoses, multiple naloxone dosing was not considered.

The researchers suggest that evaluating and monitoring nonfatal overdose events using EMS data might assist in the development of timely interventions to address the evolving opioid crisis. However, they warn that an accurate estimate of the complete injury burden of the opioid epidemic requires assessing nonfatal overdoses in addition to deaths.

**Opioid Use Disorders Among Pregnant Women in Delivery More than Quadrupled from 1999 to 2014**

National opioid use disorder rates among pregnant women presenting at hospitals for delivery more than quadrupled from 1999 to 2014, from 1.5 per 1,000 delivery hospitalizations to 6.5 per 1,000.

Rates significantly increased in all 28 states studied by Sarah C. Haight, MPH of the CDC’s Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion and her fellow researchers. The average annual rate increase was lowest in California (0.01 per 1,000 delivery hospitalizations per year), whereas rate increases in Maine, New Mexico, Vermont, and West Virginia exceeded 2.5 per 1,000 deliveries per year. In 2014, rates ranged from 0.7 (District of Columbia) to 48.6 (Vermont).

The researchers analyzed hospital discharge data from the 1999–2014 Healthcare Cost and Utilization Project (HCUP) to describe U.S. national and state-specific trends in opioid use disorder documented at delivery hospitalization. Data were analyzed from the National Inpatient Sample (NIS; 1999–2014) and the State Inpatient Databases (SID; 1999–2014) of HCUP. NIS approximates a 20 percent stratified sample of all U.S. community hospital discharges participating in HCUP and is weighted to be nationally representative. The annual number of in-hospital delivery discharges were identified from the 1999–2014 NIS and SID files using International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic and procedure codes pertaining to obstetric delivery (2). Cases of opioid use disorder were identified from ICD-9 diagnoses of opioid dependence and nondependent opioid abuse, aligning with Diagnostic and Statistical Manual-5 criteria.
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#### 2017 NASMHPD TECHNICAL ASSISTANCE COALITION WORKING PAPERS – BEYOND BEDS

- August 15-17 National Association of State Health Policy Conference
- September 6 Medicaid IAP Webinar: Using Data Analytics to Better Understand Medicaid Populations with Serious Mental Illness
- TA Network Webinars
- Call for Presentations for November 1 through 3 National Federation of Families for Children’s Mental Health Conference
- SAMHSA Funding Opportunity Announcement – Center for Eating Disorders
- HRSA Funding Opportunity Announcement: Pediatric Mental Health Care Access Program
- SAMHSA Funding Opportunity Announcement; State Opioid Response Grants
- SAMHSA Funding Opportunity Announcement; Tribal Opioid Response Grants
- Technical Assistance on Preventing the Use of Restraints and Seclusion
- Technical Assistance Opportunities for State Mental Health Authorities
- New SAMHSA-Sponsored CME Course: Clozapine as a Tool in Mental Health Recovery
- NADD Nominations Sought by August 31 for Annual Awards
- SAMHSA-Sponsored Recovery to Practice Two-Part Initiative on Recovery-Oriented Use of Medications
- NASMHPD Board & Staff NASMHPD Links of Interest
Become a Mental Health First Aid Instructor With National Council

As a trained Mental Health First Aider, you know that one 8-hour course can make a world of difference when it comes to improving the way we understand and respond to people with mental health and substance use problems.

Now, we’re inviting you to take your passion for Mental Health First Aid one step further – apply to become a Youth Mental Health First Aid Instructor in Philadelphia!

From August 27 – 29, you can become certified to teach the Youth Mental Health First Aid course in your community, giving more people the skills they need to reach out and offer support to a young person who may desperately need it.

Thank you for your dedication to helping others, and for spreading the Mental Health First Aid movement in your community.

Please send questions to: MHFAinfo@TheNationalCouncil.org or call 1-888-244-8980.

APPLY TODAY
SEATS ARE LIMITED

Join the Recovery LIVE! Virtual Event: Implementing Best Practices and Quality Standards in Recovery Housing
Thursday, August 23, 2:00 p.m. to 3:00 p.m. E.T.

Join SAMHSA’s Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) for a Recovery LIVE! virtual event on best practices and quality standards in recovery housing. A growing body of research supports the effectiveness of recovery housing in sustaining abstinence and promoting long-term recovery for individuals with substance use disorders and co-occurring mental illness and substance use disorders. The National Alliance for Recovery Residences has developed guidelines to define levels of care and standards of quality as part of its ongoing efforts to improve access to high-quality recovery housing across the United States.

During this webinar, presenters will:
- Provide an overview of the National Alliance for Recovery Residences’ national standards for recovery housing.
- Describe how the field is evolving to implement best practices.
- Discuss the challenges and successes for recovery housing operators.

REGISTER HERE FOR THE RECOVERY HOUSING WEBINAR
Study Finds Presence of Child with Risk of Self Harm in the Home Does Not Make Gun Owners More Likely to Engage in Recommended Safe Storage Measures

Only one-third of homes where children with a history of self-harm risk factors reside practice safe firearm storage, according to a recent study published online in the March 2018 issue of Pediatrics.

Lead researcher, Matthew Miller, MD, ScD, of Northeastern University, and colleagues found that households having a child or adolescent with a history of self-harm risk factors, such as mental health conditions (depression, attention-deficit/hyperactivity disorder, etc.), did not impact household decision-making among respondents regarding the storing of firearms safely (locked and unloaded), as first recommended by the American Academy of Pediatrics in 1992.

Firearms accounted for 40 percent of all suicides among children and adolescents ages 10 to 17 in 2015, with many of those children and adolescents struggling with a mental health condition.

The authors conducted a nationally representative on-line survey of 55,000 U.S. adults in 2015 to study households with firearms to determine if having children with a known mental health condition influenced the use of firearm safety storage practices. The respondents were asked to self-report: (1) if they lived with a dependent and were a caretaker or primary decision-maker for a dependent; (2) if the dependent had a history of self-harm risk factors including depression, mental health conditions other than depression, or attention deficit hyperactivity disorder; (3) if they owned a gun in the house; and (4) if they did own a gun, their firearm storage practices.

The authors found that firearms were present in 43.5 percent of households with children or adolescents (n=52) who had a known history of self-harm risk factors in contrast to 42.3 percent of households where children or adolescents (n=411) did not have a diagnosis of self-harm risk factors.

Of the parents/caretakers with a firearm in the household, 34.9 percent reported storing all guns locked and unloaded if they had dependents with a history of self-harm risk factors. In contrast, 31.8 percent of households who reported having children or adolescents with no known history of self-harm risk factors properly stored their guns.

The authors conclude that the presence of a child or adolescent in the household, regardless of whether the child or adolescent has a history of having a mental health condition, makes no significant difference in a parent/s/caretaker’s decisions whether to have firearms in the home or follow the proper firearm storage practices recommended more than 25 years ago by the American Academy of Pediatrics.

Given the prevalence of household ownership of firearms in the United States, and with two-thirds of households not properly storing guns, the conclusion is warranted that further education and outreach on firearm safety practices would be appropriate to reduce the risk among children and adolescents of fatal firearm injuries such as suicide.
A Two-Part SAMHSA-Sponsored Webinar

Securing and Using the Right Data to Improve Your State’s Mental Health Block Grant Application

Tuesday, August 21 (Part I) and Monday, August 27 (Part II), Both 12:30 p.m. to 2:00 p.m. E.T.

Developed under the Technical Assistance Coalition Contract by the National Association of State Mental Health Program Directors

Over the past few years, the National Association of State Mental Health Program Directors (NASMHPD) has seen a rapid turnover of State Mental Health Authority (SMHA) staff who collaboratively work on the Mental Health Block Grant (MHBG), in particular state planners and state data staff. This two-part series will define and underscore the importance of the relationship between the block grant planner and the state data manager/staff. A brief history of the Mental Health Block Grant, the Data Infrastructure Grant, and the Uniform Reporting System sets the context for the importance of each aspect of block grant planning. The presenters will review the required data elements for the MHBG and for the Annual Report following the structure of the WebBGAS. While the current requirements will be reviewed, it will be emphasized that these elements most likely will change over time and that the mutual understanding of the parameters within which the planner and the data manager work is the essential element of success for both the block grant planner and the data manager. Examples of how the interaction between the planner and the data manager enhance the planning process both specific to the block grant and in general will be cited. The target audience is block grant planners and data managers, particularly those who are relatively new to the process. An expected outcome is an increased understanding of and appreciation of the respective roles and responsibilities and how to make the relationship successful for both parties. In addition, viewers will gain a better understanding of history of the block grant, block grant requirements and guidance of how to more efficiently organize their state’s application.

Presenters:

- Molly Brooms, retired State Planner of the Alabama Department of Mental Health
- Melanie Harrison, Retired Chief Information Officer and IT Director of the Alabama Department of Mental Health
- Steven Dettwyler, Ph.D., SAMHSA Public Health Analyst and State Project Officer

Register HERE for Part I (August 21)  Register HERE for Part II (August 27)

We do not offer CEU credits. However, letters of attendance are offered on request. Closed-captioning is available for this webinar.

If you have any questions, please contact Kelle Masten via email or at 703-682-5187.

Virtual Meeting Co-Sponsored by the Medicaid and CHIP Coverage Learning Collaborative (MACLC) and the National Association of Medicaid Directors (NAMD)

The Role of Medicaid and CHIP in Responding to Public Health Crises & Disasters

Monday, August 13, 2:00 p.m. to 3:30 p.m. E.T.

Medicaid and CHIP have played a critical role in helping states and Territories respond to major public health crises and natural disasters such as hurricanes, flooding, and wildfires. To help Medicaid/CHIP agencies prepare for such crises and disasters, the MACLC Coverage Learning Collaborative and NAMD have developed a set of complementary tools that describe strategies available to support operations and enrollees in times of crisis.

In this all-state virtual meeting, we will: review the role of Medicaid and CHIP in responding to public health crises and disasters; provide an overview of disaster-related legal authorities; describe examples of strategies that states and Territories may leverage to respond to specific disaster-related problems; and walk-through a series of NAMD-developed operational checklists that support states and Territories pre-, during, and post-disasters. We will also hear from Medicaid leadership in Florida and Texas who will describe their on-the-ground experiences responding to Hurricanes Irma and Harvey.

Finally, we plan to provide a review of the following available tools designed to support states and Territories:

- MACLC Learning Collaborative memorandum that provides a high-level summary of the types of Medicaid and CHIP strategies states and Territories can deploy;
- MACLC Learning Collaborative companion inventory that describes in more granular detail the various strategies available to states and Territories and the action needed to effectuate them; and
- NAMD Disaster toolkit: "Leading through Emergencies: A Toolkit for Medicaid."

For more information about the session, contact MACLC@mathematica-mpr.com.

Register HERE
What’s Needed to Take Patient-Centered Measurement to the Next Level?

**Thursday, August 16, 1:00 p.m. to 2:00 p.m. E.T.**

Join the National Quality Forum on **Thursday, August 16** to learn about challenges and opportunities to improve patient-centered measurement with a particular emphasis on shared decision-making and health equity. A panel of experts will explore the roles of diverse stakeholders in advancing patient-centered measurement, examine challenges to ensuring representativeness in performance measurement, and discuss opportunities to enhance patient-provider relationships through patient-centered measurement:

- Jennifer Hale, MSN, VP of Quality and Standards, Compassus
- David Hoy, Patient Partner and Chief Operating Officer, PFCCpartners
- David Lansky, PhD, President and CEO, Pacific Business Group on Health
- Edison Machado, MD, MBA, Chief Quality Officer and Vice President of Strategic Planning, IPRO
- David White, Patient Partner, National Committee for Quality Assurance
- Tracy Spinks, BBA, Senior Director of Quality Innovation, National Quality Forum

**Register HERE!**

The National Quality Forum (NQF) is committed through its Measure Incubator® to foster learning and improvement in the measure development process. As part of this work, NQF launched the **2017-2018 Learning Collaborative Patient-Centered Measurement Webinar Series** to promote formal principles and share real-world experiences to accelerate progress toward patient-centered measure development. To-date, NQF’s **Learning Collaborative** has hosted five webinars within this series with nearly 1100 unique attendees. The August webinar is the final webinar of the 2017-2018 series. In case you missed it, you can access recordings and materials from previous webinars online.

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**CENTER FOR TRAUMA-INFORMED CARE**

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education.

**August Trainings**

**Arizona**

- 27 & 28 - Community Medical Services, Tempe
- 29 & 30 - Salt River Pima-Maricopa Indian Community, Scottsdale
- 31 - University of Arizona, Tucson

**Florida**

- 20 & 21 - Orange County Health Services Department, Ryan White Part A Program, Orlando
- 22 & 23 - Polk County Board of County Commissioners, Health & Human Services Division, Bartow

**Georgia**

- 28 - WellCare Health Plans, Atlanta

**New Jersey**

- 21 & 22 - Ann Klein Forensic Center, West Trenton
- 14 & 15 - Alliance for Positive Health, Albany

**Wisconsin**

- 21 & 22 - Adult Care Consultants, Inc., Menasha

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.
AHRQ Review of Treatments for Bipolar Disorder in Adults Finds Cognitive Behavioral Therapy No Better than Other Psychotherapies for Improving Acute Symptoms

A report issued August 7 by the Federal Agency for Healthcare Research and Quality assesses the effectiveness of drug and nondrug therapies for treating acute mania or depression symptoms and preventing relapse in adults with bipolar disorder (BD) diagnoses, including BD-I, BD-2, and BD-Not Otherwise Specified (BD-NOS).

Among the findings of the researchers engaged in the project, which involved a systematic review of 188 studies published through May 2017, were:

- Lithium, asenapine, cariprazine, olanzapine, quetiapine, risperidone, and ziprasidone may modestly improve acute mania symptoms in adults with BD-I.
- Participants on atypical antipsychotics, except for quetiapine, reported more extrapyramidal symptoms (e.g., dyskinesia), and those on olanzapine reported more weight gain, compared with placebos.
- However, when used in maintenance treatment, lithium may prevent relapse into acute episodes in adults with bipolar disorder.
- Evidence was insufficient for drug treatments for depressive episodes in adults with BD-I and BD-II.
- For adults with any bipolar disorder type, cognitive behavioral therapy may be no better than other psychotherapies for improving acute bipolar symptoms and systematic/collaborative care may be no better than other behavioral therapies for preventing relapse of acute symptoms.

The researchers admit that stronger conclusions were prevented by high rates of participants dropping out of the various studies. The AHRQ researchers offer the caveat that they found no high- or moderate-strength evidence for any intervention effectively treating any type of bipolar disorder compared to placebo or an active comparator. They say they did find scattered evidence for some drug interventions that were assessed as low-strength for adults with BD-I, but none for adults with BD-II or BD-NOS. However, most manic symptom improvements were of modest clinical significance, with values that were less than the minimally important difference (MID), but still large enough that a reasonable proportion of participants likely received a benefit.

They also note that the study excludes the effectiveness of botanicals and nutritional supplements which patients may take on their own for symptom relief.

In the background for the study, the AHRQ report calls bipolar disorder a significant individual and societal burden. It notes that recurrent episodes of mania and depression can cause serious impairments in functioning, such as erratic work performance, increased divorce rates, and psychosocial morbidity. People with bipolar disorder account for between 3 and 14 percent of all suicides, and about 25 percent of bipolar disorder patients will attempt suicide.

Further adding to the individual illness burden, according to the AHRQ, is that 92 percent of individuals with bipolar disorder experience another co-occurring psychiatric illness during their lifetime. Of all psychiatric conditions, bipolar disorder is the most likely to co-occur with alcohol or drug abuse disorders.

Included in the AHRQ review were randomized controlled trials and prospective cohorts with comparators enrolling adults with bipolar disorder of any type with follow-up of three weeks for acute mania, three months for depression, and six months for maintenance treatments. The researchers excluded studies with greater than 50 percent attrition rates (with the exception of maintenance studies with time-to-relapse and withdrawal outcomes) because of potential systematic differences between patients who did not complete their study and those who did—that is, where attrition might not have been random and/or was likely due to the disorder or treatment-relevant factors.

CMS Proposes to Limit No-Risk ACOs under the Medicare Shared Savings Program

The Centers for Medicare and Medicaid Services (CMS) on August 9 issued a proposed regulation redesigning the Medicare Shared Savings Program structure of the Accountable Care Organizations (ACOs) under which 10.5 million Medicare beneficiaries are enrolled.

Under the proposed rule, the amount of time that an ACO could remain in the program without taking on risk would be reduced to—at most—two years. Under the existing MSSP rules, ACOs have up to six years to join the second or third MSSP tracks which require them to take on risk for spending over benchmarks.

According to CMS, the Affordable Care Act-created program has shown increases in net spending, in part because 82 percent of ACOs—460 of the 561 ACOs currently operating—are operating under Track 1, under which eligible ACOs receive a share of any savings under their established benchmark, but are not required to pay back a share of spending over the benchmark.

CMS is proposing a six-month extension for current ACOs whose agreements expire at the end of 2018, along with a special one-time July 1, 2019, start date that will have a spring 2019 application period for the new participation options.

ACOs are currently evaluated based on their performance, as well as their improvement on various metrics that include how highly patients rate their doctors, how well clinicians communicate, whether patients are screened for high blood pressure, and their use of electronic health records.

The proposed rule would promote interoperability, population management, and patient control of their medical data, and improve information-sharing on such factors as opioid use, by requiring that ACOs adopt the 2015 edition of Certified EHR Technology. However, as part of the Administration’s Patients Over Paperwork initiative to reduce provider burden, the proposal would streamline the measures that ACOs are required to report, to ensure that all measures have a meaningful impact on patient care.

In addition, the proposed regulations would allow ACOs under two-sided risk to establish CMS-approved beneficiary incentive programs, through which an ACO would provide incentive payments to assigned beneficiaries who receive qualifying primary care services.

Comments are due within 60 days of official publication in the August 17 Federal Register.
Are you a consumer of behavioral health services, but are sometimes challenged to access them? Do you live in a remote area? How can you find a qualified online therapist? How do you make sure your private information remains confidential?

Consumers of behavioral health services, especially those in sparsely-populated regions or those who have difficulty getting to a provider, should become aware of how this technology can improve access to care. Webinar participants will learn what kinds of issues can be safely addressed by an online therapist, how they can find a qualified online therapist, how to ensure the information they share remains confidential, and what they can expect to pay for a good online therapist.

Register HERE

Webinar 2 – Telebehavioral Health – What Every Provider Needs to Know

Tuesday August 21, 2:00 p.m. to 3:00 p.m. E.T.

Are you a provider of behavioral health services, but are interested in expanding to telebehavioral health? Do you already use telebehavioral health but are unsure of some of the legal, ethical or technical issues?

As telebehavioral health becomes more widespread, providers will need to become aware of several issues that govern the successful provision of online services. Webinar participants will learn about the important legal issues that relate to telehealth (e.g., licensure, informed consent, privacy/confidentiality); ethical issues (e.g., competencies, documentation, marketing); clinical issues (e.g., assessment/screening, boundaries/telepresence, handling emergencies); technical issues (e.g., technology/platform choices, cybersecurity, handling repairs); and other related information.

Register HERE

About the Speaker: Dr. Marlene M. Maheu serves as the Executive Director of the Telebehavioral Health Institute, Inc. (www.telehealth.org). She oversees the development and delivery of professional training in behavioral health via an eLearning platform that has served consumers and clinicians from over 55 countries. The focus for Dr. Maheu has been legal and ethical risk management related to the use of technologies to better serve behavioral health patients. She has served as a consultant, researcher, author, trainer, and keynoter.

Second of a Two-Part SAMHSA Center for Mental Health Services-Sponsored Webinar

Mental Health Block Grant Needs Assessments

Tuesday, August 14 – 2:00p.m. to 3:00 p.m. E.T.

State needs assessments form the basis of an effective, sustainable Mental Health Block Grant State Plan. This 2-part webinar series focuses on:

1) strategies to develop an effective needs assessment, specific domains of need, and resources to support this work; and
2) using a needs assessment to articulate specific goals, objectives, strategies, and performance indicators in the State Plan.

Presenter: Molly Brooms, M.A., Retired State Planner and Director of Mental Illness Community Programs, Alabama Department of Mental Health

Register HERE for Part 2, Using State Needs Assessments to Define State Plan Priorities, Goals, and Performance Measures (August 14)
National Meeting on Advancing Early Psychosis Care in the United States  
Pre-Conference Kick-Off for the  
11th Conference of the International Early Psychosis Association  
Westin Copley Place  
10 Huntington, Avenue, Boston, Massachusetts  
Sunday, October 7, 8:30 a.m. to 3:30 p.m. E.T.

We invite you to register to attend a national meeting on Advancing Early Psychosis Care in the United States! The cost to attend is $150 if you register by September 6.

This meeting will serve as a pre-conference and kick-off for the 11th Conference of the International Early Psychosis Association. Social workers, psychologists, counselors, and nurses can earn 5 continuing education credits for $50.

This is an opportunity to be part of the conversation about the work we all do. You will get to talk with people from all over the country who are working to develop and maintain first episode psychosis programs in their communities, and also hear from the national and international leaders who are shaping and supporting the field. More than 140 people have registered so far – but don’t worry, the Westin has plenty of space.

Finally, many of you may wish to stick around for the main conference and understand the really big picture of how international research is shedding new light on the causes of and treatments for mental illness. Those who attend the FEP meeting will be eligible to receive a discounted “group rate” on IEPA conference registration.

Register HERE For the Pre-Conference Meeting

SAMHSA-Sponsored Webinar from the Center for Mental Health Services (CMHS)  
Supporting Students Experiencing Early Psychosis in Middle School and High School  
Tuesday, August 21 – 2:00 p.m. to 3:00 p.m. E.T.

Presented under Contract by the National Association of State Mental Health Programs and the NASMHPD Research Institute

Although psychosis typically emerges in late adolescence or early adulthood, some individuals begin to experience psychosis or other early serious mental illness while still in middle school or high school. This webinar will describe strategies to:

- Identify and support students with psychosis in schools
- Provide educational accommodations and modifications to facilitate school success
- Understand and address safety concerns
- Partner across students, families, and community mental health providers to support treatment and recovery for students experiencing psychosis

This webinar is intended for 1) student instructional support personnel, including school psychologists, social workers, counselors, nurses, and community-partnered school mental health professionals; and 2) staff from First Episode Psychosis programs that are planning or engaging in outreach with middle schools and high schools.

Presenters include:

- Jason Schiffman, Ph.D., Professor of Clinical Psychology, University of Maryland, Baltimore County (UMBC). Dr. Schiffman’s research and clinical work focuses on early identification and treatment of youth at risk for psychosis and reduction of stigma against people with serious mental health concerns.
- Sharon Hoover, Ph.D., Associate Professor of Child and Adolescent Psychiatry, University of Maryland School of Medicine and Co-Director, National Center for School Mental Health. Dr. Hoover’s work focuses on implementing evidence-based mental health supports and services in schools.

Register HERE
Join the NADD August-December Webinar Series

From the convenience of your own office or conference room, you and your colleagues can participate in a multitude of educational resources; varying in experiential degree. All without having to leave the office! A learner may sign up for a single webinar or for as many as he or she wishes to take.

**Register HERE Not Later Than Five Days Prior to a Scheduled Webinar**

Webinar registration is open to all participants

**Wednesday, August 15, 3:00 p.m. E.T.**

**Direct Support Professionals: Friends or Friendly? A Deeper Look into a Difficult Question**

*Level: All*

*Presenter: Rachel Jacob, The Arc of Ulster-Greene, Kingston, NY*

Is it okay for a direct support professional to also be a friend? Is it a boundary that should not be crossed? What is the difference between friends and being friendly as a direct support professional. Join Rachel Jacob as she explores this controversial and complicated topic.

**Wednesday, August 23, 3:00 p.m. E.T.**

**Understanding Behavioral and Psychiatric Symptoms of Dementia (BPSD) in Adults with Intellectual Disabilities**

*Level: Beginner/ Intermediate*

*Presenter: Kathryn Pears, MPPM, National Task Group on Intellectual Disabilities and Dementia Practices, Conway, SC*

This webinar will cover the fundamental causes of BPSD in adults with ID. Topics covered will be the role of the physical environment, pain, and caregiver interaction as triggers for behavioral disturbances. The appropriate use of medication in the management of behaviors will also be discussed.

**Friday, August 31, 3:00 p.m. E.T.**

**Designing a Communal Classroom**

*Level: Intermediate*

*Presenter: Ashleigh Molloy, PhD, Transformation Education Institute, Toronto*

A communal classroom offers a safe, inclusive, student-centered environment where students learn through collaboration and active participation. It is a place where student expertise is developed and utilized, and is diversity embraced. This webinar will empower elementary teachers and principals by providing practical strategies for immediate classroom implementation, creating a learning environment where everyone belongs.

**Wednesday, October 3, 3:00 p.m. E.T.**

**How to Prevent the Need for Seclusion, Restraint, and Other Restrictive Practices**

*Level: Advanced*

*Presenter: Gary LaVigna, PhD, BCBA-D, Institute for Applied Behavior Analysis, Los Angeles, CA*

This webinar describes a host of evidence based, non-aversive reactive strategies (NARS) that can lead to “resolution” thereby preventing the need for restrictive procedures. These NARS have been shown to be more effective than the restrictive procedures in reducing the severity of a behavioral episode and in keeping people safe.

**Friday, October 5, 3:00 p.m. E.T.**

**Addressing Mental Health Symptoms to Prevent Challenging Behaviors**

*Level: All*

*Presenters: Melissa Cheplic, MPH, The Boggs Center on Developmental Disabilities, Rutgers Robert Wood Johnson Medical School, Department of Pediatrics, New Brunswick, NJ; Tony Thomas, LISW-S, ACSW, Welcome House, Inc., WestLake, OH*

Many people with IDD engage in challenging behavior as a way to communicate and get their needs met. Some problem behaviors are caused by symptoms of psychiatric disorders and other mental health conditions. This session will review the complicated factors that contribute to behavior and provide strategies to help Direct Support Professionals address these challenges.

**Thursday, November 15, 3:00 p.m. E.T.**

**Longitudinal Trends from the Residential Information Systems Project about Services and Supports to People with IDD – How States Vary Compared to Other States and the U.S.**

*Level: Intermediate*

*Presenter: Heidi Eschenbacher, University of Minnesota, Minneapolis, MN*

The Residential Information Systems Project (RISP) has been tracking supports and services, particularly deinstitutionalization, for over 40 years. Comparing states across the United States to overall trends within the country can be revealing about how government service models differ in the types of supports and services they provide.

**Tuesday, November 20, 3 p.m. E.T.**

**Decline in Adults with Down Syndrome**

*Level: Intermediate*

*Presenter: Seth Keller, MD, National Task Group on Intellectual Disabilities and Dementia Practices, Special Interest Group Adult IDD, American Academy of Neurology, Cherry Hill, NJ*

Adults with IDD are living longer than ever before. Adults with Down syndrome are at a high risk of developing early onset Alzheimer's disease. This presentation will review the care and assessment process when decline is suspected including Alzheimer’s disease and related dementia.

Additional Webinars on December 11, 13 & 19.

Cost for Individual Webinars:

- NADD Members - $78
- Non-Members - $98

Register for the entire series and receive an additional 20 percent off! Discount Code: 5ormore-20%-off-W2018.
Though most people who experience homelessness do not suffer from a serious mental illness (SMI), SAMHSA data indicate that between 20 and 25 percent of people experiencing homelessness also have an SMI. Join us for the last two parts of a three-part introductory series aimed at helping those working with people experiencing homelessness to better understand SMI. The series will be moderated by David Miller, M.PA., project director with the National Association of State Mental Health Program Directors (NASMHPD).

Register HERE for the Webinar Series
Webinar: Best Practices for Sustaining Behavioral Health Integration Models in Health Centers Using Health Information Technology

August 22, 3:00 p.m. to 4:30 p.m. E.T.

HRSA’s Bureau of Primary Health Care (BPHC) is pleased to offer a webinar hosted by the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) that will address strategies to leverage health information technologies that support population health management and data aggregation to facilitate and sustain behavioral health interventions. Presenters will share best practices for health centers in streamlining and sustaining behavioral health workflows and maximizing their electronic health records (EHRs) to ensure comprehensive and accurate billing and coding.

After this webinar, participants will:

- Understand appropriate workflows that support sustainability of behavioral health screening, referrals, and treatment
- Identify best practices in utilizing EHRs to ensure accurate and comprehensive billing of behavioral health
- Identify best practices in working with Health Center-Controlled Networks (HCCNs) and using Health Information Technology (HIT) to support population health management and data aggregation

Presenters:
- Simon Smith, President and CEO, Clinica Family Health, Lafayette, Colorado;
- Janet Rasmussen, Vice President Integrated Services, Clinica Family Health, Lafayette, Colorado;
- Jason Greer, CEO, Colorado Community Managed Care Network (HCCN), Denver, Colorado

Registration is free and closed captioning is available upon request. The SAMHSA-HRSA Center for Integrated Health Solutions does not provide certificates of attendance or continuing education credits for webinar attendance.

Register HERE
As a policy maker, researcher or practitioner committed to improving the way our communities respond to the mental health issues of their citizens don't miss this challenging and comprehensive event.

Register now for LEPH2018 and hear:

- Professor Sir Michael Marmot deliver the 2018 LEPH Oration on 'Social Justice and Health Inequities'.
- Major sessions on 'Models of law enforcement and mental health collaboration to improve responses to persons with mental illnesses' or 'Working across sectors to develop an evidence based approach to mental health policing and distress in Scotland'
- Tom Stamatakis' timely paper addressing the 'The mental health of police personnel should be recognized as a 'mission critical' priority

Or participate in a session charged with 'Crossing the divide: searching for innovations in learning between criminal justice and public health'.

And much more - see the DRAFT PROGRAM at www.leph2018toronto.com/program

Register HERE

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**NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center**

**Snapshot of State Plans for Using the Community Mental Health Block Grant 10 Percent Set-Aside to Address First Episode Psychosis**

As a condition of receiving a Community Mental Health Services Block Grant (MHBG), states are required to ensure that 10% of their MHBG funding is set used to support programs for people with early serious mental illness, including first episodes of psychosis. The **Snapshot of State Plans** provides an overview of each state’s funding, programs, implementation status, and outcomes measures under the set-aside.

To view the Snapshot or other new resources to support early intervention in psychosis, visit the What’s New section of the NASMHPD website here: [https://www.nasmhpd.org/](https://www.nasmhpd.org/)

To view the EIP virtual resource center, visit [NASMHPD’s EIP website](https://www.nasmhpd.org/).
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our Beyond Beds series of 10 white papers highlighting the importance of providing a continuum of care.

Following are links to the reports in the Beyond Beds series.

Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care
Cultural and Linguistic Competence as a Strategy to Address Health Disparities in Inpatient Treatment
Older Adults Peer Support - Finding a Source for Funding Forensic Patients in State Psychiatric Hospitals: 1999-2016
The Role State Mental Health Authorities Can Play in Delivery of Integrated Primary and Behavioral Health Care for People with Serious Mental Illness, including those with Co-Occurring Substance Use Disorders
Crisis Services' Role in Reducing Avoidable Hospitalization
Quantitative Benefits of Trauma-Informed Care
Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014
The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity
The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System
Forensic Patients in State Psychiatric Hospitals – 1999 to 2016

2017 NASMHPD TECHNICAL ASSISTANCE COALITION WORKING PAPERS – BEYOND BEDS

31st Annual State Health Policy Conference
NASHPCONF18 | August 15-17 | Jacksonville, FL |

Celebrate the National Association of State Health Policy’s (NASHP) 31st Annual State Health Policy Conference. Planned by state health policymakers, for state health policy makers, NASHP's annual event is a “must-attend” for the state health policy community. With a carefully crafted agenda focusing on emerging issues and current best practices within states, our conference brings together the nation’s leading experts to share, learn and discuss.

The Top Five Reasons to Attend #NASHPCONF18
1) Informative sessions cover the nation’s most crucial health policy issues. #NASHPCONF18 is designed by state health policy makers for state health policy makers to explore the most up-to-date health care developments and initiatives in the United States. With 25+ thoughtfully-crafted sessions addressing the issues most important to you, as well as full-day pre-conferences that offer a deep dive into targeted topics, you'll gain critical insights into the latest advances, changes, programs, and innovations in state health policy.
2) Outstanding networking opportunities. Our conference offers non-stop opportunities to network with more than 800 state health policy leaders from across the country. Join conference roundtables to discuss best practices and solutions to pressing issues with a small group of your peers, attend the networking breakfast or Blueberry Break to socialize with colleagues, or mix business with pleasure at our two evening events!
3) They're not just speakers... They're industry thought leaders. Our #NASHPCONF18 speakers are among the most distinguished and respected thought leaders in state health policy. Conference speakers will address a host of topics covering current and important issues, including health care costs, workforce, chronic care, stabilizing the individual market, social determinants of health and much more!
4) Exclusive access to the newest technology and business intelligence. NASHP’s exclusive exhibit hall offers a diverse group of exhibitors who are all eager to present you with the latest and greatest innovative ideas and smart solutions to help you achieve your goals.
5) Discover Jacksonville, Florida. Named to Expedia’s list of 21 Super Cool Cities in the U.S., Jacksonville is the perfect destination for both relaxation and adventure. With 22 miles of beaches, dining options that range from elegant bistros to local seafood shacks, more than 20 craft breweries, a sprawling arts district, wildlife sanctuary, and so much more, there is always something to do no matter what your mood. Enjoy the beautiful views of the St. Johns River while attending #NASHPCONF18 and experience all that this super cool city has to offer!
CMS’s Medicaid Innovation Accelerator Program (IAP) is hosting a webinar to introduce states to a new technical resource designed to help state Medicaid agencies with using Medicaid claims and encounters data to gather specific insights about the population of adult Medicaid beneficiaries who have a serious mental illness in their state. This technical resource serves as a first step in assisting states with understanding key demographic attributes of this population, their use of Medicaid services, and their Medicaid service costs.

The webinar will feature an overview of the technical resource, example analyses, and a discussion with state Medicaid leaders from Pennsylvania, Virginia, and West Virginia who will share insights based on their experience conducting similar analyses. The strategies presented on this webinar will be of interest to state Medicaid agencies interested in developing data analytics to better understand their population with SMI.

Register HERE for this Webinar

The Power of Perceptions and Understanding: Changing How We Deliver Treatment and Recovery Services

This four-part webcast series from the Substance Abuse and Mental Health Services Administration (SAMHSA) educates health care professionals about the importance of using approaches that are free of discriminatory attitudes and behaviors in treating individuals with substance use disorders and related conditions, as well as patients living their lives in recovery.

The webcasts feature discussions among experts in the field of addiction treatment, research, and policy. Participants can earn free CME/CE credits for attending the one-hour webcasts. Access the webcasts HERE.

About the Initiative: The Power of Perceptions and Understanding

Millions of people in the U.S. live with a substance use disorder. In 2016, there were 20.1 million people, or 7.5 percent, aged 12 or older in 2016 who had a substance use disorder in the past year. In addition, an estimated 8.2 million U.S. adults 18 or older reported having co-occurring disorders. This means that within the previous year, they experienced both a mental illness and a substance use disorder.

Health care providers are often the first contact for addressing their patient’s substance use disorder. There is ample evidence that those who have a substance use disorder often have feelings of shame that impede treatment-seeking. Therefore, it is essential health care providers understand that negative attitudes, beliefs and language can be barriers that prevent those in need from seeking services, or even sharing information, including being in recovery.

The Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with Massachusetts General Hospital, Recovery Research Institute (link is external), is producing a series of four webcasts to educate healthcare professionals about the problems of discriminatory practices and inaccurate perceptions present in dealing with individuals with substance use disorders (SUDs) and related conditions. The topics and panel discussions will specifically address the harm caused by the negative perceptions, and the mitigating results of using discriminatory and prejudicial behaviors toward those who need care for substance use disorders as well as those living their lives in recovery.

Webcasts are open to all, but are intended to educate health care providers at all levels, to include medical doctors, physician assistants, nurses, the public health field staff, addiction treatment professionals, as well as behavioral health support staff.

Participants can earn up to 4.0 free CME/CE credits – one credit for attending each of the four one-hour webcasts.
The National Federation’s Annual Conference brings together family members, young adults, and professionals and focuses on current issues and trends pertaining to children’s mental health, from the perspective of a family-driven and youth-guided approach.

Join hundreds of mental health advocates and professionals from across the nation to share your expertise in: Family and Caregiver Support, Supports for Special Populations, Collaboration and Integration of Services Across Multiple Systems, Trauma Informed Care, Research to Practice, Engaging Youth and Young Adults, Organizational Development and Sustainability, Evidence Based Practices, Parent Peer Support Today or Providing Services and Outreach in the Digital Age.

Early Bird registration rates apply for presenters! There is also still time to be a conference exhibitor or sponsor. Learn more here.

Submit Your Presentation HERE

SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT
Center of Excellence for Eating Disorders (SM 18-021)

Funding Mechanism: Grant
Anticipated Award Amount: up to $750,000
Cost-Sharing or Matching Requirement: No
Anticipated Number of Awards: 1 Award
Anticipated Total Available Funding: $750,00 per year
Length of Project: 5 years
Closing Date for Applications: August 17, 2018

The Substance Abuse and Mental Health Services Administration (SAMHSA), is accepting applications for fiscal year (FY) 2018 Center of Excellence (CoE) for Eating Disorders (Short Title: CoE-ED). The purpose of this program is to establish one National Center of Excellence to develop and disseminate training and technical assistance for healthcare practitioners on issues related to addressing eating disorders. It is expected that the grantee will facilitate the identification of model programs, develop and update materials related to eating disorders, and ensure that high-quality training is provided to health professionals.

Addressing and treating eating disorders is a critical component of mental health care. Many individuals across the country, particularly women, face the challenges of dealing with an eating disorder in their lifetime. According to the National Institute of Mental Health, 0.5 percent to 3.7 percent of females have anorexia nervosa; approximately 1 percent of female adolescents have anorexia nervosa. Additionally, 1.1 percent to 4.2 percent of women have bulimia nervosa in their lifetime.

Eligibility: Eligible applicants are domestic public and private nonprofit entities.

Contact: Program Issues: Tracy Pogue, at (240) 276-0105 or by email at Tracie.pogue@samhsa.hhs.gov. Grants Management and Budget Issues: Gwendolyn Simpson at (240) 276-1408 or FOACMHS@samhsa.hhs.gov.
HRSA Funding Opportunity Announcement

Pediatric Mental Health Care Access Program (HRSA 18-122)

Funding Mechanism: Grant
Anticipated Number of Awards: up to 20
Anticipated Award Amount: up to $445,000
Cost-Sharing or Matching Requirement: 20 percent each year
Length of Project: 5 years

Closing Date for Applications: August 13, 2018

The Health Resources and Services Administration (HRSA) is accepting applications for fiscal year (FY) 2018 Pediatric Mental Health Care Access Program. The purpose of this program is to promote behavioral health integration in pediatric primary care by supporting the development of new or the improvement of existing statewide or regional pediatric mental health care telehealth access programs.

For purposes of this funding opportunity, telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, clinical consultation, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

For purposes of this funding opportunity, a pediatric mental health care telehealth access program for which funding may be used, will be required to perform the following activities—

(A) be a statewide or regional network of pediatric mental health teams that provide support to pediatric primary care sites as an integrated team;

(B) support and further develop organized state or regional networks of pediatric mental health teams to provide consultative support to pediatric primary care sites;

(C) conduct an assessment of critical behavioral consultation needs among pediatric providers and such providers’ preferred mechanisms for receiving consultation, training, and technical assistance;

(D) develop an online database and communication mechanisms, including telehealth, to facilitate consultation support to pediatric practices;

(E) provide rapid statewide or regional clinical telephone or telehealth consultations when requested between the pediatric mental health teams and pediatric primary care providers;

(F) conduct training and provide technical assistance to pediatric primary care providers to support the early identification, diagnosis, treatment, and referral of children with behavioral health conditions;

(G) provide information to pediatric providers about, and assist pediatric providers in accessing, pediatric mental health care providers, including child and adolescent psychiatrists, and licensed mental health professionals, such as psychologists, social workers, or mental health counselors as well as assisting with scheduling and conducting technical assistance;

(H) assist with referrals to specialty care and community or behavioral health resources; and

(I) establish mechanisms for measuring and monitoring increased access to pediatric mental health care services by pediatric primary care providers and expanding the capacity of pediatric primary care providers to identify, treat, and refer children with mental health problems.

Eligibility: State governments
Native American tribal organizations (other than Federally recognized tribal governments)
Others (see text field entitled "Additional Information on Eligibility" for clarification)
Native American tribal governments (Federally recognized)

Additional Information on Eligibility: States, political subdivisions of states, and Indian tribes and tribal organizations (for purposes of this section, as defined in § 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b)).

HRSA has scheduled the following technical assistance:
Webinar Day and Date: Friday, July 27, 2018
Time: 2 p.m. to 3 p.m. ET
Call-In Number: 1-888-600-4866 Participant Code: 556514
Web link: https://hrsa.connectsolutions.com/pmhcap_u4c_ta_session/
Playback Number: 1-888-203-1112 Passcode: 1390598

Contact: Madhavi Reddy, MSPH, Maternal and Child Health Bureau, HRSA at (301) 443-0754 or by email.
SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

State Opioid Response Grants
(FOA TI-18-015)

Funding Mechanism: Grant
Anticipated Award Amount: At least $4M for states; at least $250,000 for territories
Length of Project: 2 years
No Cost-Sharing/Match Required

The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2018 State Opioid Response Grants (Short Title: SOR). The program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). These grants will be awarded to states and territories via formula. The program also includes a 15 percent set-aside for the ten states with the highest mortality rate related to drug overdose deaths.

Grantees will be required to do the following: use epidemiological data to demonstrate the critical gaps in availability of treatment for OUDs in geographic, demographic, and service level terms; utilize evidence-based implementation strategies to identify which system design models will most rapidly and adequately address the gaps in their systems of care; deliver evidence-based treatment interventions that include medication(s) FDA-approved specifically for the treatment of OUD, and psychosocial interventions; report progress toward increasing availability of medication-assisted treatment for OUD; and reducing opioid-related overdose deaths.

The program supplements activities pertaining to opioids currently undertaken by the state agency and will support a comprehensive response to the opioid epidemic. The results of the assessments will identify gaps and resources from which to build upon existing substance use prevention and treatment activities as well as community-based recovery support services. Grantees will be required to describe how they will expand access to treatment and recovery support services. Grantees will also be required to describe how they will advance substance misuse prevention in coordination with other federal efforts. Grantees must use funding to supplement and not supplant existing opioid prevention, treatment, and recovery activities in their state. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

State allocations for the Opioid SOR grants are calculated by a formula based on the equal weighting of two elements: the state’s proportion of people with abuse or dependence on opioids (prescription opioids and/or heroin) who need but do not receive treatment (NSDUH, 2015-2016) and the state’s proportion of drug poisoning (overdose) deaths (CDC National Vital Statistics System, 2016). Each State, as well as the District of Columbia, will receive not less than $4,000,000. Each territory will receive not less than $250,000. See below (from Appendix K of the Announcement). In addition to this base distribution, $142.5 million in funding is being distributed to the ten states with the highest mortality rates due to drug poisoning deaths. This set-aside takes into account the state’s ordinal ranking in the top ten; it is not distributed equally among 10 states.

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Annual continuation awards will depend on the availability of funds, recipient progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

ELIGIBILITY: Eligible applicants are the Single State Agencies (SSAs) and territories. Please note that Tribes will be eligible to apply for opioid response funding under a separate announcement.

CONTACTS: Program Issues & Grants Management Issues: Email OPIOIDSOR@samhsa.hhs.gov.
The Substance Abuse and Mental Health Services Administration (SAMHSA) is accepting applications for fiscal year (FY) 2018 Tribal Opioid Response grants (Short Title: TOR). The program aims to address the opioid crisis in tribal communities by increasing access to culturally appropriate and evidence-based treatment, including medication-assisted treatment (MAT) using one of the three FDA-approved medications for the treatment of opioid use disorder (OUD). The intent is to reduce unmet treatment need and opioid overdose related deaths through the provision of prevention, treatment and/or recovery activities for OUD.

The program supplements current activities focused on reducing the impact of opioids and will contribute to a comprehensive response to the opioid epidemic. Tribes will use the results of a current needs assessment if available to the tribe (or carry out a strategic planning process to conduct needs and capacity assessments) to identify gaps and resources from which to build prevention, treatment and/or community-based recovery support services. Grantees will be required to describe how they will expand access to treatment and recovery support services as well as advance substance misuse prevention in coordination with other federally-supported efforts. Grantees must use funding to supplement and not supplant existing opioid prevention, treatment, and/or recovery activities. Grantees are required to describe how they will improve retention in care, using a chronic care model or other innovative model that has been shown to improve retention in care.

**ELIGIBILITY:**

An applicant must be a federally recognized American Indian or Alaska Native tribe or tribal organization. Tribes and tribal organizations may apply individually, as a consortia, or in partnership with an urban Indian organization. These entities are defined as follows:

- **Indian Tribe,** as defined at 25 U.S.C. § 1603(14) is any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C.A. § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

- **Tribal Organization,** as defined at 25 U.S.C. § 1603(26) is the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities. Provided that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.

- **Urban Indian Organization,** as defined at 25 U.S.C. § 1603(29), operating pursuant to a contract or grant with the Indian Health Service is a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in [25 U.S.C § 1653(a)].

A consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

**CONTACTS:**

**Program Issues & Grants Management Issues:** Email [OPIOIDTOR@samhsa.hhs.gov](mailto:OPIOIDTOR@samhsa.hhs.gov)
Technical Assistance on Preventing the Use of Restraints and Seclusion

For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

The National Center for Trauma Informed Care and Alternatives to Restraint and Seclusion offers on-site staff training and technical support to implement trauma-informed, strength-based approaches to prevent aversive interventions. Our in-house team and national consultants have many years of public hospital experience, both clinically and personally. This assistance is funded by SAMHSA and at no cost to your state.

To Apply for Technical Assistance, [Click Here](#). We look forward to the opportunity to work together.

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Technical Assistance Opportunities for State Mental Health Authorities

Through NASMHPD, SAMHSA supports technical assistance (TA) for state behavioral health agencies to improve mental health service systems and facilitate effective use of the Mental Health Block Grant. Under the State TA Contract, states can request off-site (such as telephone and web-based) or on-site TA, including in-person training and consultation on issues important to promoting effective community-based services. TA is provided by national experts selected jointly by the state and NASMHPD, and SAMHSA provides support to pay for consultant fees and travel expenses. States can request TA on a broad range of topics, including:

- **Improving Services & Service Delivery Systems.** Examples include tailoring care to specific groups such as older adults; implementing programs for persons in early stages of psychosis; expanding the use of person-centered treatment planning; developing crisis response services; implementing and ensuring fidelity to evidence-based practices; increasing early identification & referral to care for young people; and promoting trauma-informed, recovery-oriented care.

- **Systems Planning/Operations.** Examples include support for strategic planning; merging mental health and substance abuse agencies; leadership development; staff development; cross sector collaboration; and integration of behavioral health and primary care.

- **Expanding the Peer Workforce.** Examples include training and certification of peer specialists; peer whole health training; supervision of peer specialists; and using peer specialists to work with individuals who are deaf and hard of hearing.

- **Financing/Business Practices.** Examples include maximizing Medicaid coverage; addressing behavioral health under a managed care model; drafting performance-based contract language with providers; rate-setting practices; and compliance with Mental Health Block Grant requirements.

State Mental Health Commissioner/Directors or designees may request TA by submitting a TA request directly into SAMHSA’s online TA Tracker at [http://tatracker.treatment.org/login.aspx](http://tatracker.treatment.org/login.aspx). If you’ve forgotten your password or have other questions about using the online system, please send an e-mail to tatracker@treatment.org.

For assistance in developing a TA request, please contact your SAMHSA Project Officer or Jenifer Urff, NASMHPD Project Director for Training and Technical Assistance, at [jenifer.urff@nasmhpd.org](mailto:jenifer.urff@nasmhpd.org) or by phone at (703) 682-7558. We’re happy to discuss ideas and ways that we can support you in strengthening the mental health service system in your state.
NADD Award Nominations Sought by August 31

NADD presents five awards annually, at the NADD Annual Conference, which this year will be in Seattle, Washington, October 31 to November 2. The deadline for submitting nominations for these awards is August 31.

Frank J. Menolascino Award for Excellence - This prestigious award is given annually in the memory of Dr. Frank J. Menolascino to an individual who has demonstrated long standing excellence in the field of dual diagnosis.

Earl L. Loschen Award for Clinical Practice - This award is given to a person whose contribution in the area of clinical practice has resulted in significant improvement in the quality of life for individuals with intellectual and developmental disabilities as well as mental health needs.

NADD “Member of the Year” Award - This award is given to a person who has supported the mission of NADD through various activities that have resulted in a positive impact on NADD.

NADD DSP Award for Excellence - This Award is given annually to acknowledge a Direct Support Professional (DSP) whose contribution to supporting people who live in our communities has resulted in significant improvement in the quality of life for individuals with intellectual and developmental disabilities and mental health needs.

NADD Research Award - This award is given to recognize research that improves our understanding of mental health issues in people with intellectual and other developmental disabilities.

Click here for details.

New On-Demand Continuing Medical Education (CME) Course:
Clozapine as a Tool in Mental Health Recovery

This one-hour course offers information and resources for physicians, clinicians, and other practitioners serving people experiencing psychotic symptoms who are considering exploring the use of clozapine. Through a "virtual grand rounds," this course will help you better understand the FDA guidelines, which individuals might benefit from clozapine, the risks and benefits of the medication, and how to engage in shared decision-making with individuals about using clozapine.

In this course, you'll meet Robert, a young man with hopes of attending college and becoming a writer, who also struggles with psychotic symptoms. The course will explore the scientific evidence and best practices for how clozapine may be used as a tool to help him move closer to achieving his goals; as well as how to engage with Robert in a strengths-based, recovery-oriented way.

The faculty are national experts in recovery-oriented pharmacology, who present tips on how to engage with individuals experiencing psychotic symptoms and using clozapine as an effective tool to help them move closer to achieving their goals.

Register HERE!

Course Objectives

After viewing, learners will be able to: explain some of the benefits of initiating clozapine for psychotic symptoms and advancing recovery; articulate how shared decision-making has a role in initiating clozapine; describe the clozapine Risk Evaluation and Mitigation Strategy (REMS); and identify methods for recognizing and managing benign ethnic neutropenia, or BEN, for primary care and psychiatry providers.

Professionals will receive 1 CME credit for participation in this course. (CME provided by American Academy of Family Physicians.)
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NASMHPD Links of Interest
GUIDANCE ON THE CONTRIBUTION LIMITS APPLICABLE TO ABLE ACCOUNTS, Internal Revenue Service, Notice 2018-62

THE AGE THAT WOMEN HAVE BABIES: HOW A GAP DIVIDES AMERICA, New York Times Upshot Column, August 5


THE ILLNESS IS BAD Enough. The Hospital May Be Even Worse, Paula Span, New York Times, August 3

SOCIAL DETERMINANTS AS PUBLIC GOODS: A NEW APPROACH TO FINANCING KEY INVESTMENTS IN HEALTHY COMMUNITIES, Len M. Nichols & Lauren A. Taylor, Health Affairs, August 6

HOME, TOGETHER: NEW FEDERAL STRATEGIC PLAN TO PREVENT & END HOMELESSNESS, Abt Associates on Behalf of the United States Interagency Council on Homelessness, August 7

DRAFT GUIDANCE: OPIOID USE DISORDER: ENDPOINTS FOR DEMONSTRATING EFFECTIVENESS OF DRUGS FOR MEDICATION-ASSISTED TREATMENT GUIDANCE FOR INDUSTRY, Food and Drug Administration (FDA), August 2018

STATE OPIOID RESPONSE (SOR) GRANT FREQUENTLY ASKED QUESTIONS (FAQs), Substance Abuse and Mental Health Services Administration, August 8

VIDEO: NATIONAL WEEKEND OF PRAYER FOR FAITH, HOPE, & LIFE, National Action Alliance for Suicide Prevention, July 31


THE EFFECTIVENESS OF A PEER-STAFFED CRISIS RESpite PROGRAM AS AN ALTERNATIVE TO HOSPITALIZATION, Bouchery E.E., M.S. et al., Psychiatric Services, August 3

A SHORTER BUT EFFECTIVE TREATMENT FOR PTSD, Science News, National Institute of Mental Health, August 8

NOTIFICATION OF PATIENT OVERDOSE DEATHS REDUCES CLINICIAN OPIOID PRESCRIPTIONS, National Institutes of Health, August 9 & OPIOID PRESCRIBING DECREASES after LEARNING OF A PATIENT’S FATAL OVERDOSE, Doctor J.N. et al., Science, August 10