President Trump Directs HHS to “Use All Appropriate Measures” to Fight Opioid Epidemic

President Donald J. Trump on August 10 directed the Department of Health and Human Services (HHS) to “use all appropriate emergency and other authorities to respond to the crisis caused by the opioid epidemic.”

That directive followed a July 31 interim recommendation by the President’s Commission on Combating Drug Addiction and the Opioid Crisis, chaired by New Jersey Governor Chris Christie, that the President declare the epidemic of opioid abuse and overdoses in the nation a national emergency. Mr. Trump said in a press conference held earlier in the day on August 10, “We’re going to spend a lot of time, a lot of effort and a lot of money on the opioid crisis. This is a national emergency, and we are drawing down our reserves and doing anything we can to address this crisis.”

It is not clear what a declaration of a national emergency will accomplish, although it could authorize HHS to pay lower prices to pharmaceutical manufacturers for overdose reversal drugs. National Public Radio (NPR) reported August 8 that the prices of some brands of naloxone have escalated over recent years. The price of a vial of generic naloxone made by the company Amphastar rose from about $4 in 2009 to about $16 this year, according to investment firm SSR Health, who researched the story for NPR.

More than 33,000 Americans died from opioid overdoses in 2015, according to the National Institute on Drug Abuse (NIDA). Most opioid-overdose deaths are linked to prescription pain pills, though the use of heroin is growing rapidly, accounting for almost 13,000 deaths in 2015, according to NIDA.

Two pharmaceutical manufacturers -- Mylan NV and Mallinckrodt Plc -- were subpoenaed in July by the Justice Department over the sale, marketing, and manufacture of pain drugs. Several states have sued opioid manufacturers, blaming them for the rise in addiction and seeking to recover damages.

In June, Arizona joined Alaska, Florida, Maryland, Massachusetts, and Virginia as the sixth state to declare a statewide opioid epidemic. The state orders vary but widely expand access to the overdose antidote naloxone and give states the ability make rules about opioid prescribing.

A study published August 10 in the American Journal of Public Health found that, for the years 2013 to 2015, 375,266 non-research opioid-related payments were made to 68,177 physicians (1 in 12) in the United States, totaling $46,158,388. The top 1 percent of physicians in the 29-month study received 82.5 percent of the total payments in dollars. Abuse-deterrent formulations constituted 20.3 percent of the total payments, and buprenorphine marketed for addiction treatment constituted 9.9 percent.

The study found that most of the payments were for speaking fees or honoraria (63.2 percent of all dollars), with food and beverage payments the most frequent (93.9 percent of all payments). Physicians specializing in anesthesiology received the most in total annual payments (median = $50; interquartile range = $16–$151).

The authors of the study, Dr. Scott E. Hadland of the Boston Medical Center and Boston University School of Medicine, and epidemiologists Maxwell S. Krieger and Brandon D. L. Marshall of the Brown University School of Public Health, recommend an examination of industry influences on opioid prescribing. (Continued on page 7)
CERTIFIED PEER SPECIALIST TRAINING FOR INDIVIDUALS WHO ARE DEAF AND AMERICAN SIGN LANGUAGE USERS

The Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) is recruiting qualified individuals who are deaf, use ASL, are seeking employment and want to take Certified Peer Specialist (CPS) training to learn how to use their personal experience in mental health recovery to help other individuals who are deaf and have mental health needs. OMHSAS is offering this training opportunity to individuals from other states who are deaf and ASL users and meet their state/territory training requirements to become a CPS. Priority will be given to Pennsylvania residents. Deadline for applying is November 13, 2017.

The 75 hour (10-day) training is scheduled for December 4-15, 2017. The training will be held at Hyatt Place, 440 American Ave., King of Prussia, PA 19406.

Certified Peer Specialists are trained to:
- offer support and assistance in helping others in their mental health recovery
- inspire hope and share their mental health recovery story to help others
- promote empowerment, self-determination, understanding, coping skills and resiliency

CPS training/employment guidelines for Pennsylvania residents:
- Deaf and ASL user
- 18 years of age or older
- Received or is receiving mental health services for serious mental illness
- Have a high school diploma or general equivalency diploma
- From 2015 through 2017:
  - maintained at least 12 months of successful work or volunteer experience, or
  - earned at least 24 credit hours from a college or post-secondary educational institution
- Individuals must be seeking employment and willing to work upon completion of CPS training

Training fee options for Pennsylvania residents:
1. If eligible, OVR may pay for your training and provide a paid internship. Contact OVR by October 15, 2017.
2. An individual not eligible for OVR services will be responsible for the cost of the training and associated costs.

Out of state applicants: Please contact PJ Simonson for information regarding training fees.
To complete an online training application: email PJ Simonson and ask for an application for the CPS Training for deaf candidates. The forms will be emailed to you to complete online. Once finished, return the application to PJ.

Questions about the Training, Contact: PJ Simonson | RI Consulting | Phone: 602.636.4563
Questions about OVR Services, Contact: Randy Loss | Office of Vocational Rehabilitation | Phone: 717.787.5136

HONORING THOSE WHO SERVE: HOPE, RESILIENCE, AND RECOVERY
2017 VOICE AWARDS
WEDNESDAY, AUGUST 16
Los Angeles, CA

The Voice Awards recognize television and film productions that educate the public about behavioral health and recovery.

Register to Watch On-Line
Wednesday, August 16
7:30 p.m. to 9:30 p.m. Pacific Time

Children’s Mental Health Initiative (CMHI)
National Evaluation Web Event Training Series:
Evaluating Systems of Care in Tribal Communities
Tuesday, September 26, 2:30 p.m. to 4 p.m. ET

Register HERE
Suicide Prevention Practices in Corrections May Isolate Inmates and Alienate Services

Some of these controversies he mentions include:

**Suicide Precautions Are Often Overly Restrictive and Severely Punitive** — There are cases where interventions implemented for an inmate in suicidal distress are more restrictive, leading to inmates not revealing their suicidal ideation for fear of being placed in isolative conditions. For example, some correctional facilities place an inmate on 24-hour suicidal watch in a confined cell wearing a safety smock. The author cites research by Way and colleagues showing that 75 percent of inmates reported they didn’t disclose their suicidal ideation for fear of being transferred to an observation cell and not having access to their familiar items (e.g., books, writing materials, own clothes), being in an unfamiliar environment, and having routines disrupted.

The article notes an extreme example of inmates being transferred to 3-by-3 feet in diameter and 7 feet in height observation cages, deemed “squirrel cages” by inmates. These restrictive precautions may exacerbate the inmate’s mental illness.

**Contracting for Safety** — In addition to being found ineffective, there are no national standards or policies promulgated by the National Commissioner on Correctional Health Care (NCCHC) on the use of inmate “no harm” contracts. The author points out that most clinicians conclude that when an inmate becomes suicidal, a written contract doesn’t prevent self-harm.

**Pulse Oximetry and Other Anti-Suicide Technology** — After Mr. Hayes outlines different technology-based suicide alert systems, he concludes that all of these systems have one commonality—they further silo correctional, medical, and mental health staff from the inmate placed on suicidal watch. Furthermore, the implementation of these types of technology doesn’t get to the core issue of suicide prevention—identifying inmates with suicidal ideation that are not easily recognized.

**Rating Scales** — Some correctional facilities have implemented a numerical scale system to rate an inmate’s potential risk of suicide. However, suicide prevention experts underscore that there isn’t a rating scale that fully detects levels of suicidality in correctional settings.

To reduce the rate of suicides in correctional facilities the author recommends the following:

1. Develop suicide prevention policies that focus on inmate safety that are least restrictive to the inmate (e.g., the inmate has access to personal belongings, telephone privileges and personal visits);
2. Allow correctional staff discretion in referring all inmates with potential suicidal ideation to a mental health professional to conduct a comprehensive suicide risk assessment; and
3. Develop practices that fully integrate correctional, mental health and medical staff.

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**SAMHSA-SPONSORED WEBINAR OPPORTUNITY**

**Issues and Considerations Associated with Measuring the Duration of Untreated Psychosis (DUP) in First Episode Psychosis Programs**

*Tuesday, August 22, 2 p.m. to 3:30 p.m. ET*

Reducing the Duration of Untreated Psychosis, or DUP, is a key tenet of early intervention in psychosis. Both research and common sense suggest that the earlier the intervention in the course of psychosis, the better the outcomes. However, despite international consensus on this, there is less agreement on how DUP should be measured and, more importantly, how to incorporate this measurement into routine practice. As part of an ongoing series of webinars related to measurement issues in first episode programming, this webinar will review the literature on DUP, examine different DUP measures, and consider the implications of implementing this practice in community mental health settings. The webinar will help inform early psychosis programs and state leaders about the important considerations when integrating DUP measurement into routine clinical care.

**Presenters:**

- Kate Hardy, Clin.Psych.D, Stanford University
- Rachel Loewy, Ph.D., Univ. of California San Francisco
- Tara Neindam, Ph.D. Univ. of California Davis

Feel free to forward this announcement to others who may be interested in this presentation!
Position Available

DIRECTOR OF NETWORK DEVELOPMENT – FULL TIME

MHA-NYC is at the cutting edge of harnessing new technologies to expand methods in which consumers can receive clinically sound behavioral health services. MHA administers three national networks of crisis services (including the National Suicide Prevention Lifeline, the national Disaster Distress Helpline, and the NFL Life Line) and supports the VA-operated Veterans Crisis Line. MHA also operates 14 crisis lines, including New York State’s HOPEline for addictions and the groundbreaking, multi-access, multi-lingual behavioral health and crisis contact center, NYC Well. The organization is a national and local leader in developing and implementing innovative new approaches to providing behavioral health services and interventions via telephone, web chat, and SMS text message.

Position Objective: The Director of Network Development is a senior management position responsible for providing leadership for the 24/7 operations of the National Suicide Prevention Lifeline (a network of 165+ independently owned crisis centers across the country) and related subnetworks. Primary responsibilities include oversight of all aspects of operations including network capacity, sustainability, infrastructure, quality improvement and contract management. The Network Development Director is the primary liaison between Lifeline’s partners in capacity building and sustainability (such as the National Association of State Mental Health Program Directors and the National Council for Behavioral Health). The Director of Network Development collaborates with IT Department staff to ensure continuous technical operation of all hotline/chat/text programs and support of all systems during emergencies. The Director of Network Development collaborates with the Finance Department and directly supervises all staff in the Network Development Division.

Primary Program: National Suicide Prevention Lifeline

Reports to: Associate Project Director

Essential Duties and Responsibilities:

• Supervise the ND Operations staff to ensure the 24/7 operation of the National Suicide Prevention Lifeline and its subnetworks
• Coordinate with MHA-NYC IT team to ensure continuous operations and reporting capabilities and to maximize efficient connectivity and capacity to respond to client contacts (geo-location capabilities, telephony and chat software platforms, etc.)
• Oversee the development of a plan to regularly test systems and ensure 24/7 access to hotline and chat programs.
• Oversee a plan for Quality Improvement to review call/chat trends, troubleshoot concerns/complaints, and share data with MHA-NYC team, funders and other key stakeholders ensuring that all operational grant related program goals and objectives are measured, met and or exceeded
• Oversee all related program subcontractors, including RFPs, contracts, deliverables and invoicing to ensure all performance metrics are met or exceeded
• Supervise the Lifeline network response to suicidal individuals corresponding with the White House to facilitate prompt, appropriate outreach of designated center towards better ensuring the safety and care of the correspondent
• Supervise the Network Development Staff in the development and execution of effective network membership recruitment and retention strategies to increase capacity for the Lifeline (including Spanish subnetwork) and Lifeline Crisis Chat. Work with funders and stakeholders to recommend sustainable models for Lifeline services.
• Act as a project (and media) spokesperson/representative for Lifeline at conferences, meetings and committees, where indicated, re: capacity/partnership-building efforts
• Regularly review call/chat volume and connectivity reports to identify service gaps within states; continuously monitor states with low in-state answer rates and work with stakeholders to increase capacity
• Work with key stakeholders (NASMHPD, AAS, NATCON NASCONC, CUSA, , SAMHSA Grantees, 211, AIRS, CARF, State Mental Health Directors) and other partners to engage new centers and promote funding; develop and disseminate reports for stakeholders as needed
• Lead efforts to define and expand program knowledge and expertise and provide technical assistance to crisis centers related to capacity building and sustainability (funding streams, payment methods, efficiencies, etc.); develop and initiate a plan to collect and distribute related practices, policies, procedures and training tools; monitor relevant blogs and list-serves and promote Lifeline when applicable
• Work with National Council and related stakeholders/leaders to develop strategies for enhancing integration of crisis services into behavioral healthcare systems
• Respond to inquiries from stakeholders for program data and information
• Assist with grant writing, report writing and program conceptualization
• Other duties as assigned

Qualifications: The ideal candidate will have a Master’s Degree in business administration, project management, public health/administration, counseling/social work or related field and at least 10 years of management/experience. Experience in the non-profit sector, mental health, suicide prevention, crisis intervention and/or mental health information and referral services experience a plus. Knowledge and expertise public health issues such as capacity building and sustainability (funding streams, payment methods, efficiencies, etc.) preferred. Applicants should be comfortable working independently. Applicants must be willing to work in New York City or, as a secondary preference, Washington, D.C.

How to Apply: Interested applicants should submit resume and cover letter to careers@mhaofnyc.org. Please put “Director of Network Development” in the subject line of your email. All qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, sexual orientation, national origin, sex, age, disability or marital status.
WEBINAR OPPORTUNITY

Medicaid Coverage and Financing of MAT, Current Status, and Promising Practices

Thursday, August 17, 3:30 p.m. to 5 p.m. ET

Join us for an upcoming webinar on a forthcoming update to the 2014 SAMHSA report, Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders. We will review information on state Medicaid payment policies for medication-assisted treatment (MAT), and speakers will present case studies of innovative MAT models. This up-to-date information about Medicaid MAT coverage will be helpful for consumers and family members, providers, health plan and Medicaid staff, policymakers, and government officials.

After this webinar, participants will:

- Understand how MAT currently is covered under Medicaid at the state level
- Understand barriers to MAT coverage and possible actions to improve coverage
- Be able to describe some innovative financing models

Presenters:

- Mitchell Berger, SAMHSA
- Peggy O’Brien, IBM Watson Health
- Colleen LaBelle, Boston University Medical Center
- Mark Stringer, Missouri Department of Mental Health
- Molly Carney, Evergreen Treatment Services

Contact the webinar organizers with questions or technical concerns by emailing communications@thenationalcouncil.org.

Second in a Two-Part Webinar Series for Faith-Based and Community Leaders on the Opioid Crisis

Join the U.S. Department of Health and Human Services Partnership Center and experts from SAMHSA and the Centers for Disease Control and Prevention (CDC) for the second in a two-part webinar series specifically geared towards faith-based and community leaders on the opioid crisis.

There Is Hope: Treatment, Recovery, and Prevention

Wednesday, August 16, Noon to 1 p.m. ET

Connecting people to treatment and recovery support has been shown to be effective and can save lives. During part two of this series, experts from SAMHSA and the CDC will review early intervention and treatment options, and they will discuss the essential role that the community plays in recovery support and prevention. They will also discuss strategies for getting ahead of the problem, the impact of adverse childhood experiences on the development of a substance use disorder, and how upstream preventative action can restore hope and lead to a brighter and healthier future for generations to come. The webinar will close with a Q&A session and a review of resources
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

Maryland
August 17 - Baltimore City Health Dept.
August 24, 25, and 28 – SAMHSA, Rockville

Massachusetts
August 15 – Department of Mental Health/Department of Disability Services, Pittsfield

New York
August 31 - The Charter High School for Law and Social Justice, the Bronx

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.

WEBINAR OPPORTUNITY

Implementing Change: Working to Address the Intersections of Juvenile Justice and Youth Homelessness

September 21, 2 p.m. to 3:30 p.m. ET

Sponsored by the Coalition for Juvenile Justice

A growing number of communities are working to ensure that young people do not experience homelessness as a result of involvement with the justice system, and that similarly, they do not come in to contact with the system because they are experiencing homelessness. On any given night nearly 1.3 million young people are experiencing homelessness. Many of these youth will also come in to contact with law enforcement, be arrested, and/or be incarcerated. Join us to learn how Philadelphia, Pa., and Minnesota are working to combat this cycle, and learn about the Principles for Change, a series of policy recommendations that communities and states can adopt to help address these intersections, and the application of these principles for youth in custody.

The webinar is free for all to attend.

Presenters Include:

- Callie Aguilar, Juvenile Justice Specialist, Minnesota
- Jennifer Pokempner, Juvenile Law Center, Child Welfare Policy Director
- Elizabeth Seigle, Grantee Technical Assistance Manager, Council of State Governments
- Naomi Smoot, CJJ, Executive Director

Register HERE
A historical overview of the origin, purpose, and impact of the Mental Health Block Grant (MHBG): Second in a Two-Part Series

New to State Mental Health?
Do you work on your state’s Mental Health Block Grant Application?
Need a “refresher” on the history of our Mental Health System?
Want to know how the 2016 Cures Act has impacted the Block Grant?

Recently, the National Association of State Mental Health Program Directors (NASMHPD) has seen a rapid turnover of State Mental Health Authority (SMHA) staff who work on the MHBG, in particular state planners. This turnover has resulted in much of the institutional knowledge about the MHBG, and its role in helping states create robust mental health systems, disappearing from many state systems. This two-part webinar series will focus on the history and context of the MHBG to bring together the threads of psychiatric treatment over time, the development of the federal structure for mental health services, and the legislative and legal milestones in public mental health services. It will showcase how the 1982 block grant requirements were embedded in the prior history and context and continue to impact how our system operates today.

While the presentations will be open to anyone, they will be targeted primarily to State personnel, especially new state planners. It is expected that a greater understanding of the block grant requirements will be achieved by knowing the broad-stroke history of mental illness treatment, the creation and history of the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS), the origin of the MHBG, and the respective roles of SAMHSA, the State Project Officers, the State Planner (including a few tips to help organize the process), and the Planning Council. Part Two will also highlight the recent statutory changes stemming from the 2016 Cures Act.

Friday, August 18, 2 p.m. to 3:30 p.m. ET– PART TWO

Part Two will focus on the following areas AFTER the 1982 Mental Health Block Grant:

- History of Psychiatric Treatment in the US
- Research, Legislative, and Legal Milestones
- Overview of the Mental Health Block Grant and its requirements
- Roles and Responsibilities of SAMHSA, State Project Officers, Block Grant Monitors, State Planner, and the State Planning Council

Register HERE for Part II of the Webinar Series

In consultation with SAMHSA, NASMHPD is excited to be working with Molly Brooms, a retired State Planner from Alabama, to develop and present these two webinars.

A.G. Announces Justice Department Plan to Go After Doctors, Pharmacies on Opioids

(Continued from page 1) Attorney General Jeff Sessions announced on August 2 that the Justice Department has created a new Opioid Fraud and Abuse Detection Unit pilot program that will analyze death rates of patients with opioid prescriptions and go after doctors and pharmacies suspected of healthcare fraud in over-prescribing and distributing opioids.

The data analytics team will look at which physicians are writing opioid prescriptions at a rate that far exceeds their peers; how many of a doctor’s patients died within 60 days of an opioid prescription; the average age of the patients receiving these prescriptions; pharmacies that are dispensing disproportionately large amounts of opioids; and regional hot spots for opioid issues.

In a speech at a Columbus, Ohio police academy, he said the new program would detail 12 Assistant U.S. attorneys for three years to jurisdictions hit particularly hard by the opioid epidemic. He said southern Ohio would be one of the 12 areas targeted by the new initiative.

Other areas to be targeted include middle Florida, eastern Michigan, northern Alabama, eastern Tennessee, Nevada, eastern Kentucky, Maryland, western Tennessee, eastern California, middle North Carolina, and southern West Virginia.

With these “With these new resources, we will be better positioned to identify, prosecute and convict some of the individuals contributing to these tens of thousands of deaths a year,” Sessions said.
Recovery to Practice Announces an On-Demand Continuing Medical Education (CME) Webinar Series

Clinical Decision Support for Prescribers Treating Individuals with Co-Occurring Disorders

This two-course series offers information and resources for physicians, clinicians, and other practitioners serving individuals with serious mental illness and co-occurring substance abuse disorder.

In this scenario-based series, participants meet “Nick,” a young father with many strengths and who is challenged by both substance abuse and mental illness. The course explores the question: How do I approach Nick and help him meet his needs in ways that are both clinically sound and recovery-focused?

The faculty are national experts in recovery, including psychiatrists, a psychologist, a social worker, a nurse, and peers. They offer tools, tips, and strategies for addressing Nick’s needs, and those of other individuals facing similar challenges.

Course 1: Principles, Assessment, and Psychopharmacology in Recovery-Oriented Care

Course 2: Engagement, Staged Interventions, and Recovery Supports for Co-Occurring Disorders

Watch one or both courses at your convenience! Each course is approved for 1.5 AAFP (American Academy of Family Physicians) prescribed credits.

Course Objectives

After viewing, learners will be able to:

1. Summarize a recovery-oriented approach to the treatment of individuals with co-occurring mental and substance abuse disorders.

2. Describe the process of recovery-oriented, strength-based engagement, assessment, and intervention, including psychopharmacology treatment, for individuals with co-occurring mental and substance abuse disorders.

3. Describe non-medication recovery and support approaches for individuals with co-occurring mental health and substance abuse conditions.

Course Faculty

Curley Bonds, M.D.
Medical Director,
Didi Hirsch Mental Health Services

Wayne Centrone, N.M.D., M.P.H
Senior Health Advisor, Center for Social Innovation
Executive Director of Health Bridges International

Chris Gordon, M.D.
Medical Director and Senior Vice President for Clinical Services, Advocates, Inc.
Associate Professor of Psychiatry, Harvard Medical School

Jackie Pettis, M.S.N, R.N.
Advisor and Trainer for Psychiatry to Practice Project

Ken Minkoff, M.D.
Senior System Consultant, ZiaPartners, Inc.
Clinical Assistant Professor of Psychiatry, Harvard Medical School

Kim Mueser, Ph.D.
Executive Director, Center for Psychiatric Rehabilitation, Boston University

Melody Riefer, M.S.W., Senior Program Manager, Advocates for Human Potential
Webinar Series: Communities Addressing Trauma and Community Strife through Trauma-Informed Approaches: Trustworthiness and Transparency in a Community Setting

Register [HERE](#)

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Center for Trauma-Informed Care and Alternatives to Restraint and Seclusion (NCTIC) is pleased to present a 6-part series entitled “Communities Addressing Trauma and Community Strife Through Trauma-Informed Approaches.” SAMHSA/NCTIC is offering this virtual webinar series highlighting communities working to improve the resiliency of its members and responsiveness to community incidents. The series framework follows SAMHSA’s six principles of trauma-informed approaches, as described in [SAMHSA’s Concept of Trauma and Guidance for Trauma-Informed Approaches](#).

SAMHSA’s NCTIC is tasked with the design and implementation of a technical assistance strategy to assist publicly funded systems, agencies, and organizations across the country in preventing the use of restraint, seclusion, and other forms of aversive practices through trauma-informed approaches. NCTIC supports SAMHSA’s Trauma and Justice Strategic Initiative goal of implementing trauma-informed approaches in health, behavioral health and related systems. Specifically, this series addresses SAMHSA’s objective to develop a framework for community and historical trauma and a trauma-informed approach for communities. The series is open to all interested in addressing community trauma and healing.

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Webinar Series: Trauma-Informed Innovations in Crisis Services

July - September 2017 (4th Monday of each month) 3 p.m. to 4 p.m. E.T.

Register [HERE](#)

NCTIC is also pleased to announce the opportunity to participate in the webinar series Trauma-Informed Innovations in Crisis Services. This series highlights the innovative work of crisis service providers employing a trauma-informed approach, including prevention, engagement, and inclusion of lived experience, and peer support. Each 60-minute webinar focuses on how an agency implements the principles from [SAMHSA's Concept and Guidance for Trauma-Informed Approaches](#): Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment, Voice and Choice, and Cultural, Historical, and Gender Issues. A moderated Q&A session follows the presentation. Intended audiences for this webinar series include: state mental health authorities, providers of crisis prevention and intervention services, as well as peers, families, and community members.

According to SAMHSA’s publication: Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies, “National statistics attest to the significant need for crisis services. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health condition. Not everyone will experience a need for crisis services but some factors may increase the risk of crisis such as poverty, unstable housing, coexisting substance use, and other physical health problems. Research based on the effectiveness of crisis service has been growing, with evidence that crisis stabilization, community-based short-term crisis care, peer crisis services, and mobile crisis services can divert people from unnecessary hospitalizations and ensure the least restrictive treatment option. A continuum of crisis services can assist in reducing costs and address the problem that lead to the crisis. The primary goal is to stabilize and improve symptoms of distress and engage people in the most appropriate treatment.

More and more states/organizations have developed innovative crisis services/teams through the implementation of SAMHSA’s Trauma-Informed Approaches. Crisis Services/Supports may include: short-term crisis residential programs, crisis stabilization programs (i.e., community-based, ER, psychiatric ER), peer-run and other crisis respite programs, comprehensive psychiatric emergency response centers, emergency response recovery/detox programs, or mobile crisis outreach programs.

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Check Out the Newest TA Network Monthly Minute: Better Behavioral Health Care through Psychotropic Medication Consultation

This month’s edition focuses on support for primary care providers in the use of psychotropic medication consultation to address the behavioral health needs of children, youth and young adults. Assisting primary care providers to engage in behavioral health consultation is one way to circumvent the shortage of behavioral healthcare providers that many communities face. This short animated video provides an overview of the topic and is accompanied by related resources and links to access additional information.

[Click here](#) to review previous Monthly Minutes.
Funding Opportunity Announcement
Lifeline Network State Capacity Building Initiative

The National Suicide Prevention Lifeline (the Lifeline) released a new Request for Proposals (RFP), **State Capacity Initiative**, on August 1

The Lifeline is facing challenges in ensuring that every state has a crisis center which is a Lifeline member, and ensuring that most calls can be answered within the state from which the caller is phoning. In order to help address these challenges, Mental Health Association of New York City (MHA-NYC) released an RFP in the amount of $460,000 to at least one state striving to maintain at least 70 percent of in-state calls, to award assistance to a local center (or centers) to better manage these calls.

States applying for these funds to support a center (or centers) answering Lifeline calls must submit a plan for sustaining the funds to their designated center(s) after the contract period ends. The funds will be available for one year only.

**To view the RFP, visit:**
https://suicidepreventionlifeline.org/state-capacity-building-initiative/

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NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

In the spring of 2015, NASMHPD launched an Early Intervention in Psychosis (EIP) virtual resource center, which was made possible through the generous support of the Robert Wood Johnson Foundation (RWJF). The intent of the EIP site is to provide reliable information for practitioners, policymakers, individuals, families, and communities in order to foster more widespread understanding, adoption and utilization of early intervention programming for persons at risk for (or experiencing a first episode of) psychosis. The site includes information from the national RWJF-funded demonstration to identify and prevent the onset of psychotic illness – the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) – as well as a variety of other early intervention initiatives.

EIP is designed to provide an array of information through a consolidated, user-friendly site; and it is updated on a periodic basis. To view the EIP virtual resource center, visit [NASMHPD's EIP website](#).

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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.
State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

NASMHPD coordinates a variety of SAMHSA-sponsored technical assistance and training activities under the State TA Project.

**To Request On-site TA:** States may submit requests for technical assistance to the on-line SAMHSA TA Tracker, a password-protected system. All of the Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can give authorization to other SMHA staff as well. Once in this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals the state is seeking to address via the support.

On average, a given TA project includes as many as 10 days of consultant time (including prep and follow-up), along with coverage of consultant travel to your state.

The log-in for the Tracker is: [http://tatracker.treatment.org/login.aspx](http://tatracker.treatment.org/login.aspx). If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: tatracker@treatment.org.

Note that technical assistance under this project cannot be specifically focused on institutional/hospital-based settings.

For answers to other questions, contact your CMHS State Project Officer for the Mental Health Block Grant, or NASMHPD’s Pat Shea by email or at 703-682-5191.

**Technical Assistance Products for Services to Persons Experiencing a First Episode of Psychosis**

With support from the Center for Mental Health Services, NASMHPD and NRI have developed a second set of technical assistance materials that address issues with programming for individuals experiencing a first episode of psychosis. The products are listed below.

- **Policy Brief:** The Business Case for Coordinated Specialty Care for First Episode Psychosis
- **Toolkits:** Supporting Full Inclusion of Students with Early Psychosis in Higher Education
  - Back to School Toolkit for Students and Families
  - Back to School Toolkit for Campus Staff & Administrators
- **Fact Sheet:** Supporting Student Success in Higher Education
- **Web Based Course:** A Family Primer on Psychosis
- **Brochures:** Optimizing Medication Management for Persons who Experience a First Episode of Psychosis
  - Shared Decision Making for Antipsychotic Medications – Option Grid
  - Side Effect Profiles for Antipsychotic Medication
  - Some Basic Principles for Reducing Mental Health Medicine
- **Issue Brief:** What Comes After Early Intervention?
- **Issue Brief:** Age and Developmental Considerations in Early Psychosis
- **Information Guide:** Snapshot of State Plans for Using the Community Mental Health Block Grant (MHBG) Ten Percent Set-Aside for Early Intervention Programs (as of September 2016)
- **Information Guide:** Use of Performance Measures in Early Intervention Programs

These products are in addition to those that were developed last year as well as other materials on first episode programming. They can be obtained at [http://www.nasmhpd.org/content/information-providers](http://www.nasmhpd.org/content/information-providers). Any questions or suggestions can be forwarded to either Pat Shea ([Pat.shea@nasmhpd.org](mailto:Pat.shea@nasmhpd.org)) or David Shern ([David.shern@nasmhpd.org](mailto:David.shern@nasmhpd.org)).
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NASMHPD Links of Interest
Geographic Variation in Opioid- and Heroin-Involved Drug Poisoning Mortality Rates, Ruhm C.J., PhD, American Journal of Preventive Medicine, August 7
Mortality and Self-Harm in Association With Clozapine in Treatment-Resistant Schizophrenia, Wimberly T. et al., American Journal of Psychiatry, July 28 (The results of this study demonstrate a nearly twofold higher mortality rate among individuals with treatment-resistant schizophrenia not treated with clozapine compared with clozapine-treated individuals. Furthermore, the results suggest a harmful effect of other antipsychotics regarding self-harm compared with clozapine.)
Clozapine Underutilization: Addressing the Barriers, Assessment #1 in a Series of Eight Briefs on the Use of Technology in Behavioral Health, Love R.C. PharmD, BCPP, FASHP, Kelly D.L., PharmD, BCPP, Freudenreich O., MD, FAPM, Sayer M.A., BS, National Association of State Mental Health Program Directors, September 2016
Dynamics of Homelessness in Urban America, Glynn C., Fox E.B., Unpublished, July 28 (Study examines the relationship between rent levels and homelessness in the 25 largest U.S. metropolitan areas.)
Take the Generic Drug, Patients Are Told—Unless Insurers Say No, Pro Publica & the New York Times, August 6
Preventive Effects of Suvorexant on Delirium: A Randomized Placebo-Controlled Trial, Hatta K., MD, PhD et al., Journal of Clinical Psychiatry, August 7
The Doctor Will Analyze You Now: A Health Center for Native Alaskans Brought Mental and Physical Care under One Roof, with Impressive Results. Why isn’t it more popular? Politico, August 9