House Energy and Commerce Schedules June 15 Vote on Mental Health Reform Bill

The House Energy and Commerce Committee has announced it will “mark up” (vote) on a once-again revised version of Rep. Tim Murphy’s (R-PA) Helping Families in Mental Health Crisis Act on June 15.

Committee staff began circulating among stakeholders the revised version of the bill, which differs from the one voted out of the Committee’s Health Subcommittee during a November 3, 2015 10-hour long voting session. Provisions of that earlier Majority Amendment version were controversial among Democratic members of the Committee, who offered their own version for consideration.

The Democrat’s measure was quickly rejected by Committee Chairman Fred Upton (R-MI), but he promised committee Democrats to continue working to find compromise before scheduling a vote in the full committee. The version being considered next week contains many of the provisions in the Democratic version. It also eliminates many of the more controversial provision in the Murphy bill, including incentive payments for states that adopt assisted outpatient treatment procedures and amendments to the Health Insurance Portability and Accountability Act (HIPAA) which would have loosened perceived restrictions on providers sharing patient health information with family.

The legislation still contains HIPAA language, but in a form considered to be less offensive to advocates if still somewhat ambiguous.

The coverage for adult inpatient mental health services in an IMD has been modified in the new version to mirror the coverage included in the Medicaid managed care regulations adopted last month by the Centers for Medicare and Medicaid Services (CMS). Those regulations permit capitated payments to managed care organizations for IMD stays of 15 days or less in a month. The previous version of the legislation would have covered stays in IMDS, in both fee-for-service and managed care, for not more than 20 days in a month.

The new version makes the Mental Health Block Grant set-aside for first episode psychosis services permanent, but limits the set-aside to 5 percent, rather than the current level of 10 percent. However, the legislation permits states to defer setting aside the 5 percent in one year, as long as the combined set-aside for two successive years is 10 percent.

While the newest version of the legislation would not completely eliminate SAMHSA, it would put the agency and its Administrator under a new Assistant Secretary, shift the agency’s and the Administrator’s responsibilities to newly created entities, require consultation with other Federal agencies with far less practical experience, and subject SAMHSA to various audits and studies. Although the Administrator retains the authority to administer grants she/he is required to consult with the Director of the National Institute of Mental Health (NIMH) prior to awarding grants. NASMHPD has voiced concerns about these provisions.

Especially of note is language in § 106(c)(7) of the bill requiring an independent audit of SAMHSA to determine whether SAMHSA’s “focus on recovery is appropriate.” NASMHPD has advised committee staff that we find the language to be simultaneously ambiguous and to dictate a forgone conclusion. NASMHPD suggested alternative language to ensure an unbiased evaluation.

In addition, NASMHPD suggested that § 603 of the bill, which encourages NIMH to “conduct or support research on the determinants of self-directed and other violence connected to mental illness” include data on violence against individuals with mental illness.

NASMHPD also objected to the repeal of an existing program that provides funding for community-based transition mental health services to previously incarcerated youth.

**Work Days Left in the 114th Congressional Session (2015-2016) (as currently scheduled)**

- 38 – House Work Days before Election Day
- 16 – House Work Days after Election Day
- 41 – Senate Work Days before Election Day
- 20 – Senate work Days after Election Day
Study Finds Nearly All ACA Benchmark Plans Violate ACA and Parity Rules for Unrestricted Access to Substance Use Disorder Services

A report from a study by the National Center on Addiction and Substance Abuse released June 7, *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*, finds that nearly all of the 2017 state-designated Essential Health Benefit (EHB) benchmark plans are non-compliant with Affordable Care Act (ACA) requirements and/or provide substance use disorder (SUD) treatment benefits that fail to conform to the Mental Health Parity and Addiction Equity Act (MHPAEA).

Neither the ACA nor the supporting regulations define which SUD services must be covered by Marketplace plans. Instead, CMS adopted a “benchmark approach” that allows each state to adopt its own definition. The benchmark approach requires each state to select an existing employer-sponsored plan (either a small-group, state employee, federal employee or HMO plan) to serve as the EHB-benchmark plan.

The insurance plans selected to serve as the states’ 2017 EHB-benchmark plan are not subject to MHPAEA. However, any future Marketplace plans modeled on the 2017 EHB-benchmark plans will have to comply with MHPAEA. The National Center notes that the Centers for Medicare and Medicaid Services (CMS) recognized this could create problems because non-MHPAEA-compliant EHB-benchmark plans would not provide a sufficient template for future Marketplace plans, and that it would have been easier for issuers if states chose an MHPAEA-compliant plan for the 2017 EHB-benchmark plan. However, the National Center says time constraints precluded states from doing so.

Key findings of the paper include:

- Over two-thirds of plans contain obvious violations of the ACA’s mandate that SUD treatment benefits be covered.
- 18 percent of plans are clearly noncompliant with parity requirements, with an additional 31 percent of plans conducting possible parity violations.
- None of the plans provide comprehensive coverage for SUD treatment by covering the full array of critical benefits without imposing treatment limitations. The most frequently excluded or not explicitly covered benefits are residential treatment and methadone maintenance therapy, which the National Center contends should be covered mandatorily.
- Plan documents for 88 percent of state plans lack sufficient detail to fully evaluate parity compliance and/or the adequacy of addiction benefits.

The report notes specifically that Mississippi’s and South Carolina’s 2017 EHB-benchmark plans contain a Uniform Individual Accident and Sickness Policy Provision Laws (UPPL) provision which allows insurance providers to deny coverage for injuries sustained by a person who was under the influence of alcohol or other drugs at the time of the injury. The National Center says these laws deter health care providers from identifying and treating SUDs and recommends that UPPL provisions be prohibited in all Marketplace plans.

The report also notes that the 2017 EHB-benchmark plans for California, Colorado, Pennsylvania and Virginia require excessively high daily (e.g., $500 per day up to $2,500) or per admission ($750) co-payments for inpatient and/or residential SUD services. The report recommends that high daily or per admission co-payments for SUD services be banned in Marketplace plans and that states find ways to ensure that cost-sharing obligations do not deter patients from seeking the necessary care. The EHB law already prohibits plans from imposing lifetime and annual dollar limits on SUD benefits.

Noting that a majority of the 2017 EHB-benchmark plans require prior authorization for a range of SUD services, the National Center suggests that, even in cases where such requirements are technically in parity with prior authorization requirements for comparable medical services, excessive prior authorization requirements are not clinically appropriate for treatment of SUDs, as they can delay necessary clinical care and inhibit access to appropriate clinical services. The National Center urges HHS and the other agencies responsible for implementation of MHPAEA to confirm whether prior authorization requirements for SUD benefits violate parity when they are not clinically appropriate. It also suggests that, if no parity violation is found, HHS should ask states to consider removing these requirements.

The National Center also says additional guidance is needed regarding parity requirements for intermediate services because the Federal regulations are ambiguous. It says the current requirement that plans that cover intermediate SUD services assign those benefits to the same benefit classification as comparable intermediate medical services is inadequate for ensuring equal coverage of intermediate services. It points to findings that several 2017 EHB-benchmark plans cover intermediate medical services (i.e., skilled nursing facility, home health care) but exclude or omit information about coverage of intermediate SUD services (i.e., residential treatment, intensive outpatient, day/partial hospitalization programs). It says this should not be permissible under either the ACA or MHPAEA.
Senate Appropriations Panel Approves FY 2017 Funding for Health and Human Services

On June 9, the Senate Appropriations Committee voted out a Labor-HHS funding bill for the first time in seven years. Both Chairman Thad Cochran (R-MS) and Ranking Member Patty Murray (D-WA) touted the Senate bill as a bipartisan effort.

At this point, the bill contains no controversial policy riders that might sink passage. However, policy riders could be added on the floor. The House has not yet voted on Labor-HHS funding, and it is scheduled to be taken up last among all appropriations bills being considered in that chamber.

The funding agreement funds HHS at $76.9 billion, a $1.4 billion increase above FY2016. It includes the following:

- **Substance Abuse and Mental Health Services Administration (SAMHSA)** - $3.7 billion for SAMHSA, which is $8 million more than the President's request.
- **Mental Health** – an $80 million increase above FY2016 funding levels. It provides $541.5 million, an increase of $30 million above FY2016, for the Mental Health Block Grant and continues the set-aside for serious mental illness activities at 10 percent. The bill also provides $50 million in funding for CHCs to provide mental health services at community health centers across the country.
- **Fighting Opioid Abuse** – $261 million, an increase of $126 million or 93 percent over FY 2016, for Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Resources and Services Administration programs targeted to combat opioid abuse.

Specifically, the bill provides a $28 million increase for a CDC Prescription Drug Overdose program, a $49 million increase to SAMHSA for treatment, prevention, and overdose reversal, and $50 million for Community Health Center treatment and prevention. The bill continues to provide $1.9 billion for the Substance Abuse Prevention and Treatment Block Grant and $94 million in mandatory funds to Community Health Centers, and it provides an additional $52.5 million to the National Institute on Drug Abuse at the NIH.

The bill includes $60 million for state grants to expand access to drug treatment services for individuals with a dependence on prescription opioids or heroin; this is $35 million more than in FY 2016. The bill also includes $26 million, $14 million more than FY 2016, to help states purchase emergency devices that rapidly reverse the adverse effects of opioid overdoses, train first responders on how to use the emergency devices, and increase public awareness of the dangers of opioid use.

- **National Institutes of Health (NIH)** – $34.1 billion, an increase of $2 billion above FY2016. The bill includes:
  - $300 million for the Precision Medicine Initiative, an increase of $100 million;
  - $1.39 billion for Alzheimer's disease research, an increase of $400 million;
  - $250 million, an increase of $100 million, for the BRAIN Initiative to map the human brain;
  - **Workforce** - $50 million for the Health Resources and Services Administration's Behavioral Health Workforce Education and Training Program (BHWET) and $9.9 million for grants to institutions of higher education to recruit and train behavioral health professionals.
  - **Community Health Centers (CHCs)** – $1.49 billion, level with FY2016. Combined with the mandatory funding provided in the Medicare Access and CHIP Reauthorization Act of 2015, the program level for CHCs is $5.1 billion, $150 million more than President's request and equal to the FY 2016 level. The bill directs that not less than $100 million be used to expand mental health services and services to prevent and treat opioid abuse underserved areas.
  - **Rural Health Care** – $152.6 million, an increase of $3 million above FY 2016 funding levels, for rural health programs. This includes an additional $1 million in funding, for a total of $18 million, for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans’ care between the Department of Veterans Affairs and rural providers outside the VA provider network.
  - **Enhancing Care for individuals with Alzheimer’s disease.** The bill includes a new provision that requires CMS to cover patient-centered comprehensive Alzheimer’s disease care planning services.
  - **Public Health Preparedness and Response** – The bill maintains FY 2016 funding levels for these activities, including **Public Health Emergency Preparedness (PHEP)** – $660 million – to help states prepare, respond, and recover from emerging threats such as natural disasters, disease outbreaks, and chemical, biological, radiological, and nuclear threats.
  - **Preventive Health and Health Services Block Grant (Prevent Block Grant)** – $160 million, level with FY 2016 funding levels. The Block Grant provides flexible funding for states to implement prevention activities according to local health needs.

The Children’s Mental Health set-aside proposed by the Obama Administration for prodromal interventions is not included, because NIMH told the Committee that further evidence of effectiveness of the intervention is needed before those interventions are widely adopted.

The bill also rescinds three separate funding authorizations for the Children’s Health Insurance Program (CHIP) totaling $6 billion. In addition, it eliminates funding for 18 programs, including the State Health Insurance Assistance Program for Medicare beneficiaries.
Health Affairs Focuses on Suicide as an Emerging Health Care Priority and Zero Suicide as a Prevention Strategy in the Primary Care Setting

An article in the June issue of the journal Health Affairs calls suicide prevention an emerging priority for health care and examines the feasibility of improving suicide prevention in health care settings through the Zero Suicide model for better identifying and treating patients at risk for suicide.

The article’s authors, mental health expert Michael F. Hogan and Julie Goldstein Grumet, Director of Health and Behavioral Health Initiatives at the Suicide Prevention Resource Center, note that suicide is the tenth leading cause of death in the U.S., accounting for more than 40,000 deaths annually. Additionally, there are almost 500,000 emergency department (ED) visits annually resulting from intentional self-harm. In 2010, costs for ED visits and hospitalizations associated with self-injury among young adults, ages 15 to 24, were projected by the Centers for Disease Control and Prevention (CDC) at $2.6 billion.

The authors note that, despite recent Federal efforts, such as the passage of the Garrett Lee Smith youth suicide prevention grant program administered by SAMHSA, and the establishment of the Suicide Prevention Resource Center, the National Suicide Prevention Lifeline, and the Veterans Affairs national hotline for veterans in crisis, the number and rate of suicide deaths continue to rise. In 2001 there were 30,622 deaths from suicide (a rate of 10.75 people per 100,000); by 2014 there were 42,773 deaths (a rate of 13.41 people per 100,000).

The authors say health care providers playing an ongoing, rather than visit-based role would be as useful for suicide prevention as they are in the management of other chronic health conditions. But until very recently, suicide prevention was not defined as a core responsibility of either mental health care or health care, except in inpatient settings. On February 24, the Joint Commission signaled a new focus on suicide prevention across health care settings by releasing Sentinel Event Alert 56, the aim of which is to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicidal ideation.

The authors suggest there is considerable evidence that suicide prevention in mental health services can be improved. They say mental health professionals receive only minimal training on suicide prevention, and the routine standard of care is to hospitalize patients at high risk of suicide, discharging them once the risk is judged to be reduced, with guidance to engage in follow-up care. However, only about half of patients complete a follow-up out-patient visit within a week, even though studies have found the risk of suicide is more than three times as likely the first week after discharge from a psychiatric facility and remains significantly above the base rate the entire year.

In 2010, then-Health and Human Services Secretary Kathleen Sebelius and then-Secretary of Defense Robert Gates launched the National Action Alliance for Suicide Prevention, under which several task forces were created. The Clinical Care and Intervention Task Force examined research on detecting and managing suicidality and considered various ongoing efforts to reduce suicide in health care settings, eventually concluding there was strong evidence for successfully detecting and managing suicidality in health care.

The Task Force report found that three common factors were key to the successes of programs: (1) “core values”—the belief and commitment that suicide can be eliminated in a population under care by improving service access and quality and through continuous improvement; (2) “systems management”—taking systematic steps to create a culture that no longer finds suicide acceptable, [and] sets aggressive but achievable goals to eliminate suicide attempts and deaths among members; and (3) “evidence-based clinical care practice” delivered through standardized risk stratification, targeted evidence-based clinical interventions, accessibility, follow-up and engagement and education of patients, families, and health care professionals. The Task Force named the approach it recommended Zero Suicide. (cont’d on page 5)
Health Affairs Examines Suicide Prevention Strategies in the Primary Care Setting

(cont’d from page 4) The Zero Suicide approach was refined, implemented, and tested in 2013–14 by prototype behavioral health and integrated primary care programs. Pilot testing found the approach could be feasibly implemented in ordinary care settings—built into routine clinical workflow, carried out successfully by current staff, provided without new funding, and measured successfully.

At Centerstone, a large Tennessee behavioral health nonprofit, the baseline rate for suicide before Zero Suicide implementation was 31 people per 100,000; the suicide rate two years into implementation dropped to 11 per 100,000. At the Institute for Family Health, a network of community health centers in New York, after a safety-planning template was embedded into the electronic health record and training and monitoring were provided, safety-plan usage by primary care providers for patients with a positive suicide screen increased from 38 percent to 84 percent over two years.

The authors say that to make suicide prevention a core responsibility of health systems, developing better measures for suicidality, and changing standards of care such as follow-up after discharge will be necessary. They also point to a need for a suicide care pathway into electronic health records.

They acknowledge that inadequate reimbursement for the clinical activities of suicide prevention care can be an obstacle, but say it is less a problem since passage of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act. They say that, while there are many challenges to improving screening, assessment, and basic management of suicidality in general medical settings, improving payment for integrated behavioral health services, expansion of the patient-centered medical home model, and an increased patient preference for integrated care are likely to create an improved environment for suicide prevention in primary care.

The authors insist the assessment and treatment of suicidality in the behavioral health sector needs to be improved, because suicidal patients are generally referred to behavioral health providers, who often lack professional training in this area. Additionally, essential aspects of managing and treating suicidality (safety planning, lethal means reduction, direct treatment of suicidality, and persistent supportive contacts) are not standard in most behavioral health settings.

However, they are optimistic that, as more states evaluate data on deaths and amend their suicide prevention plans, their attention will turn to improving suicide prevention care through the Zero Suicide model.

![10 Leading Causes of Death by Age Group, United States – 2014](chart)

Chart by Centers for Disease Control and Prevention (CDC)
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. 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 Pat Shea at NASMHPD at 703-682-5191 or pat.shea@nasmhpd.org.

UPCOMING WEBINARS

Medicaid IAP Targeted Learning Opportunity - CDC Guideline for Prescribing Opioids for Chronic Pain

Monday, June 13 -- 3:30 p.m. to 5 p.m. ET

Register HERE

The next TLO session for the Medicaid Innovation Accelerator Program will focus on disseminating key points and recommendations from the recently published CDC opioid prescribing guideline for primary care providers who are treating adult patients for chronic pain in outpatient settings. The goal of the guideline is to help providers and patients—together—assess the benefits and risks of opioid use. It encourages providers to consider the unique needs of each patient in order to provide safer, more effective pain treatment while reducing risks of addiction and overdose. The webinar will highlight how different state Medicaid agencies are implementing strategies to reduce opioid prescribing while meeting the clinical needs of their beneficiaries.

Ensuring Stakeholder and Family Engagement in Organizational Oversight of Community Behavioral Health Services

Monday June 13 – 2 p.m. to 3:30 p.m. ET

Register HERE

Sponsored by SAMHSA and presented by the National Council for Behavioral Health, National Federation of Families for Children’s Mental Health and the National Alliance on Mental Illness

Adults, youth and children with lived experience and families of those affected by mental illness and behavioral health challenges have emerged as some of the leading voices in the modern day development of comprehensive resilience and recovery services. Some behavioral health payers in today’s health care arena are requiring states and organizations to diversify the stakeholder groups that contribute to and govern overall program development and implementation. This webinar will explore how organizations can incorporate consumer, family and community perspectives in organizational decision-making, and how states can encourage behavioral health organizations to include consumers, families and community partners perspectives’ in governance and decision making through formal and informal mechanisms. Learn strategies you can use to engage families, consumers, and other community-based stakeholder voices in the development of behavioral health programs. The panel of experts:

- Sita Diehl, Director of Policy and State Outreach, National Alliance on Mental Illness
- Dr. Lynda Gargan, Executive Director, National Federation of Families for Children’s Mental Health
- Larry Fricks, Director, Appalachian Consulting Group; Deputy Director, SAMHSA-HRSA Center for Integrated Health Solutions

When in the seminar room, the Adobe Connect Log-in screen appears, select "Enter as a Guest," enter the name and state of the participant in the "Name" field (Ex. Jane Doe-AK) and click on "Enter Room."

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

On June 7, the journal Health Affairs presented a briefing on Behavioral Health in an Era of Reform at the National Press Club in Washington D.C. Papers highlighted from the June Issue of the magazine were presented in four panels of presenters: 1) Insurance Coverage and Parity; 2) Meeting Behavioral Health Care Needs; 3) Interaction with the Criminal Justice System; and 4) Equity. The event concluded with a roundtable. The magazine is subscription-only, but the June articles include:

Federal Parity in The Evolving Mental Health And Addiction Care Landscape, by Bloomberg School of Public Health’s Colleen L. Barry, University of Maryland School of Medicine’s Howard H. Goldman, and Harvard Medical School’s Haiden A. Huskamp

Insurance Financing Increased For Mental Health Conditions But Not For Substance Use Disorders, 1986–2014, by Truven’s Tami L. Mark, Tracy Yee, Katharine R. Levit, Jessica Camacho-Cook, and Eli Cutler, and SAMHSA’s Christopher D. Carroll

Building the Mental Health Workforce Capacity Needed To Treat Adults With Serious Mental Illnesses, by the New York State Psychiatric Institute at Columbia University’s Mark Olfson

Removing Obstacles to Eliminating Racial And Ethnic Disparities In Behavioral Health Care, by Margarita Alegría, Kiara Alvarez, Rachel Zack Ishikawa, Karissa DiMarzio, and Samantha McPeck of the Massachusetts General Hospital’s Disparity Research Unit

Quality Measures For Mental Health And Substance Use: Gaps, Opportunities, and Challenges, by the National Quality Forum’s Dr. Harold Alan Pincus and Sarah Hudson Scholle, New York State Psychiatric Institute at Columbia University’s Brigitta Spaeth-Rublee, RAND’s Kimberly A. Hepner, and Mathematica’s Jonathan Brown

US Veterans’ Use Of VA Mental Health Services And Disability Compensation Increased From 2001 To 2010, by Jack Tsai and Robert A. Rosenheck of Yale University’s VA New England Mental Illness, Research, Education, and Clinical Center

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.
Webinar Opportunity: Technology in Recovery by Those Living with Schizophrenia

Tuesday, June 21, 2016 at 2 to 3:30 pm ET

Sponsored by SAMHSA and presented by Mental Health America and National Alliance on Mental Illness

Technology has become increasingly important in the recovery process for those with mental health disorders. In particular, research is growing around programs focused on aspects of schizophrenia and related disorders that are not as well supported by traditional treatment, including cognitive skills, employment, and social skills. These evidence-based practices support individuals in developing meaningful roles in the community and in improving the management of physical and mental health. Panelists will discuss their programs, in addition to future development and expansion of the use of technology in the recovery process for individuals diagnosed with schizophrenia.

The panelists for this webinar:
- Ray Gonzales, LISW, Executive Director at the Center for Cognition and Recovery, LLC
- Ken Duckworth, M.D., Medical Director for NAMI, the National Alliance on Mental Illness
- Katrina Gay, National Director, Communications & Public Affairs for the National Alliance on Mental Illness

Register HERE

When in the seminar room, the Adobe Connect Log-in screen appears, select "Enter as a Guest," enter the name and state of the participant in the "Name" field (Ex. Jane Doe-AK) and click on "Enter Room."

Questions should be addressed to NASMHPD's Kelle Masten via email or at 703-682-5187.

Substance Abuse and Mental Health Services Administration presents

NATIONAL BLOCK GRANT CONFERENCE

Building and Sustaining State Behavioral Healthcare Systems

8:30 a.m., Tuesday, August 9, 2016 through
12 noon, Thursday, August 11, 2016

Hyatt Regency Crystal City
2799 Jefferson Davis Highway
Arlington, VA 22202
(703) 418-1234

REGISTER BY FRIDAY, JULY 8, 2016

For more information or assistance, please contact Rachel Freeland at
(240) 645-4457 or samhsaconf16@jbsinternational.com

8
FOA: Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness

**FOA Number:** SM-16-011  **Posted on Grants.gov:** Monday, April 18, 2016  **Application Due Date:** June 16, 2016

- **Anticipated Total Available Funding:** $13,250,000
- **Anticipated Number of Awards:** Up to 15 awards
- **Anticipated Award Amount:** Up to $1 million/year
- **Length of Project:** Up to 4 years

**Cost Sharing/Match:** No

**Description:** The Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2016 Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness. This 4-year pilot program, established by § 224 of the Protecting Access to Medicare Act of 2014 (PAMA), enacted April 1, 2014, is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness (SMI). AOT is defined under PAMA as "medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a state or local court to order such treatment." AOT (also known as involuntary outpatient commitment, conditional release, and other terms) involves petitioning local courts to order individuals to enter and remain in treatment within the community for a period of time. AOT is intended to facilitate the delivery of community-based outpatient mental health treatment services to individuals with SMI who are under court order as authorized by state mental health statute.

Grants will only be awarded to applicants that have not previously implemented an AOT program. "Not previously implemented" means that, even though the state may have an AOT law, the eligible applicant has not fully implemented AOT approaches through the courts within the jurisdiction. In addition, grants will only be awarded to applicants operating in jurisdictions that have in place an existing, sufficient array of services for individuals with SMI such as Assertive Community Treatment (ACT), mobile crisis teams, supportive housing, supported employment, peer supports, case management, outpatient psychotherapy services, medication management, and trauma-informed care. A portion of the grant funding may be used to enhance the array of services.

Service delivery should begin by the 4th month of the project at the latest.

**Eligibility:** Eligible applicants are: states, counties, cities, mental health systems (including state mental health authorities), mental health courts, or any other entity with authority under the law of the state in which the applicant grantee is located to implement, monitor, and oversee AOT programs. Applicants must operate in jurisdictions that have in place an existing, sufficient array of services for people with SMI such as those mentioned in the previous paragraph.

Proposed budgets may not exceed the amount listed in the tier chart in the FOA in total costs (direct and indirect) in any year of the proposed project. The amount of each grant will be based on the population of the area, including the estimated number of individuals to be served under the grant. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions.

**Contacts:** **Program Issues:** Mariam Chase, Community Support Programs Branch, Center for Mental Health Services, SAMHSA, 240-276-1904. **Grants Management and Budget Issues:** Gwendolyn Simpson, Office of Financial Resources, Division of Grants Management, SAMHSA, 240-276-1408

**Application Materials:** You must respond to the requirements in both the FOA PART I and PART II.

- FOA document Part I (PDF | 515.5 KB)
- FOA document Part I (DOC | 317 KB)
- FOA document Part II (PDF | 433.03 KB)
- FOA document Part II (DOC | 156.5 KB)

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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.

SAMHSA's 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.
Request for Information (RFI): NIMH Request for Brief Perspectives on the State of Mental Illness Research

Notice Number: NOT-MH-16-015  Release Date: May 20, 2016  Response Date: June 30, 2016

Background: This Request for Information (RFI) invites brief perspectives on the state of mental illness research and the National Institute of Mental Health's role in the development of this research. In preparation for the next NIMH Director, NIMH is seeking external input to develop briefing materials that will represent the full diversity of perspectives on mental illness research. NIMH welcomes feedback from investigators, investigator-sponsors, clinicians, advocates, and any other stakeholders who participate in or are otherwise invested in mental illness research.

Information Requested: NIMH invites comments on the state of mental illness research and NIMH's role in the future development of this research. This RFI seeks input from stakeholders from the scientific research community and the general public. The NIMH seeks comments on any or all of, but not limited to, the following topics:

- basic neuroscience research
- translational research
- clinical research
- intervention research
- services research
- Research Domain Criteria initiative (RDoC)
- global mental health
- translational biomarkers
- diversity and training of the workforce
- advocacy and outreach efforts
- the Institute's intramural research efforts

Respondents should identify the category to which they are responding. Comments may focus on current efforts, research gaps, or suggested investments in the selected category and/or on the ways that NIMH may have a greater impact on this area.

NIMH requests that respondents take the current NIMH Strategic Plan for Research (http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml) into consideration when providing comments on research directions and opportunities. The NIMH launched this plan in 2015 as a commitment to accelerate the pace of scientific progress by generating research over the subsequent 5 years.

How to Submit a Response: Comments should be concise and may not exceed 500 words per category. Multiple submissions on different topic areas from the same individual are acceptable. All responses must be submitted electronically by June 30, 2016 to: https://nimhrfi.nimh.nih.gov/portal/.

Please direct all inquiries to: Marlene J Guzman, National Institute of Mental Health (NIMH).

Webinar Opportunity

Suicide Postvention in Schools: Responding Effectively! Preventing Contagion

Tuesday, June 14, 1 p.m. to 1:45 p.m. ET

Suicide is the second leading cause of death for youth between the ages of 15 to 24. Frequently communities and school systems are unprepared when a suicide occurs. In this 45-minute webinar, internationally recognized expert, Scott Poland, Ed.D., will offer postvention strategies, recommendations and resources for school personnel and community leaders. Dr. Poland, Professor at the College of Psychology and the Co-Director of the Suicide and Violence Prevention Office at Nova Southeastern University in Fort Lauderdale, is an internationally recognized expert on school crisis and youth suicide and has authored or co-authored five books and numerous chapters on the subject. He previously directed psychological services for a large Texas school system for 24 years and is a past President of the National Association of School Psychologists and a Past Prevention Director for the American Association of Suicidology. He has testified about the needs of children before the U.S. Congress on four occasions. He has also been involved as an expert witness in numerous legal cases where schools were sued following a suicide.

Contact Karen Carlucci at Kognito for any questions about the webinar.

Register HERE
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More NASMHPD Links of Interest

Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits is a new SAMHSA/DOL online and printable brochure containing examples of common limits that are placed on mental health and substance use disorder benefits and services subject to parity. It educates consumers about how to find information about their health plan benefits and coverage, as well as their right to appeal a claim. Hard copies are available by calling 1-866-444-3272.

Archive of June 7 White House Live Event “Making Health Care Better Series on Mental Health” (start at the 45-minute mark)

Healthy Aging Begins at Home - This Bipartisan Policy Center (BPC) report, issued in May, looks at America’s aging demographics and the investments that will have to be made to help preserve dignity and independence in old age. The BPC Senior Health and Housing Task Force that wrote the report sees a critical need to make important connections that span across the disparate disciplines of housing, architecture, health care, information technology, telecommunications, transportation, urban planning, and financial services.

Department of Labor Checklist: Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) That Require Additional Analysis to Determine Mental Health Parity Compliance