Federal Opioid Commission Hears Testimony on Importance of Medicaid Funding for Treatment as Senate’s Major Medicaid Cuts are Revealed

Members of President Trump’s Opioid Commission heard repeated testimony at its first meeting on June 16 that the repeal of Medicaid expansion contained in the American Health Care Act was “the elephant in the room” that could decimate effective treatment for opioid addiction.

Dr. Joseph Parks, the Medical Director for the National Council on Behavioral Health and a former chair of the NASMHPD Medical Directors Council, told the Commission “Medicaid is the largest national payer for addiction and mental health treatment. Since the majority of increased opiate deaths and suicide occur in young and middle-aged adults - which is the expansion population—the Medicaid expansion must be maintained and completed.”

North Carolina Governor Roy Cooper (D-NC) told the Commission, “We’re kidding ourselves if we don’t think that what is happening over in Congress regarding issues of health care matters to this issue. If we make it harder for people to get health care coverage, it’s going to make this crisis worse.”

But it fell to former Congressman Patrick Kennedy to utilize the oft-used elephant metaphor to emphasize that Medicaid is “the largest provider of coverage for mental illness and addiction in this country. So we have to mention that any repeal of Medicaid is a repeal of coverage that we currently have out there.

Witnesses also suggested that a separate $45 billion fund for addressing substance use disorder treatment and prevention would likely fail to off-set the Medicaid cuts. Partnership for Drug Free Kids CEO Marcia Lee Taylor said the fund and its one-time infusion of funds “will run out of money very fast, states will be left to scramble, and people with addictions will go without help—period.”

In a separate analysis published in The Hill on June 20, former Health and Human Services Assistant Secretary for Planning and Evaluation Richard G. Frank projected it would take $183 billion over 10 years to cover the treatment opportunities eliminated by the AHCA cuts.

The New York Times estimates the opioid epidemic killed somewhere between 59,000 and 65,000 Americans in 2016, an increase of 19 percent over the 52,404 deaths reported in the previous year. That is the largest annual jump ever recorded in the United States, making drug overdoses the leading cause of death among Americans under the age of 50, and exceeding the peek years of death by car crashes and HIV-related illnesses, and gun deaths.

According to data compiled by the Associated Press, Medicaid expansion accounted for 61 percent of total Medicaid spending on substance use disorder treatment in Kentucky, 47 percent in West Virginia, 56 percent in Michigan, 59 percent in Maryland, and 31 percent in Rhode Island. In Ohio, the expansion accounted for 43 percent of Medicaid spending in 2016 on behavioral health, a category that includes mental health and substance abuse.

Despite the testimony, it appears that the U.S. Senate will be voting next week on its version of the AHCA, a version little changed from the House bill passed in May, except it makes even deeper cuts in the

(Continued on page 3)
The U.S. Preventive Services Task Force Recommends Screening for Obesity in Children and Adolescents, and Referral to Comprehensive, Intensive Behavioral Interventions

The U.S. Preventive Services Task Force (USPSTF) has recommended that clinicians screen for obesity in children and adolescents 6 years and older, and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

The Grade B recommendation by the USPSTF means, under § 2713 of the Affordable Care Act, that insurers must offer coverage of the screening and referral without patient cost-sharing, beginning in the next benefit year following the recommendation. It would likely not require the recommended interventions themselves to be exempt from cost-sharing.

The recommendation is published in the June 20 issue of the Journal of the American Medical Association.

Prior to making the recommendation, the USPSTF reviewed 45 trials (n = 7099) of behavioral interventions for obesity. Of these, 42 trials (n = 6956) used multi-component interventions targeting lifestyle change (counseling on diet, increasing physical activity or decreasing sedentary behavior, and addressing behavior change) to limit weight gain or decrease weight. Three smaller trials assessed different behavioral approaches (weight loss maintenance, regulation of cues for overeating, and interpersonal therapy). Intervention trials with an estimated 26 hours or more of contact consistently demonstrated mean reductions in excess weight compared with usual care or other control groups after 6 to 12 months, with no evidence of causing harm. Generally, intervention groups showed absolute reductions in Body Mass Index (BMI) of 0.20 or more and maintained their baseline weight within a mean of approximately 5 pounds, while control groups showed small increases or no change in BMI scores, typically gaining a mean of 5 to 17 pounds. Only 3 of 26 interventions with fewer contact hours showed a benefit in weight reduction.

Approximately 17 percent of children and adolescents ages 2 to 19 years in the United States have obesity (defined as an age- and gender-specific BMI in the 95th percentile or greater). Almost 32 percent of children and adolescents are overweight or have obesity (defined as an age- and sex-specific BMI in the 85th to 94th percentile).

Obesity in children and adolescents is associated with morbidity such as mental health and psychological issues, asthma, obstructive sleep apnea, orthopedic problems, and adverse cardiovascular and metabolic outcomes (high blood pressure, abnormal lipid levels, and insulin resistance). Children and adolescents may also experience teasing and bullying behaviors based on their weight. Obesity in childhood and adolescence may continue into adulthood and lead to adverse cardiovascular outcomes or other obesity-related morbidity, such as type 2 diabetes.

Although the overall rate of child and adolescent obesity has stabilized over the last decade after increasing steadily for three decades, obesity rates continue to increase in certain populations, such as African American girls and Hispanic boys. The proportion of children who meet the criteria for severe obesity (class II [120 percent of the 95th percentile] or class III [140 percent of the 95th percentile]) also continues to increase.

“SAFETY” Cognitive Behavioral Family Therapy May Prevent Youth Suicides

Self-directed behaviors that result in injury or non-suicidal self-injury (NSSI) are a predictive factor for future suicide attempts in youth. To gain a better understanding of effective interventions for this high-risk group, a study funded by the National Institute of Mental Health and American Foundation of Suicide Prevention evaluated the Safe Alternatives for Teens and Youths (SAFETY)—a cognitive-behavioral family treatment program aimed at promoting teen safety.

Dr. Joan Rosenbaum Asarnow and other researchers from the University of California Los Angeles’ School of Medicine and University of Texas Southwestern Medical School found that participants who engaged in the SAFETY program had a higher probability of survival without a suicide attempt or other self-harm at the three month mark in comparison to six suicide attempts in the controlled group.

The study’s findings, published in the June 2017 edition of the Journal of the American Academy of Child and Adolescent Psychiatry, support another randomized trial demonstrating cognitive-behavioral family therapy being an effective intervention in reducing suicide attempts among high-risk youth.

The SAFETY program is a 12-week, two-person intervention course designed to treat NSSI youth to focus on family treatment to protect the youth; the goal of the program is to assist youth in identifying safe and healthy alternatives to suicidal behaviors when interpersonal problems and stress arise. One therapist works with family members and the other with the youth using a cognitive-behavioral model focused on events prior to the incident; cognitive, behavioral, emotional, and environmental processes and triggers that led to the event; and consequences from the suicide attempt or NSSI. One session is conducted in the family’s home to discuss safety tips, such as using a lockbox to secure lethal items.

Sessions focus on activity scheduling, processing positive thoughts, problem solving skills, and understanding emotions and distress. Youth also create a “hope box” that contains keepsake reminders for wanting to live and cues for activating their safety plan. Parent sessions focus on encouraging listening skills and validating emotions, educating about emotions, stress and depression. The average youth studied participated in 9 SAFETY sessions, with 70 percent receiving 9 to 12 sessions.

The adolescents studied were between the ages of 12 to 18 with a suicide attempt or other (Continued on next page)
Senate’s Version of AHCA Released, Scheduled for Vote Next Week, Makes Significant Medicaid Cuts through Per Capita Cap Restructuring and Reduced Inflation Index

(Continued from page 1)

Medicaid program than the House’s $834 billion in cuts.

The Senate draft version, entitled the Better Care Coordination Act, was released to public scrutiny on June 22, but will still be subject to a “vote-a-rama” on amendments when the bill reaches the Senate floor for a vote next week.

Section 202 of the bill authorizes appropriations in FY 2018 of a $2 billion fund designated for state grants to support substance use disorder treatment and recovery support services for individuals with mental or substance use disorders.

The per capita cap restructuring of the Medicaid program included in the House bill has survived in the Senate bill as expected, but with a lower inflation growth rate than in the House bill, beginning in 2025. The lower growth rate eliminates the one-percent add-on for the aging and individuals with disabilities and sets the index at the Consumer Price Index-Urban (CPI-U) rather than the higher CPI-Medical, beginning in 2025. The CPI-M is projected to grow at about 3.7 percent over the next decade, but the CPI-U would only grow at about 2.4 percent.

However, rather than setting FY 2016 as the base period for calculations, states will be permitted to choose eight consecutive quarters in FYs 2014 through 2016 as their base.

On the up side for Medicaid expansion states, the repeal of the Affordable Care Act’s expansion contained in the House bill is spread out over three years, beginning in 2025.

As in the House version, states could receive waivers of some of Obamacare’s consumer protections, under § 1332 of the Affordable Care Act (ACA), including the provision of essential health benefits (EHBs). However, unlike under the House bill, states and plans could not waive them for people with pre-existing health conditions.

The ACA mandate that EHBs be included in Medicaid alternative benefit plans is repealed. But a provision creating a block grant alternative to per capita caps requires that mental health and substance use disorder services be included.

And there is one unexpected surprise: optional Medicaid coverage of 30 consecutive days in a month or 90 days in a year of psychiatric services in an IMD.

“SAFETY” Cognitive Behavioral Family Therapy May Prevent Youth Suicides

(Continued from page 2) self-directed behaviors in the previous three months. A total of 42 youth (88 percent female, 21 percent gay or bisexual) were randomized either to the SAFETY program or to the standard treatment protocol (parent education and community support). All participants were living at home, with no plans of residential treatment. Almost half of the participants reported substance use. Participants were measured at baseline, three months or at the end of the treatment period, and were followed up at the six to twelve month mark.

The researchers commented, “Although adolescence is a period when youth’s focus shift to peers, brain regions in areas are responsible for planning and inhibitory control are still developing, and parents and other adults can play key protective roles.”

Projected Average Rates of Growth for Medicaid Enrollees by Category and Various Measures of Inflation (2017-2026) (Per Republican Policy Committee)

SAMHSA-Sponsored Webinar
Successful State Agency Collaboration to Improve Behavioral Health Service Systems
Thursday, June 29, 3 p.m. to 4:30 p.m. ET
Developed under Contract with Advocates for Human Potential

Achieving important behavioral health policy goals requires the coordinated, collaborative efforts of programs located within different state agencies.

The purpose of this webinar is to provide information to state agency personnel as they consider new opportunities to collaborate with other state and local agencies in providing behavioral health services. This webinar will provide participants with a framework for collaboration and an example of a state behavioral health program which was implemented because of successful collaboration among state agencies and partnerships with local agency staff.

Presenters:
Martha Fleetwood, Executive Director, HomeBase
Patsy Carter, Ph.D., Director of Children’s Clinical Services, Missouri Department of Mental Health

Register HERE
SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENTS

Comprehensive Addiction and Recovery Act: Building Communities of Recovery (TI-17-015)

Application Due Date: July 3.
Anticipated Total Available Funding: $2,600,000
Anticipated Number of Awards: 13
Anticipated Award Amount: Up to $200,000 per year
Length of Project: Up to 3 years
Cost Sharing/Match Required? Yes

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), is accepting applications for fiscal year (FY) 2017 Comprehensive Addiction and Recovery Act: Building Communities of Recovery (BCOR). The purpose of this program is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery support from substance abuse and addiction. These grants are intended to support the development, enhancement, expansion, and delivery of recovery support services (RSS) as well as promotion of and education about recovery. Programs will be principally governed by people in recovery from substance abuse and addiction who reflect the community served.

WHO CAN APPLY: The statute limits eligibility for this program to Recovery Community Organizations (RCOs) that are domestic private nonprofit entities in states, territories, or tribes. RCOs are independent, non-profit organizations led and governed by representatives of local communities of recovery. To ensure that recovery communities are fully represented, only organizations controlled and managed by members of the addiction recovery community are eligible.

CONTACTS: Program Issues: Matthew T. Clune at (240) 276-1619 or Matthew.clune@samhsa.hhs.gov
Grants Management Issues: Eileen Bermudez at (240) 276-1408 or FOACSAT@samhsa.hhs.gov

State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (TI-17-16)

Application Due Date: Monday, July 3, 2017
Anticipated Total Available Funding: $3,300,000
Anticipated Number of Awards: 3
Anticipated Award Amount: Up to $1,100,000
Length of Project: Up to 3 years
Cost Sharing/Match Required? No

Eligibility: Single State Agencies for Substance Abuse

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for fiscal year (FY) 2017 Comprehensive Addiction and Recovery Act of 2016, State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (Short Title: PPW-PLT). The purpose of the program is to enhance flexibility in the use of funds designed to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance abuse agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery. SAMHSA seeks to: 1) reduce the abuse of alcohol and other drugs; 2) increase engagement in treatment services; 3) increase retention in the appropriate level and duration of services; and 4) increase access to the use of medications approved by the Food and Drug Administration in combination with counseling for the treatment of drug addiction.

Contacts: Program Issues: Linda White-Young, LICSW, Center for Substance Abuse Treatment (CSAT), SAMHSA, 240-276-1581
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

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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.
A 2009 Institute of Medicine Report found that one-half of America’s children will have a mental-health disorder by age 18. Mental health treatments are the largest Medicaid cost for children, increasing $1 billion annually. Medicaid data show mental health treatments are the largest cost for children, and rising in cost at a billion dollars a year. A Wall Street Journal investigation revealed that 40.4 million children out of 75 million received at least one prescription for psychotropic medications in 2009. The implications of this epidemic paint a poor picture of the future of the country economically, socially, and even from a perspective of national defense.

However, that same IOM report highlighted one universal strategy, the PAX Good Behavior Game (PAX GBG), which can be deployed as a practical, proven, early preventive strategy that also has treatment effects. SAMHSA has funded a successful real-world replication of the strategy in more than 20 sites in the U.S. A major mental-health journal cited the strategy as the next big thing for a public-health approach to the prevention of psychiatric disorders. The embedded daily environmental approach also improves all academic outcomes, while reducing teacher stress. The Surgeon General has cited the same strategy for substance abuse prevention. Now, with nearly 10,000 teachers trained, the core results from the original studies at Johns Hopkins have been replicated in the United States, Canada, Ireland, and Estonia.

This webinar, which includes short video segments from mental health leaders who are actual users and beneficiaries, explains how the PAX Good Behavior Game (PAX GBG) is being successfully deployed as a highly cost-effective strategy to prevent, intervene and even treat pediatric psychiatric disorders while embedded in normal, everyday routines in schools. This is happening with the involvement of state agencies, health-care systems, community and advocacy groups, and researchers. The strategy has a 60-to-1 rate of return, and can start small so that the strategy can be woven into a new way of doing business for children’s mental, emotional, and behavioral health. The goal of the webinar is to provide a practical path for mental health directors and providers for bringing this cost effective strategy to their communities.

**Presenter:** Dennis D. Embry, Ph.D., President/Senior Scientist of PAXIS Institute; Board of Directors, National Federation of Families for Children’s Mental Health; and Scientific Advisor, Children’s Mental Health Network.

**Register HERE**

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**NASMHPD Annual 2017 Meeting**

**Sunday, July 30 through Tuesday, August 1**

**Renaissance Capital View Hotel, 2800 S. Potomac Avenue, Arlington, Virginia**

*(Rooms Available at Government Rate at the Renaissance Capitol View)*

The 2017 NASMHPD Annual Meeting will run three full days, in collaboration with the NASMHPD Research Institute (NRI), and include a day of meetings for the NASMHPD Division representatives.

The NASMHPD Divisions include the Children, Youth and Families Division; the Financing and Medicaid Division; Forensic Division; the Legal Division; the Medical Directors Council; the Older Persons Division; and the Offices of Consumer Affairs (National Association of Consumer/Survivor Mental Health Administrators – NAC/SMHA).

The meeting will include extended time for State Mental Health Commissioners and Divisions to meet together as well as separately. There will also be a day with State Mental Health Commissioners and Divisions meeting together on NRI research data and initiatives that tie in with the Commissioners’ and Divisions’ priorities and concerns.

**Registration for State Mental Health Commissioners:** $600  
**Registration for Additional State and/or Division Representatives:** $400

Contact Yaryna Onufrey with any questions.
Center for Trauma-Informed Care
NASHMPD 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.

June Trainings
Virginia
June 29 - Chesterfield County Mental Health Support Services, Chesterfield

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

SAMHSA Launches NREPP Learning Center
SAMHSA has launched a new Learning Center for its revamped National Registry of Evidence-Based Programs and Practices (NREPP).

The NREPP site is designed to provide resources for developing, implementing, and sustaining culture-centered and evidence-based programs and practices. Learning Center tools provide practical support for using evidence-based programs and practices to improve the behavioral health of clients, family members, and communities. Learning Center resources are organized around five themes:

- Emerging Evidence in Culture-Centered Practices;
- Developing an Evidence-Based Practice or Program;
- Implementing a Program;
- Sustaining a Program; and
- Behavioral Health Topics.

There is also a Resource Library.

SAMHSA Funding Opportunity Announcement
Cooperative Agreements to Implement Zero Suicide in Health Systems (SM-17-006)

Application Due Date: Tuesday, July 18, 2017
Length of Project: Up to 5 years
Anticipated Total Available Funding: $7.9 million ($2 million for tribes and tribal organizations)
Anticipated Number of Awards: Up to 13
Anticipated Award Amount: Up to $700,000/year
Cost Sharing/Match Required? No

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2017 Cooperative Agreements to Implement Zero Suicide in Health Systems (Short Title: Zero Suicide). The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. The purpose of this program is to implement suicide prevention and intervention programs, for individuals who are 25 years of age or older, that are designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for such individuals who are at risk for suicide. Grantees will implement the Zero Suicide model throughout their health system.

Health systems that do not provide direct care services may partner with agencies that can implement the Zero Suicide model. For communities without well-developed behavioral health care services, the Zero Suicide model may be implemented in Federally Qualified Health Centers or other primary care settings.

Eligibility - Eligible applicants are statutorily limited to:

- States, District of Columbia, and U.S. Territories health agencies with mental health and/or behavioral health functions;
- Indian tribe or tribal organization (the term ‘Indian tribe’ and ‘tribal organization’ are defined in § 4 of the Indian Self-Determination and Education Assistance Act.);
- Community-based primary care or behavioral health care organizations;
- Emergency departments; or
- Local public health agencies.

Contacts:
Program Issues: James Wright, LCPC, Suicide Prevention Branch, Center for Mental Health Services, by email or at 240-276-1854

Grants Management and Budget Issues: Gwendolyn Simpson, Office of Financial Resources, by email or at 240-276-1408
Webinar Series: Trauma-Informed Innovations in Crisis Services

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

Register HERE

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) is pleased to announce the opportunity to participate in an upcoming Webinar Series: “Trauma-Informed Innovations in Crisis Services.” The series will run from April – September 2017 on the 4th Monday of each month, from 3:00 to 4:00 p.m. Eastern Time. This webinar series will highlight 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 will focus on how an agency implements one of the principles from SAMHSA’s Concept and Guidance for a Trauma-Informed Approach: Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment, Voice and Choice, and Cultural, Historical, and Gender Issues. After the provider presentations, a moderated Q&A will follow. 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. The research base 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 insure 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 of these services is to stabilize and improve symptoms of distress and engage people in the most appropriate treatment.

In response to these trends and statistics, 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, mobile crisis outreach programs.

Implementing Trauma-Informed Innovations in Crisis Services: The Principle of Empowerment, Voice and Choice

Monday, June 26, 3 p.m. to 4 p.m. E.T.

This principle is rooted in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. There is a recognition of the ways in which trauma survivors, historically, have been diminished in voice and choice. Victoria Welle, program coordinator with the Grassroots Wellness Peer-Run Respite and Learning Community in Wisconsin, will share how the peer-run respite fosters empowerment, voice and choice as part of an overall trauma-informed approach, and that people seeking support have the opportunity for shared decision-making and goal setting to determine the plan of action they need to heal and move forward.
Webinar: Communities Addressing Trauma and Community Strife through Trauma-Informed Approaches: Trustworthiness and Transparency in a Community Setting
(The second in a 6-part webinar series)

June 26, 1 p.m. to 2:30 p.m. ET

Registration Link: https://nasmhpd.adobeconnect.com/communityvln_reg/event/event_info.html

Please note: You may see a sign-in dialogue box when you register, simply hit okay and it will take you directly to the registration page. The Adobe Connect platform will allow 300 people to call in using telephone lines and an additional 1,000 listening on their computers. We advise people to listen in groups as much as possible due to the expected audience size.

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 announce the second webinar in the 6-part series entitled “Communities Addressing Trauma and Community Strife Through Trauma-Informed Approaches”:

Trustworthiness and Transparency: Handle with Care
Monday, June 26, 1:00 – 2:30 PM ET

This webinar offers innovative best practices for helping to mitigate the negative effects experienced by children’s exposure to trauma and highlights a promising initiative (Handle with Care) between schools, law enforcement and treatment providers. Handle with Care, provides the school with a “heads up” when a child has been identified by law enforcement at the scene of a traumatic event. Schools are responding with interventions to help mitigate the trauma and mental health providers are co-locating at the school to provide services. Handle with Care programs promote safe and supportive homes, schools, and communities that protect children, and help traumatized children heal and thrive. Andrea Darr, Director, West Virginia (WV) Center for Children’s Justice, WV State Police, Crimes Against Children Unit, and Lt. Chad Napier, Prevention Resource Coordinator for Appalachia HIDTA will present on this unique collaboration between the educational system and law enforcement and provide guidance for replication for interested communities.

Learning Objectives:
1. Better understand the impact of trauma on a child’s ability to learn;
2. Identify crimes impacting local schools and students;
3. Describe proven classroom and school-wide interventions to help students exposed to trauma; and
4. List examples of collaborative efforts to better serve children exposed to trauma.

Presenters:
Lt. Chad Napier (retired)
Prevention Resource Coordinator for Appalachia HIDTA

Chad Napier is the Prevention Coordination for Appalachia HIDTA (High Intensity Drug Trafficking Area) for West Virginia and Virginia. Prior to this position, he spent twenty years in law enforcement in 2015

Andrea Darr
Director, WV Center for Children’s Justice

Andrea Darr is the director of the West Virginia Center for Children’s Justice which promotes and supports a statewide trauma-informed response to child maltreatment and children’s exposure to violence. The Center, housed in the Crimes Against Children Unit at the WV State Police, streamlines resources and minimizes duplicative efforts to address challenges, barriers, gaps and needed improvements in working child maltreatment cases. The Center includes the WV Children’s Justice Task Force and the WV Handle with Care Initiative.

About the Series
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, and is open to all interested in addressing community trauma and healing.
Webinar Opportunity

The Importance of Care Coordination: Real-World Considerations for Managing Individuals with Schizophrenia

*Tuesday, June 27, 2:30 p.m. to 3:30 p.m. ET*

Presented by the National Council for Behavioral Health and funded by Alkermes, Inc.
Program speakers are under contract with Alkermes, Inc.

Schizophrenia is a complex condition associated with a vast array of distinct clinical profiles, co-morbidities and significant medical expenditures. In 2013, the economic burden for schizophrenia in the US was estimated at $155.7 billion. The rapidly evolving healthcare landscape has created new fee schedules and payment models that may require a changed approach to treatment and service delivery. How can payers address the complex challenges of expanding and improving services while simultaneously bending the cost curve? Join the National Council for Behavioral Health to learn about care coordination for people living with schizophrenia. By examining real-world pilot projects, you may be able to garner insights on models of care coordination that may be relevant to plan challenges for the management of people with schizophrenia.

Register [HERE](#).

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](#).

Future of Health Care: Balancing Coverage and Cost in Medicaid

*Thursday, June 29, 10 a.m. to 11:30 a.m. E.T.*

Bipartisan Policy Center
1225 Eye Street NW, Suite 1000, Washington, D.C. 20005

Join the Bipartisan Policy Center’s third in a series of public events to develop effective and politically viable solutions to the nation’s health care challenges. As the Senate considers H.R. 1628, the American Health Care Act of 2017, BPC has been convening a group of state administrators, providers, and policy experts to discuss Medicaid policies that expand administrative flexibility without creating financial risk for states, the federal government, and beneficiaries of the program.

Panelists:
Gail Wilensky, Economist, Senior Fellow, Project HOPE
Cindy Mann, Partner, Manatt, Phelps & Phillips, LLP and former director of the Center for Medicaid and CHIP
Henry Claypool, Policy Director, Community Living Policy Center, UCSF

Register [HERE](#)  Can’t join in person? The event will be [webcast](#).
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 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
  o Back to School Toolkit for Students and Families
  o 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
  o Shared Decision Making for Antipsychotic Medications – Option Grid
  o Side Effect Profiles for Antipsychotic Medication
  o 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. Any questions or suggestions can be forwarded to either Pat Shea (Pat.shea@nasmhpd.org) or David Shern (David.shern@nasmhpd.org).
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NASMHPD Links of Interest

The Impact of the AHCA on Federal and State Medicaid Spending and Medicaid Coverage: An Update, Urban Institute, June 2017

Implementing Evidence-Based Prevention by Communities to Promote Cognitive, Affective, and Behavioral Health in Children; Proceedings of a Workshop, National Academy of Medicine, Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education and Health and Medical Division, June 2017

Behavioral Health Barometer, United States, Volume 4, Substance Abuse and Mental Health Services Administration, June 2017

FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38, Departments of Labor, Health and Human Services, and Treasury, June 16

Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations, Departments of Labor, Health and Human Services, and Treasury, June 16

Medicaid and the Opioid Epidemic, Medicaid and CHIP Payment and Access Commission, June 2017 Report to Congress on Medicaid and CHIP

Mandatory and Optional Enrollees and Services in Medicaid, Medicaid and CHIP Payment and Access Commission, June 2017 Report to Congress on Medicaid and CHIP

IMPACT Act Standardized Patient Assessment Data Project, Beta Test Participant Provider (Medicare) Recruiting Video, Centers for Medicare and Medicaid Services, May 16

GOP Health Bill is a Disaster for Opioid Crisis, Dr. Vivek Murthy, USA Today, June 22