2018 Affordable Care Act Individual Health Insurance Enrollment Period Opens with Uncertainty

The 45-day 2018 enrollment period for the Affordable Care Act’s (ACA’s) individual health insurance marketplace opened November 1 amid uncertainty, with experts predicting enrollment through Healthcare.gov could drop by 1.1 million below the 2017 enrollment of 9.2 million.

The Federal government has halved the 2017 enrollment period for 2018, with a deadline of December 15, and has reduced moneys available for outreach by 90 percent and funding for Marketplace navigators by 39 percent—although navigator programs in Ohio (71 percent) and South Carolina (50 percent) have seen considerably deeper cuts. In Georgia, what had been the largest navigator group, Insure Georgia, lost 86 percent of its $2.3 million Federal grant and had to lay off half its staff.

Those cuts, and continual efforts by Congressional Republicans and the President to repeal the Affordable Care Act has likely created considerable consumer uncertainty whether the ACA marketplace even still exists. And with the President’s termination of the cost-sharing reduction (CSR) payments to insurers, potential enrollees may be unsure whether they can even afford the premium payments expected to rise on average by 37 percent, on top of 24 percent increases in 2017.

But in fact, approximately 80 percent of marketplace enrollees will continue to qualify for advance premium tax credits designed to reduce the cost of premiums to about $75 per month, according to the Department of Health and Human Services. Individuals with incomes of less than about $48,000 per year, and families with incomes of roughly $98,400 will be eligible for those premium subsidies. And the increased premiums resulting from the elimination of the CSRs have actually made the premiums for plans other than the benchmark silver plans—such as the more comprehensive gold plans—cheaper than for the silver plans.

In fact, analysis released by Avalere Health on November 2 revealed that 98 percent of counties with exchanges operated by HealthCare.gov will have free bronze plan options for low-income consumers age 50 earning 150 percent of the Federal Poverty Level (FPL) or less ($18,090 for an individual or $36,900 for a family of four). Further, 10 percent of counties will have free gold plan options available to individuals making $18,090, or 150 percent FPL. Avalere links the increased availability of free plan options to the Administration’s decision to end cost-sharing reduction (CSR) payments to insurers. This decision has led to substantially higher premium subsidies in 2018, as insurers increase premium levels on silver-level plans to make up for the lack of CSR payments. Avalere warns, however, that bronze plans have higher out-of-pocket costs like deductibles and co-insurance. “While some consumers may be able to pay less in monthly premium by choosing a bronze plan, they may also have to pay more when they visit a doctor or hospital,” according to Avalere Senior Vice President Elizabeth Carpenter.

Get America Covered, a new organization founded by Lori Lodes and Josh Peck, two Obama Administration alumni, will be trying to close some of the gaps left by the Trump Administration’s cuts to enrollment outreach through partnerships with existing community organizations. They held events November 1 in Florida, North Carolina, New York, Tennessee, and Virginia. Former President Barack Obama released a video encouraging enrollment, while former West Wing cast member Bradley Whitfield has recorded videos encouraging enrollment for social media, in partnership with former CMS Acting Administrator Andy Slavitt.

The night before enrollment opened, CMS sent a notice telling navigators and enrollment officials that it would shut down HealthCare.gov for maintenance from 10 p.m. E.T until “the morning” of open enrollment. That surprised those who believed sign-ups would be available starting shortly after midnight. And neither Health and Human Services Acting Secretary Eric Hargan nor CMS Administrator Seema Verma appeared at events promoting enrollment. In fact, during an appearance at a Council for Affordable Health Coverage event, Hargan criticized the ACA for driving up prices.

In those states that run their own insurance exchanges, consumers will have more than the 45 days to sign up. The deadline is January 14 in Minnesota, January 15 in Washington State, January 12 in Colorado, and January 31 in California and New York.

The penalty for non-enrollment by an adult individual in 2018 can be in excess of $700 and for a child about $350, with a maximum penalty for a family around $2100.
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The Ripple Effect of Opioids on Child Welfare  

*Thursday, November 16, 1 p.m. to 2 p.m. ET*

The opioid epidemic's impact on Child Welfare is front page news. Yet the ripple effect goes undocumented - skyrocketing caseloads increases the volume and rate of information flooding into the agency. Learn how Fairfield County (OH) teamed up with Ohio’s Attorney General on a public awareness campaign and implemented an approach to manage the information overload.

**Presenters:**
- Kristi Burre, Deputy Director, Fairfield County Child and Adult Protective Services
- Rich Bowlen, Vice President, Protective Services, Northwoods

[Register HERE](#)

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SAMHSA-SPONSORED WEBINAR  
Parity: Access to Mental Health and Substance Use Care  
*Tuesday, November 7, 3 p.m. to 4:30 p.m. E.T.*

Despite passage of a federal parity law, many Americans still struggle to find quality, affordable mental health and substance use care. Many people struggle to find in-network care and face restrictions on the type of care they need. In addition, many people are also unclear of their rights under the law.

This webinar will explore the current status of the federal parity law, discuss strategies for educating people about the law, and share tools that were developed by the White House and SAMHSA to help ensure people get the right care at the right time.

**Presenters:**
- Tim Clement, MPH - Policy Director of the ParityTrack project, which is a joint project of The Kennedy Forum and The Scattergood Foundation.
- Alice Dembner - Director of the Substance Use Disorders Project at Community Catalyst, which focuses on promoting new ways to prevent and treat alcohol and drug problems. Key initiatives of this program include advancing early intervention with youth, ensuring access to quality services, promoting treatment and social services rather than incarceration, and integrating substance use treatment fully into the health system.

[Register HERE](#)

If you have any questions, please contact Kelle Masten via email or at 703-682-5187.
NRI Study Examines the Trends in Psychiatric Inpatient Capacity in Each State, Nationwide

A study reported by the NASMHPD Research Institute last month concludes that many of the recent studies finding shortages in hospital inpatient capacity fail to include a comprehensive depiction of the total inpatient and other 24-hour mental health residential treatment capacity in various settings across the nation or to acknowledge changing trends in the use of psychiatric inpatient services.

Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014 is part of the 2017 Technical Assistance Coalition’s Beyond Beds series of working papers examining alternatives to inpatient treatment. It finds that 24-hour, high-level, intensive mental health treatment exists in a variety of settings, including specialized public and private psychiatric hospitals, psychiatric inpatient, and licensed residential treatment units in general hospitals and other organizations, non-residential treatment centers (non-RTCs) for children and adults (organizations that provide intensive 24-hour treatment services but that are not licensed as “inpatient” services), Veterans Affairs (VA) Medical Centers, Department of Defense Medical Centers, and psychiatric inpatient units within jails and prisons inaccessible by the public. In addition, many general hospitals without special mental health units provide inpatient treatment for individuals with mental illnesses in “scatter beds”.

The paper attempts to roughly inventory the number of beds in each setting, combining information from multiple data sources to estimate the overall inpatient and other 24-hour inpatient capacity in the U.S. in 2014 and trends over the past 44 years. It finds that, as of 2014, the year for which the most recent data on specialty mental health providers are available, there were over 170,000 residents in inpatient and other 24-hour residential treatment beds on any given night, an average of over 53.6 patients per 100,000 population.

The report was authored by NRI’s Ted Lutterman and Robert Shaw, National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) Executive Director Ron Manderscheid, PhD. (a former Center for Mental Health Services Director) and University of Massachusetts Medical School Adjunct Professor William Fisher, PhD.

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NASMHPD Guest Blog – Data Needed on Brain Injury Caused by Overdoses

...by Wayne Lindstrom, Director, Behavioral Health Services Division & CEO, Behavioral Health Collaborative, New Mexico Human Services Department

Statistics regarding overdose and secondary hypoxic/anoxic brain injury (HAI) are hard to come by. To the best of my knowledge, we do not know what percentage of drug overdoses result in brain injury. We do not even have an accurate number of how many overdoses there are to produce a denominator. That said, fully understanding this problem becomes more complicated because some people will recover after a short period of injury, but anecdotal information suggests that these are more the exception.

HAI should be one of the major arguments for meaningful harm reduction that stresses the importance of having naloxone widely available—to help people prevent getting HAI which can result in death, cardiac arrest, or serious brain injury. In New Mexico, we have been increasingly focused on teaching people how NOT to overdose in the first place, to have a rescue buddy, to take turns using, to have an overdose response plan, to provide rescue breathing, and of course, call 911. We also talk to people about their vulnerability to future/subsequent overdoses after their first.

Most often, HAI is extremely costly. People can be in a coma for weeks in an intensive care unit, and come out of it unable to function. People can end up with extended hospital stays followed by long stays in a rehabilitative hospital. One of the questions that we should be asking is, “Is the rate of HAI going up or down due to the widespread use of naloxone?” Any such data will be confounded by the fact that the number of people using high-dose prescription opioids and heroin is continuing to increase in the US, and the amount of fentanyl is markedly increasing as well.

Many people that are repeatedly using heroin containing an unknown concentration and unknown amount of fentanyl, are putting their brains through repeated short periods of hypoxia, if not anoxia. As a result, both permanent and temporary injury to the brain and other parts of the nervous system is probably occurring repeatedly in injection drug users. That is a good reason to have an overdose victim on Medication-Assisted Treatments (MATs) for an extended period of time to increase the likelihood that the brain and the rest of the nervous system will potentially ameliorate these repeated insults. As you are aware, some MAT researchers are now recommending a minimum of two years on one of these medications to allow the brain to heal from the repetitive hypoxia it was exposed to.

Bottom line, I believe that we have not focused nearly enough on HAI and its implications. I am advocating that both NASMHPD and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) coalesce around this issue, along with our Federal partners, to study the incidence and prevalence of HAI associated with overdoses, and establish appropriate HAI-related protocols for preventing, intervening, and treating this secondary effect of overdose.
Livestream the 50-STATE SUMMIT on PUBLIC SAFETY

November 13 & 14

On November 13–14, The Council of State Governments Justice Center, in partnership with the Association of State Correctional Administrators, is hosting an unprecedented convening of lawmakers, corrections administrators, law enforcement officials, and behavioral health professionals from all 50 states to analyze and discuss local trends in public safety. The event will examine crime, corrections, and behavioral health trends state by state to develop effective solutions that elected officials at all levels of government can support. Topics that will be covered during the live-streamed portion of the event include: reducing crime and strengthening communities; breaking the cycle of reoffending; and, strategies to enable reinvestments in public safety.

Confirmed speakers include:

- Rod Rosenstein, Deputy Attorney General, U.S. Department of Justice
- Matt Bevin, Governor, Kentucky
- U. René Hall, Chief, Dallas (TX) Police Department

Study Finds Scans of Brain Activity May Help Identify Suicidal Ideation

A study published online October 30 in the journal *Nature Human Behavior* reports that a series of brain patterns in response to a set of written words can help distinguish young adults with suicidal ideation.

The researchers, led by Marcel Just at Carnegie Mellon University and David Brent with the University of Pittsburgh, studied the brain activity of 34 young adults, 17 with suicidal ideation and 17 without. The study participants read 30 words that were categorized into three concepts: positive affect (e.g. “bliss,” “carefree,” “praise”), negative affect (e.g. “cruelty,” “evil,” “trouble”), or related to suicide (e.g. “death,” “hopeless,” “suicide”). The participants read and thought about the meaning of each word for three seconds while undergoing a functional MRI scan (fMRI), allowing the researchers to monitor the neural response to each word.

The researchers found that the neural responses to six words—“death,” “trouble,” “carefree,” “good,” “praise,” and “cruelty”—across five specific brain regions had the most significant differences between the suicidal ideation group and the control group, as illustrated below. The brain regions included the left superior medial frontal area, medial frontal/anterior cingulate, right middle temporal area, left inferior partial area and the left inferior frontal area. The scientists indicate these brain regions are strongly associated with self-referential thought, a common behavior in suicidal patients.

Next, the data was transferred to a “machine-learning algorithm” that was able to identify subjects with and without suicidal ideation with a 91 percent accuracy. Dr. Just and colleagues used the same algorithm to identify subjects in the suicidal ideation group who had previously attempted suicide as opposed to simply contemplating an attempt. The algorithm was 94 percent accurate in predicting whether someone had previously attempted suicide.

The research team further examined the emotions associated with the six words that the machine-learning algorithm used, in order to determine which group—suicidal ideation versus non-suicidal ideation—in which the participant belonged by adding neural signatures for different emotions (sadness, anger, shame, and pride), known as explainable artificial intelligence. The machine-learning algorithm was 85 percent accurate in identifying which subjects had suicidal thoughts based on the emotions the six words evoked. Dr. Just commented in the Carnegie Mellon University press release on the study, “People with suicidal thoughts experience different emotions when they think about some of the test concepts. For example, the concept of ‘death’ evoked more shame and more sadness in the group that thought about suicide. This extra bit of understanding may suggest an avenue to treatment that attempts to change the emotional response to certain concepts.”

Further research with a larger sample is needed to determine if the study’s findings can be replicated. If so, brain scans may be an effective medical tool to assist clinicians in predicting future suicidal behavior in their patients.

The research team also included Lisa Pan from the University of Pittsburgh, Vladimir Cherkassky of Carnegie Mellon, Dana McMakin with Florida Atlantic University, Christine Cha of Columbia University and Matthew Nock from Harvard University.
The Centers for Medicare and Medicaid Services on November 1 issued a revision to a July 2015 State Medicaid Division Letter (SMDL) that authorized the use of a § 1115 waiver to provide a continuum of care for substance use disorders (SUDs), including inpatient care within a residential treatment center.

CMS calls the process described in the revised SMDL “a more flexible, streamlined approach to accelerate states’ ability to respond to the national opioid crisis,” but the new guidance establishes new state requirements not imposed in the earlier guidance. States must address, in their applications and throughout the waiver timeline, goals and milestones specified in the guidance.

Mandated goals include: 1. increased rates of identification, initiation, and engagement in treatment; 2. increased adherence to and retention in treatment; 3. reductions in overdose deaths, particularly those due to opioids; 4. reduced utilization of treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; 5. fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and 6. improved access to care for physical emergency departments and inpatient hospital settings for health conditions among beneficiaries.

Milestones which must be reported to CMS over the five-year duration of the waiver include: 1. access to critical levels of care for opioid use disorder (OUD) and other SUDs; 2. widespread use of evidence-based, SUD-specific patient placement criteria; 3. use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications; 4. sufficient provider capacity at each level of care; 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and 6. improved care coordination and transitions between levels of care.

CMS will work with states to establish residential treatment provider qualifications that meet nationally recognized, SUD-specific, evidence-based program standards. Implementation of these program standards is a critical milestone that states must address as part of the demonstrations. While states are working toward implementing nationally recognized SUD-specific program standards as provider qualifications for residential treatment facilities, the Special Terms and Conditions of the waivers will specify the qualifications states must use in the interim for residential treatment facilities that qualify as IMDs but receive Federal funding through these demonstrations.

Applications must include the following information:

- a comprehensive description of the demonstration, including the state’s strategies for addressing the goals and milestones discussed above;
- a comprehensive plan to address opioid abuse, including aggressive preventive measures and strategies to improve access to treatment and recovery support services for Medicaid beneficiaries and an assessment of how this demonstration will complement and not supplant state activities called for or supported by other Federal agencies and funding streams;
- a description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost-sharing (premiums, copayments, and deductibles) required of individuals in the demonstration, to the extent such provisions would vary from the state’s current program features and the requirements of the Medicaid law;
- a list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- an estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations. Specifically, CMS requests that states’ fiscal analyses demonstrate how the proposed changes will be budget-neutral, i.e., will not increase Federal Medicaid spending. CMS says it will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;
- enrollment data, including historical SUD coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- written documentation of the state’s compliance with Federal public notice requirements, with a report of the issues raised by the public during the comment period and how the state considered those comments when developing the final demonstration application;
- the research hypotheses that are related to the demonstration’s proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators, and
- an Implementation Plan.

An hour after the SMDL was released, the President’s Commission on Combating Drug Addiction and the Opioid Crisis held its final meeting and released its final report. The Commission’s 56 recommendations include:

- creating uniform state block grants to fund substance use disorder activities that combine the multiple block grants currently available from multiple agencies;
- establishing a coordinated system for tracking all Federally-funded initiatives;
- using student assessment programs such as Screening, Brief Intervention and Referral to Treatment (SBIRT) to identify at-risk youth who may need treatment;
- removing pain survey questions entirely on patient satisfaction surveys, so that providers are never incentivized for offering opioids to raise their survey score; and
- establishing Federal drug courts in all 93 Federal District Court districts to divert defendants into treatment.
Join Optum at its Opioid Insights for Action Day at the OptumLabs Research & Translation Forum in Boston.

The U.S. opioid epidemic is complex, and will take creative collaboration among diverse stakeholders to develop solutions that reverse its trajectory. OptumLabs is convening industry experts and influencers to explore and drive change by partnering on this immense health system challenge.

Join us November 16 as we immerse you in a “living lab” designed to evaluate what’s working — and what’s not — and translate insights into action. Don’t miss this opportunity to connect virtually with stakeholders to drive system change.

Engage with Optum, OptumLabs, and our partners and discover how we’re working together with a world class health care data set to:

- Build a Key Performance Metric Dashboard in 4 domains—prevention, pain management, OUD treatment and maternal & child health
- Drive innovative research projects and actionable insights
- Deliver key programs aimed at reversing the opioid epidemic

**Register NOW**

**KEYNOTE SPEAKERS**

**The Opioid Epidemic: How We Got Here, How We End It**

*Michael Botticelli*
Executive Director, Grayken Center for Addiction Medicine,
Boston Medical Center;
Former Director, Office of National Drug Control Policy

**The Opioid Crisis - Changing the Trajectory**

*Gary Mendell*
Founder and CEO, Shatterproof

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**HHS Community Health News**

**National Native American Heritage Month - November**

This November, join HHS and the Office of Minority Health in celebrating Native American Native Heritage Month. Here are ways that you can commemorate this important observance:

- Educate your community! Read up on the history of the Native peoples of the Americas and the creation of Native American History Month.
- Raise awareness! Organize a community event to raise awareness about the health disparities that exist among Native American communities.
- Share your story! How is your community celebrating Native American Heritage Month? Share your story or tweet with us throughout the month.
- Chart your family health history. Knowing your family history is important to understanding your risk for disease and helping your clinicians provide the best care. The My Family Health Portrait tool from the U.S. Surgeon General’s Office provides a private and easy-to-use web-based resource to organize family health history information.

**On Opioids/Substance Use Disorders**

*Recording: Hope In Action: An Overview of the Practical Toolkit for Faith and Community Leaders in the Face of the Opioid Epidemic.*

Faith leaders and your community can support prevention efforts, reduce risk, and provide support to those who are in and seeking recovery. This webinar reviews the six different strategies outlined in the Partnership Center’s Practical Toolkit.

**Community Capacity Building**


The HHS Partnership Center convened national experts to talk about the opioid epidemic and other addictions to raise awareness, encourage compassion, reinforce the role of community and families in long-term recovery and prevention, and make a call to action. Here is a link to watch the recording of the live stream event.

Please help us spread awareness by sharing this information with your community and feel free to use the following language on social media:

- #Recovery, Prevention & Hope: Hear From National Experts About The #OpioidCrisis, #PartnersInHope
- Learn About Opioids, Treatment, #Recovery, & Prevention With #PartnersInHope
NEW!!! - Interactive Map of Peer Support Accreditation Programs
The University of Illinois at Chicago’s Center on Integrated Health Care & Self-Directed Recovery—funded by the National Institute on Disability, Independent Living, and Rehabilitation Research and the Center for Mental Health Services—has created an interactive map of U.S. mental health peer certification programs. Use the map to learn the status of each state’s certification program, whether its peer services are Medicaid-reimbursable, and the number of specialists trained there thus far.

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

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

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

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

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

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

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

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.
UPCOMING WEBINAR OPPORTUNITY

First Episode Psychosis Resources: Focus on Effective Treatment Options

Wednesday, November 15, 2 p.m. to 3:30 p.m. ET

About 3 percent of Americans will experience an episode of psychosis during their lifetime. In most cases, individuals experience a first episode of psychosis during their teen years or early adulthood. Research shows that providing early access to treatment and services improves outcomes and reduces disability. With support from SAMHSA, NASMHPD and NRI have produced several technical assistance resources related to the development and implementation of effective programming to support people experiencing early serious mental illness, especially first episodes of psychosis.

This webinar will provide an overview of 13 new TA resources, which are available on the NASMHPD website at https://www.nasmhpd.org/content/information-providers. In addition, national experts will provide a more in-depth look at two of the resources focused on effective treatment options:

- **Cognitive Behavioral Therapy for Psychosis (CBTp)**
  Kate Hardy, Clin. Psych. D., Stanford University Dept. of Psychiatry and Behavioral Health

- **Treating Affective Psychosis within Coordinated Specialty Care**
  Iruma Bello, Ph.D., Columbia University Medical Center Dept. of Psychiatry and New York State Psychiatric Institute

**REGISTER HERE**

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**SAMHSA Minority Fellowship Program: 2017-2018 Application Dates**

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<tr>
<th>Grantee Organization</th>
<th>Application Period for the MFP Traditional PhD Program</th>
<th>Application Period for the MFP- Masters Level Youth Focused Program</th>
<th>Application Period for the MFP- Masters Level Addictions Counseling Focused Program</th>
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Developing Solutions for Social Isolation in the U.S.: Learning From the World
2017 Call for Proposals from the Robert Wood Johnson Foundation

Application Deadline: December 21, 2017, 3 p.m. ET

Social connections can help us thrive. But too many people feel disconnected from society and from life, and that contributes to a host of physical, mental and emotional health problems. School children, teens, new mothers, immigrants, LGBT people, people living in remote areas, even millennials with thousands of Facebook friends, often feel excluded or like they don’t belong.

We want to learn about solutions that have worked in other countries to address social isolation across all ages and life stages, so that we can strengthen social connection in the United States. Are you a U.S.-based organization that wants to adapt an idea from overseas? Or an international institution with an idea that could work in the United States?

Purpose
At the Robert Wood Johnson Foundation (RWJF), we believe that everyone in America—no matter who that person is, how much money they have, or where they live—should have as much opportunity as possible to pursue a healthier life. We call that vision a Culture of Health and we work with people across the country to build a Culture of Health. Across the globe, countries are taking steps to improve health and well-being in their communities. RWJF is eager to learn from those countries. We are collaborating with people and organizations around the world to uncover insights that can inspire us all to imagine new possibilities and to surface practical solutions that can be adapted here in the United States.

With this call for proposals (CFP), RWJF is looking for the best ideas from around the world that address social isolation and promote positive, healthy social connections, and well-being.

Eligibility and Selection Criteria
RWJF is looking for applicants who represent organizations from a wide range of fields and disciplines—both within and outside the health sector. We encourage proposals from both U.S.-based applicants to adapt an overseas idea, and from international applicants with ideas that could work in the United States. We encourage submissions from teams that include both U.S. and international members. We seek to attract diversity of thought, professional background, race, ethnicity, and cultural perspective in our applicant pool. Building a Culture of Health means integrating health into all aspects of society, so we encourage multisector partnerships and collaboration.

Proposals must fit with the topic and populations described, integrate global ideas into the project, and must highlight the connections to the Culture of Health Action Framework.

See full Call for Proposals for more information.

Key Dates
November 9, 2017 (1–2 p.m. ET)  Informational webinar for prospective applicants.  Registration is required.
December 21, 2017 (3 p.m. ET)  Deadline for receipt of proposals.
Mid-April 2018  Semifinalists notified and asked to address questions in scheduled telephone call with RWJF staff.
May 1–15, 2018  Telephone calls with semifinalists. Please hold these dates on your calendars.
Mid-June 2018  Finalists notified.
September 2018  Grants begin.

Total Awards
Up to $2.5 million will be available for this funding opportunity.
Projects may be up to three years in duration

Key Materials
- Preview a sample proposal before submitting
- Funding Opportunity Brochure (PDF)
- Frequently Asked Questions

Apply HERE
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.

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.
The CDC reports that every day in the United States, one person dies every 16 minutes from an opioid overdose. State and local governments seek solutions to fight this epidemic that impacts citizens in every state, at all socioeconomic levels, and at every age.

Hear from Dr. Andrew Kolodny, M.D., Co-Director, Opioid Policy Research, Brandeis University, as he delivers an overview of how the crisis began with the culture of over-prescription, current trends in overdose deaths, and strategies for bringing it under control.

Learn how the Commonwealth of Massachusetts is responding to the crisis, as Jennifer Toth, Associate Director, Information and Referral Services, Health Resources in Action (HRiA), discusses the model Massachusetts Substance Use Helpline, which employs technology and an expert, caring team to address the opioid health challenge.

Presenters:
- Dr. Andrew Kolodny, Co-Director Opioid Policy Research, Brandeis University
- Jennifer Toth, Associate Director, Information and Referral Services, Health Resources in Action
- Host: Bob Nevins, Director of Health and Human Services Strategy, Oracle
- Moderator: Ann Flagg, Director, APHSA’s Center for Child and Family Well-Being

Register HERE
75-Hour (10-Day) Certified Peer Specialist Training for Individuals Who Are Deaf and American Sign Language Users

December 4 to 15, 2017
Hyatt Place, 440 American Ave, King of Prussia, PA 19406

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.

The following is a link to a video announcement in ASL providing details on this important training: https://youtu.be/Ehm14SdALZ4

Certified Peer Specialists will be 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
• Has received or is receiving mental health services for serious mental illness
• Has a high school diploma or general equivalency diploma
• From 2015 through 2017:
  o maintained at least 12 months of successful work or volunteer experience, or
  o earned at least 24 credit hours from a college or post-secondary educational institution
• Must be seeking employment and willing to work upon completion of CPS training

To complete an online training application, email PJ.Simonson@riinternational.com to request an application for the CPS Training for Deaf Candidates. Forms will be emailed to you to complete online and return.

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 Certified Peer Specialist. Out of state applicants should contact PJ Simonson for information regarding training fees.

Application Deadline is November 13

Please address questions via email to PJ Simonson at RI Consulting or via phone at (602) 636-4563.

Centers for Medicare and Medicaid Services Special Open Door Forum Medicare Card Project

Thursday, November 9, 2 p.m. to 3 p.m. ET

This call will educate State Medicaid Agencies, Medicaid providers, Managed Care Organizations, Medicaid partners, and other Medicaid stakeholders about the change from Social Security Number-based Health Insurance Claim Numbers to new Medicare Beneficiary Identifiers (MBIs). A question and answer session follows the presentation. CMS will discuss:
• Background and implementation
• MBI format
• Timeline and milestones, including the transition period
• Beneficiary outreach and education
• How to get ready for the new number

To participate: Dial-In Number: 800-837-1935; conference ID #: 49255212
TTY services dial 7-1-1 or 800-855-2880

For more information, visit the New Medicare Project website and Transcripts webpage.
The entire ADHD community will convene in Atlanta at the 2017 Annual International Conference on ADHD. CONNECT AND RECHARGE is the theme of the first-ever joint CHADD and ADDA Conference, to be held November 9 through 12 at the Atlanta Hilton.

The leading non-profit organizations serving the ADHD community, CHADD (Children and Adults with Attention Deficit Hyperactivity Disorder) and ADDA (Attention Deficit Disorder Association), have teamed up to create three-and-a-half days of ADHD-focused science, education, events and activities. The ADHD community will bond and learn about this challenging and complex disorder.

Conference sessions cover many essential topics: getting organized, planning for post-secondary education, school collaboration and supports, IDEA and education law, and evidence-based interventions including medications and more. Special activities teach social skills, let attendees connect with experts, and each other. Informal sessions connect groups ranging from “Women with ADHD to “LGBT, Poly Adults” to “Parents with ADHD”.

For more information, see the International ADHD Conference Web Site or call toll-free at 1-800-233-4050.

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The 5 Ways Juvenile Court Judges Can Use Data brief provides examples of how juvenile court judges can use aggregate data to learn more about their courtroom practices and the jurisdictions they serve. This brief is one of a series, supported by the Office of Juvenile Justice and Delinquent Prevention’s (OJJDP) Juvenile Justice Model Data Project.

Remembering Trauma: Connecting the Dots between Complex Trauma and Misdiagnosis in Youth is a short film from The National Child Traumatic Stress Network. The film highlights the importance of using a trauma lens when working within child-serving systems and the potentially detrimental impact of not incorporating a trauma framework. The film follows a traumatized youth from early childhood to older adolescence illustrating his trauma reactions and interactions with various service providers.

Call for proposals: NICWA’s 36th Annual Protecting Our Children National American Indian Conference on Child Abuse and Neglect will be held in Anchorage, Alaska, on April 15-18, 2018. This conference will focus on the well-being of tribal youths. Proposals should focus on children’s mental health; child welfare, foster care, and adoption services; judicial and legal affairs; and youth and family involvement. Submission deadline: Nov. 16.

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SAMHSA Webinar Opportunity

Strategies To Finance Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC)

Monday, November 6, 3 p.m. to 4 p.m. ET

This webinar will showcase the Financing Guidance for IECMHC in the Center of Excellence Toolbox’s Financing Section. The webinar presenters will share how they have created successful and sustained funding streams for IECMHC, including a discussion about developing a funding strategy and examples of IECMHC funding resources and pathways.

Register HERE
Recovery to Practice Announces an On-Demand Continuing Medical Education (CME) Webinar Series

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

Didi Hirsch Mental Health Services Project

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

Executive Director of Health Bridges International

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

Melody Riefer, M.S.W., Senior Program Manager, Advocates for Human Potential

Registered Here
NASMHPD has just released 11 new SAMHSA technical assistance resources to support states in implementing the Mental Health Block Grant’s 10% Set-Aside for early serious mental illness, including programs to serve people experiencing a first episode of psychosis. These resources provide reliable information for practitioners, policymakers, individuals, families, and communities to promote access to evidence-based treatment and services with the long-term goals of reducing or eliminating disability and supporting individuals in pursuing their life goals.

The resources are posted on the Early Intervention in Psychosis Virtual Resource Center on the NASMHPD website, which also includes information from the national RWJF-funded demonstration to identify and prevent the onset of psychotic illness and other early intervention initiatives. The virtual resource center provides an array of information that is updated on a periodic basis. A number of new resources have been posted in the “What’s New” section on the NASMHPD website:

**Fact Sheet: Cognitive Behavioral Therapy for Psychosis (CBTp)** by Kate Hardy
Cognitive Behavioral Therapy for Psychosis (CBTp) is a psychotherapy that has been shown to be effective in first episode programming. This fact sheet provides a brief, clear overview of the principles and techniques that are used in CBTp. Specific examples are included to aid in service delivery.

**Brochure: Right from the Start: Keeping Your Body in Mind**
Adapted from a brochure by the Greater Manchester Mental Health NHS Foundation
People experiencing psychosis may be at higher risk for physical illnesses such as diabetes, so it’s important to promote physical and mental health together as part of a comprehensive wellness plan. This brochure provides simple tips and a checklist for people experiencing psychosis for the first time and those who care for them to support healthy, active lives.

**Information Brief: First-Episode Psychosis: Considerations for the Criminal Justice System**
by Leah G. Pope and Stephanie Pottinger (Vera Institute of Justice)
People experiencing psychosis are over-represented in the criminal justice system, and research indicates that many people have interactions with the justice system prior to receiving treatment for mental health issues. Using the Sequential Intercept Model as a framework, this information brief offers suggestions for the justice system to identify and divert people from jails and prisons and into effective Coordinated Specialty Care programs.

**Information Brief: Outreach for First Episode Psychosis**
Given the desire to identify and provide services to individuals experiencing a first episode of psychosis as soon as possible, it is important to systematically reach out to organizations and people who are likely to be in contact with them. In this information brief we summarize insights from interviews that were conducted with several programs and state mental health authorities throughout the country regarding their outreach strategies.

**Issue Brief: Measuring the Duration of Untreated Psychosis within First Episode Psychosis Coordinated Specialty Care**
by Kate Hardy, Tara Niendam, and Rachel Loewy
One of the strongest predictors of positive outcomes in first episode psychosis is the duration of untreated psychosis (DUP). It is therefore important that programs attempt to monitor progress in reducing DUP. In this issue brief, we discuss the complex set of issues involved in reliably measuring DUP and suggest strategies that programs may employ to address these challenges.

**Issue Brief: Understanding and Addressing the Stigma Experienced by People with First Episode Psychosis**
by Patrick Corrigan and Binoy Shah
Stigma – which includes stereotypes, prejudice, and discrimination – can lead to diminished self-esteem and confidence. It can deprive people who have been diagnosed with mental illnesses of important life opportunities. This issue brief examines the issue of stigma for people experiencing a first episode of psychosis through two key questions articulated by the National Academy of Sciences: What is the stigma? And How might this stigma be diminished?

**Issue Brief: Substance-Induced Psychosis in First Episode Programming** by Delia Cimpian Hendrick and Robert Drake
People who use alcohol and other psychoactive drugs, especially heavy users, are prone to psychotic episodes that are not always recognized as being due to acute intoxication or withdrawal. Recognizing and appropriately responding to substance-induced psychosis may improve long term outcomes. In this issue brief we discuss the epidemiology, diagnosis, and treatment of individuals whose psychosis is related to substance use.

**Issue Brief: Workforce Development in Coordinated Specialty Care Programs** by Jessica Pollard and Michael Hoge
As Coordinated Specialty Care (CSC) has grown in the United States, there has been increased attention to the workforce challenges related to operating these programs. In this issue brief, we address a set of recurring questions related to workforce competencies, recruitment, retention, effective orientation, and training and supervision that are critical for the ongoing development of effective CSC programs. We provide strategies for a comprehensive workforce development effort.

**Issue Brief: Treating Affective Psychosis and Substance Use Disorders within Coordinated Specialty Care** by Iruma Bello and Lisa Dixon
While much of the literature supporting the use of Coordinated Specialty Care is based on research with individuals who have non-organic and non-affective psychosis, some programs may also treat individuals whose have affective psychoses or are substance involved. In this brief we detail the special considerations and approaches that may be used with individuals in CSC programs with affective or substance-related conditions.

**Guidance Manual: Educating Communities to Identify and Engage Youth in the Early Phases of an Initial Psychosis: A Manual for Specialty Programs** by William McFarlane and Rebecca Jaynes
The PIER program has a nationally-recognized model for community outreach that seeks to include the full range of settings in which individuals with a first episode of psychosis may appear. In this guidance manual, PIER leaders describe their conceptualization of this task, underscore its fundamental importance for affecting population outcomes, and provide detailed guidance regarding the elements of a comprehensive outreach and public education effort.

To view the EIP virtual resource center, visit NASMHPD’s EIP website.
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NASMHPD Links of Interest

DEATHS INVOLVING FENTANYL, FENTANYL ANALOGS, AND U-47700 — 10 STATES, JULY–DECEMBER 2016, MORBIDITY AND MORTALITY WEEKLY REPORT, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), OCTOBER 27
DRIED BLOOD SPOT ANALYSIS FOR THERAPEUTIC DRUG MONITORING OF CLOzapine, DEERS L.M. PHARM D ET AL, JOURNAL OF CLINICAL PSYCHIATRY, OCTOBER 30
RANDOMIZED CONTROLLED TRIAL OF THE METROPOLITAN POLICE DEPARTMENT BODY-WORN CAMERA PROGRAM, BROOKINGS INSTITUTION AND THE D.C. GOVERNMENT (THE Lab@DC) & DO BODY-WORN CAMERAS IMPROVE POLICE BEHAVIOR, JENNIFER L. DOLEAC, BROOKINGS INSTITUTION, MEDIUM.COM, OCTOBER 31
HEALTH PLAN CHOICE AND PREMIUMS IN THE 2018 FEDERAL HEALTH INSURANCE EXCHANGE, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE), DEPARTMENT OF HEALTH AND HUMAN SERVICES, OCTOBER 30
PROJECTED MARKETPLACE ENROLLMENT IN THE ABSENCE OF ACA SABOTAGE, EMILY GEE AND THOMAS HUELSKOTTER, CENTER FOR AMERICAN PROGRESS, OCTOBER 30
SURGEON GENERAL JEROME ADAMS DISCUSSES OPiOIDS AND THE IMPORTANCE OF PARTNERSHIPS AT NASMHPD CONF 17, NATIONAL ACADEMY FOR STATE HEALTH POLICY NEWSLETTER, OCTOBER 31 & SURGEON GENERAL ADAMS OFFICIAL STATEMENT, OCTOBER 26
GIVING URBAN HEALTH CARE ACCESS ISSUES THE ATTENTION THEY DESERVE IN TELEMEDICINE REIMBURSEMENT POLICIES, YASH S. HULGOL, ADITI JOSHI, BRENDAN G. CARR & JUDD E. HOLLANDER, HEALTH AFFAIRS BLOG, OCTOBER 12
UNIVERSITY OF CALIFORNIA SAN FRANCISCO SMOKING CESSATION LEADERSHIP CENTER VIDEOS: TIPS FROM FORMER SMOKERS, UPDATED SEPTEMBER 22
SECOND LADY KAREN PENCE ANNOUNCES PLANS FOR HER INITIATIVE, ART THERAPY: HEALING WITH THE HeART, WHITE HOUSE PRESS OFFICE, OCTOBER 18