West Virginia Receives CMS Approval for Coverage for 30-Day Inpatient Substance Use Disorder Treatment Services Under Medicaid § 1115 Continuum of Care Waiver

West Virginia Medicaid officials received approval from the Centers for Medicare and Medicaid Services (CMS) on October 6 to cover 30 days of inpatient substance use disorder services under a new five-year § 1115 waiver.

The waiver approval, effective January 1, 2018 through December 31, 2022, is the fifth granted under a July 2015 State Medicaid Director Letter informing states of the option of using waivers to design service delivery systems that provide a continuum of care for individuals with substance use disorders.

West Virginia has the highest rate of drug overdose deaths of any state in the country. A December 2016 Centers for Disease Control and Prevention (CDC) analysis found that the rate of drug overdose deaths in the state was 41.5 per 100,000, compared to the national rate of 16.3 per 100,000, with drug overdose deaths in West Virginia rising from 2014 to 2015 by 16.9 percent to 725 in 2015.

In addition to the short-term residential treatment, the waiver authorizes a Federal match for expenditures for methadone treatment and peer recovery support services. The latter must be provided by appropriately trained staff working under the supervision of a competent behavioral health professional (as defined by the State). A peer recovery coach must be certified through a West Virginia Department of Health and Human Resources-approved training program that provides peer support providers with a basic set of competencies, as well as continuing education. The peer must demonstrate the ability to support the recovery of others from substance use disorders.

Treatment services delivered to residents in an institutional care setting, including facilities that meet the definition of an institution for mental diseases (IMD), can be provided to Medicaid recipients with an SUD diagnosis when determined to be medically necessary by a Medicaid managed care organization utilization staff in accordance with an individualized service plan. MCO utilization staff, physicians, or medical directors must perform independent assessments to determine level of care and length of stay recommendations based on the American Society of Addiction Medicine (ASAM) Criteria multidimensional assessment criteria.

Room and board costs are not allowable costs under the waiver for residential treatment service providers, unless the facility qualifies as an inpatient facility under § 1905(a) of the Social Security Act.
The Center for Mental Health Services (CMHS) has announced it will fund another year of the Transformation Transfer Initiative (TTI) administered in part by NASMHPD. CMHS is expected to award six TTI contracts of $220,000 each to support programs that develop, strengthen, or sustain innovative projects or programs focusing on Recovery Oriented Cognitive Therapy. These flexible TTI funds will be used to identify, adopt, and strengthen transformative initiatives and activities that can be implemented in the state, either through a new initiative or expansion of one already underway. All proposals should focus on SMI or SED populations.

All states and territories are eligible to apply, using the application linked here, and all proposals are due back to NASMHPD by October 27, 2017.

Recovery Oriented Cognitive Therapy is a teachable and transformative evidenced-based practice that operationalizes recovery and resiliency. According to recent studies, people with schizophrenia, even those in the most chronic conditions, can see dramatic illness improvements using Recovery Oriented Cognitive Therapy. It is a treatment approach that prioritizes attainment of personally set goals, removal of roadblocks, and engagement of individuals in their own psychiatric rehabilitation. It is a collaborative, person-centered, and personalized treatment with all interventions based on the individual’s cognitive case formulation, tailored for patients who have difficulties with attention, memory, and executive functioning, and/or who have low motivation. Further, it employs a variety of methods to target negative attitudes and associated beliefs to foster change, promote personal mastery, and remove roadblocks to the self-sustaining movement toward recovery. State systems can promote continuity of care and improve outcomes by implementing this approach in many different places within their service system, such as jails, nursing homes, ACT teams, hospitals, and programmatic residences. In addition, many different mental health providers can be trained in CT-R, such as social workers, nurses, clinicians, front-line staff, case managers, and peer specialists.

As an example, Dr. Paul Grant from the University of Pennsylvania presented at the NASMHPD Annual 2017 Meeting on how Recovery Oriented Cognitive Therapy can be utilized to help people with long lengths of stay and stuck in hospitals move successfully to the community.

When choosing a proposed initiative, applicants should keep in mind the TTI requirement for measurable outcomes and the short period of time from proposal to implementation to reporting of initiative outcomes.

Questions regarding the TTI application or a proposal, should be directed to David Miller, NASMHPD Project Director, the staff lead on this project. Mr. Miller can be reached at 703-682-5194, or david.miller@nasmhpd.org

Veterans Affairs Releases National and State-by-State Data on Veteran Suicides

For the first time ever, the U.S. Department of Veterans Affairs (VA) has released national and state suicide data reports for veterans in all 50 states, the District of Columbia, and Puerto Rico. The analyses, released September 15, are part of the VA’s Call to Action initiative designed to prevent suicides, an initiative that has included examining over 55 million health records from 1979 to 2014.

The data indicates that veterans’ suicides are highest in western and rural areas. The most current data from 2014 shows that Montana, Utah, Nevada, and New Mexico had the highest rates of veteran suicides (60 per 100,000) in comparison to the national veteran rate of 38.4. The overall rate for the Western region was 45.5 per 100,000, with the other regions having rates below the national rate. Other states with high veteran suicide rates include West Virginia, Oklahoma, and Kentucky; these states also had more widespread use of prescription pain medications, such as opioids. A VA report, published online on January 5, 2016 in the journal Pain, found that veterans receiving the highest dosage for opioids were two times as likely to die by suicide than veterans receiving the lowest dosage.

Demographically, veteran women had a suicide rate found to be 2.5 times higher than for female civilians. For men the suicide risk was 19 percent higher among veterans than among male civilians. Middle-age and older adult veterans (50 and older) accounted for approximately 65 percent of veteran suicides. When adjusting for differences in age and sex, the risk for suicide was 22 percent higher among veterans than for non-veteran adults.

The state-by-state variation suggests that multiple factors contribute to veteran suicides, including social isolation, gun ownership, opioid abuse, and lack of access to health care. The national data indicates that 70 percent of the veterans who take their lives were not connected to the VA healthcare system. Even among those connected to the VA system, many veterans living in states with the highest veteran suicide rate were found to have needed to drive 70 miles or more to reach the closest VA medical center.

In a September 15 VA press release, VA Secretary Dr. David J. Shulkin commented, “I am committed to reducing [v]eteran suicides through support and education. We know that of the 20 suicides a day that we reported last year, 14 are not under VA care. This is a national public health issue that requires a concerted national approach.” The press release further noted that the data aims to help the VA’s Office of Mental Health and Suicide Prevention develop policies for targeting high-risk populations by working with community providers and stakeholders to expand the network of support for veterans in crisis.
President Orders Agencies to Broaden Insurance Market Beyond ACA Individual Health Plans, Ends Cost-Sharing Reduction Subsidies to Marketplace Insurers

President Donald Trump announced October 12 that the White House would cease paying cost-sharing reduction subsidies (CSRs) to Affordable Care Act marketplace insurers, just hours after signing an Executive Order directing agencies to open the insurance market to so-called “association” and “short-term” plans exempt from ACA limits.

The cost-sharing payments, which were created as part of the health care law, help compensate health insurers for lowering the copays and deductibles that their lower-income customers must pay. But they were then held unconstitutional by a Federal court in 2015 in a lawsuit brought by House Republicans because Congress never appropriated the funds for their payment.

Most states have already approved premiums for the 2018 benefit year, so it is unclear whether the loss of the subsidies will immediately impact individual health coverage premiums. Of the 12 million people who bought health insurance through the ACA marketplace in 2017, about 7 million benefited from the payment of the CSRs. CSR payments cost the federal government $7 billion in 2017, which means that, on average, CSRs lowered out-of-pocket costs by about $1,000 for each person.

The Executive Order signed earlier in the day prioritizes three areas for changes in Federal health care policy: association health plans (AHPs), short-term, limited-duration insurance (STLDI), and health reimbursement arrangements (HRAs).

It orders the Secretary of Labor to, within 60 days, propose regulations or revise guidance, consistent with law, to expand access to health coverage by allowing more small employers to form AHPs. The Secretary is directed to consider expanding the conditions that satisfy the commonality-of-interest requirements under current Department of Labor advisory opinions interpreting the definition of an “employer” under § 3(5) of the Employee Retirement Income Security Act of 1974 (ERISA). The Secretary of Labor is also to consider ways to promote AHP formation on the basis of common geography or industry.

The result could be that new association health plans would be considered large employers not subject to the same rules as individual or small-group plans under the ACA. They would not have to cover all of the law’s essential health benefits or meet other statutory requirements such as the Medical Loss Ratio requirement that 80 or 85 percent of premium be spent on actual health care costs.

The Executive Order also directs the Secretaries of the Treasury, Labor, and Health and Human Services, within 60 days of the Order, to propose regulations or revise guidance, consistent with law, to expand the availability of STLDI. To the extent permitted by law and supported by sound policy, the Secretaries are directed to consider allowing such insurance to cover longer periods and be renewed by the consumer.

Short-term plans are currently exempt from insurance rules, and can reject or charge higher prices to customers with pre-existing health conditions, provide less comprehensive coverage, and charge higher deductibles. Their premiums tend to be lower because they cover fewer benefits. Under current regulations, they can be purchased for only three months at a time, as interim coverage for individuals between jobs.

Finally, the Executive Order provides that, within 120 days of the date of the order, the Secretaries of the Treasury, Labor, and Health and Human Services must propose regulations or revise guidance, to the extent permitted by law and supported by sound policy, to expand employers' ability to offer HRAs to their employees. An HRA is an IRS-approved, employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums.

Critics of the Executive Order fear that the skimpier, lower cost plans permitted under the order will appeal to younger, healthier individuals, leaving older, less healthy insureds in the risk pool for the individual market, and thereby further driving up ACA marketplace premiums. But because the Executive Order, and the Administrative Procedure Act, require a public comment period before the mandated regulations can be adopted by the agencies, the new plans are unlikely to be operational, in the market, before mid-2018.

However, the Trump Administration has been taking other actions perceived as impairing the ACA marketplace. On August 31, the Department of Health and Human Services said it would cut the Affordable Care Act’s advertising budget by 90 percent, to $10 million, and would also reduce spending on groups that help customers find the appropriate insurance plan by 39 percent, down from $62.5 million during the last enrollment period. The administration called the cuts necessary reductions for programs that have run their course and aren’t efficient.

Bloomberg is reporting today that cuts to organizations employing the navigators who help individuals through the enrollment process have been deeper than expected, and that no rationale has been provided for the size of the cuts. Catherine Edwards, the executive director of the Missouri Association of Area Agencies on Aging, told Bloomberg that her group helped 3,945 people sign up for health insurance this year, but it is likely to cut 20 fewer navigators this year than the 2016 total of 72, leaving some rural areas of the Missouri without any enrollment assists.

Bloomberg also reports significant funding cuts of 36 percent to 71 percent for navigator programs in Arizona, Wisconsin, South Carolina, and Ohio.
SAMHSA-Sponsored Webinar Opportunity
In partnership with the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, the Behavioral Health Education Center of Nebraska, and the Annapolis Coalition on the Behavioral Health Workforce

State Solutions in Workforce Webinar: Wisconsin's Leadership Empowerment Institute

*Wednesday, October 18, 2 p.m. to 3 p.m. Eastern Time*

Participate in the next quarterly webinar that will highlight current innovations in developing the nation's addiction and mental health workforce. The fifth webinar in this ongoing series will look at Wisconsin's Leadership Empowerment Institute's five-month program to develop the next generation of leaders in the behavioral health field, specifically leaders in the African American, Latino, Hmong, and Native American communities. Leaders from each community represented in the program served as advisors for this project, which included a series of skill-building workshops and trainings.

**Register HERE**

Mark Your Calendars:
The sixth part of this series, Workforce Retention With New York and Columbia University, will take place on Wednesday, January 17, 2018, at 2 p.m. Eastern Time.

**Watch the Previous Webinars**

Questions regarding this webinar should be directed to Valerie Kolick at valerie.kolick@samhsa.hhs.gov.

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**Register HERE**

**FREE WEBINAR ON COPING WITH STRESS AND DEPRESSION**

*Wednesday, November 1 at 7 p.m. to 8:30 p.m. Eastern Time*

Join us to learn
• ways to fit mindfulness into your busy schedule
• how to recognize signs of stress and depression
• what resources are available for you

Families for Depression Awareness
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.
Study Finds Medical Licensure Application Questions on Applicants' Mental Health History Act as a Barrier to Physicians Later Seeking Treatment

Researchers at the Mayo Clinic Program on Physician Well-Being and the American Medical Association, led by Dr. Liselotte N. Dyrbye, have published a study finding that medical licensure application questions on mental health conditions act as a barrier to more than 40 percent of licensed physicians later seeking help for mental illness.

Of 5,829 applicants surveyed in the study, 2,325 reported that potential repercussions of answering questions about their mental health on licensing applications would make them reluctant to seek treatment. The reluctance to seek help was found to be even more pronounced in states where licensing applications questioned doctors about mental health conditions previous to the most recent year. Physicians in those states were at least 20 percent more likely than doctors in states that asked only about current possible impairment to say they would be reluctant to seek psychological treatment.

The Federation of State Medical Boards advises licensure boards not to ask about mental health history and indicates that doing so might violate the Americans with Disabilities Act. Yet the study’s researchers found that 32 of 48 state licensing boards continue to question doctors about their mental health history.

Dr. Dyrbye called for state licensing boards to limit application and renewal questions about mental health to just current possible impairment. She told Reuters in a phone interview published October 10 that the American Psychiatric Association has found no evidence that a doctor who has been treated for a mental illness is any more likely than a doctor with no history of mental health care to harm a patient.

“We want to lift the barriers to care for mental health conditions before physicians medicate themselves,” she told Reuters. “We need to get people help earlier in the process. Our goal is to improve the work lives of physicians so they can deliver excellent, compassionate care to their patients.”

The study appears in the October 27 Mayo Clinic Proceedings.

| National Suicide Prevention Lifeline Provides Disaster Distress Crisis Support |

The Disaster Distress Helpline (DDH) is the nation’s only hotline dedicated to providing year-round disaster crisis counseling. This toll-free, multilingual, crisis support service is available 24/7 via telephone (1-800-985-5990) and SMS (text ‘TalkWithUs’ to 66746) to residents in the U.S. and its territories who are experiencing emotional distress or other mental health concerns related to natural or human-caused disasters.

Callers and texters are connected to trained and caring professionals from a network of crisis centers across the country. Helpline staff provide supportive counseling, including information on common stress reactions and healthy coping, as well as referrals to local disaster-related resources for follow-up care and support.

Visit [http://disasterdistress.samhsa.gov](http://disasterdistress.samhsa.gov) for additional information and resources related to disaster behavioral health.

**Disaster Distress Helpline: 1-800-985-5990**

- Available 24 hours a day, 7 days a week, year-round
- Toll-free
- 3rd-party interpretation services are available to connect crisis counselors and callers in 100+ languages
- Direct crisis counseling in Spanish available 24/7 via “press 2” hotline option
- TTY: 1-800-846-8517; individuals who are deaf, hard of hearing or who have a speech disability may also use the texting option or a preferred relay 3rd-party service provider to connect with the toll-free hotline

**SMS: Text ‘TalkWithUs’ to 66746**

- Available 24 hours a day, 7 days a week, year-round
- Standard text messaging / data rates apply (according to each subscriber’s mobile provider plan)
- Spanish-speakers in the U.S. can text ‘Hablanos’ to 66746
- Palau, Marshall Islands, American Samoa, Guam, Northern Mariana Islands, Federated States of Micronesia text ‘TalkWithUs’ or ‘Hablanos’ to 1-206-430-1097
- US V.I., Puerto Rico text ‘TalkWithUs’ or ‘Hablanos’ to 1-212-461-4635
### SAMHSA Minority Fellowship Program: 2017-2018 Application Dates

<table>
<thead>
<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>
<th>Application Link and organization contact</th>
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<tr>
<td>American Association for Marriage and Family Therapy</td>
<td>12/2/2017 – 1/31/2018</td>
<td>12/2/2017 – 1/31/2018</td>
<td>N/A</td>
<td><a href="http://www.aamftfoundation.org/Foundation/What_We_Do/MFP/Application_Information/Application_Information.aspx">http://www.aamftfoundation.org/Foundation/What_We_Do/MFP/Application_Information/Application_Information.aspx</a></td>
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<td>American Nurses Association</td>
<td>4/30/17 - 4/30/18</td>
<td>Applications Open Until all vacancies filled</td>
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<td>American Psychiatric Association</td>
<td>11/1/2017-1/30/2018</td>
<td>N/A</td>
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<td><a href="http://www.psychiatry.org/residents-medical-students/residents/fellowships/about/samhsa-minority-fellowship">http://www.psychiatry.org/residents-medical-students/residents/fellowships/about/samhsa-minority-fellowship</a></td>
</tr>
<tr>
<td>NAADAC: the Association for Addiction Professionals</td>
<td>N/A</td>
<td>N/A</td>
<td>Applications accepted on rolling basis until all vacancies filled.</td>
<td><a href="https://www.naadac.org/About-the-nmfp">https://www.naadac.org/About-the-nmfp</a></td>
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### October TA Network Events

**Youth Leaders LC: Working with LGBTQI2-S Youth**

*Thursday, October 26, 3:30 p.m. - 5 p.m. ET*

"Direct Connect" is a virtual forum led by Youth M.O.V.E. National for youth and young adults to develop professional skill sets via virtual training opportunities, connect as a community to share and gather new resources, and unite with other youth advocates and professional peers from across the country. October's Direct Connect offering will be presented by Peter Gamache, PhD, and cover the topic of working with youth and young adults in the LGBTQI2S community.

- 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.
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.

KEYNOTE SPEAKERS

AUTISM

Lauren Turner-Brown, PhD
Assistant Director, UNC TEACCH Autism Program
Assistant Professor, Departments of Psychiatry and Psychology, University of North Carolina at Chapel Hill

DM-ID-2

Robert Fletcher, DSW, NADD-CC
NADD Founder & CEO
Kingston, NY
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:
  - Maintained at least 12 months of successful work or volunteer experience, or
  - Earned at least 24 credit hours from a college or post-secondary educational institution
- 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.

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International Association of Peer Supporters (iNAPS)
11th Annual Peer Support Conference

October 16 to 18, 2017
Phoenix, Arizona

Register HERE
Behavioral health is in flux because of the upheaval and uncertainties in the larger healthcare environment. The danger is that some of the recent gains in behavioral health may be undermined, if not lost. The challenge for the field is how to build on its successes as changes occur in funding and insurance, clinical and care models, workforce, and the emergence of new technologies. Come join us at our 58th Annual Conference to discuss these issues and more.
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

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
Coping Strategies for Anxious Kids
What Parents Need to Know

Topics will include:
- How to identify an anxious child
- How to change anxious thinking
- The science and biological roots of anxiety in children
- How computer technology is transforming the understanding of anxiety
- Current treatment options (medications & CBT: cognitive behavioral therapy).

NIMH-Sponsored Presentation

Thursday, October 19, 7 p.m. to 8:30 p.m.
Johns Hopkins University Montgomery County, Maryland Campus
9601 Medical Center Drive
Building 9605 (Building III) Room 121, Rockville, MD 20850

Presenter: Erin D. Berman, Ph.D. Clinical Psychologist, NIMH
Free and open to the public. This event will not be recorded. Seating is limited.
Register: https://copingstrategies.eventbrite.com

SAVE THE DATE

The 18th Annual Behavioral Health Informatics Conference and Exposition: Meeting the Information Management Needs of Mental Health and Substance Use Programs

WEDNESDAY, MAY 2 – THURSDAY, MAY 3, 2018
Sheraton Carlsbad • 5480 Grand Pacific Drive • Carlsbad, CA 92008

Learn from presentations that address:
- Uses of health information technology to support the many changes prompted by health care reform and criminal justice-related reforms.
- Practical uses of health information exchange to support coordination across multiple systems of care.
- Progressing from basic EHR implementation to optimization and improvement.
- Enhancing client recovery and wellness through innovative mobile apps and related technologies.
- Leveraging data analytics and visualizations to provide decision support and quality management.
- Applying the most recent developments in privacy and security regulations for sharing clients’ behavioral health-related information.

Participate in discussions and network with your colleagues! Meet the major software companies serving mental health and substance use programs and evaluate their products – all in one exhibit hall!
NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

NASMHPD has just released 11 new SAMSHA 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:

Fact Sheet: Cognitive Behavioral Therapy for Psychosis (CBT) by Kate Hardy
Cognitive Behavioral Therapy for Psychosis (CBT) 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 CBT. 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 Cimpean 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.

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.
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 is provided on a broad range of topics, including:

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

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

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

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

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

For assistance in developing a TA request, please contact your SAMHSA Project Officer or Jenifer Urff, NASMHPD Project Director for Training and Technical Assistance, at jenifer.urff@nasmhpd.org 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.

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CENTER FOR TRAUMA-INFORMED CARE

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

**October Trainings**

**Michigan**

October 17 - Coalition On Temporary Shelter, Detroit

**New Jersey**

October 30 to November 1 - Ancora Psychiatric Hospital, Ancora

*For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.*
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NASMHPD Links of Interest

NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT: CHARTBOOK ON RURAL HEALTHCARE & SLIDE PRESENTATION, Agency for Healthcare Research and Quality (AHRQ), October 2017

ONE NATION OVERDOSED: HOW CHILDREN COPE WITH A PARENT’S ADDICTION, NBC News

A GENERATION AT RISK: CHILDREN AT CENTER OF AMERICA’S OPIOID CRISIS, NBC News

FREQUENTLY ASKED QUESTIONS ON THE MENTAL HEALTH PARITY FINAL RULE FOR MEDICAID AND CHIP, Centers for Medicare and Medicaid Services, October 11

THE CASE FOR CONFRONTING LONG-TERM OPIOID USE AS A HOSPITAL-ACQUIRED CONDITION, Michael Schlosser, Ravi Chari, & Jonathan Perlin, Health Affairs Blog, September 8

WHY ARE MORE AMERICAN TEENAGERS THAN EVER SUFFERING FROM SEVERE ANXIETY?, Benoit Denizet-Lewis, New York Times Magazine, October 11

NATIONAL INSTITUTE OF MENTAL HEALTH RELEASES STRATEGIC RESEARCH PRIORITIES UPDATE, October 6

HEALTH CARE IN THE SUBURBS: AN ANALYSIS OF SUBURBAN POVERTY AND HEALTH CARE ACCESS, Schnake-Mahl A.S. & Sommers B.D., Health Affairs, October 2017

PRESIDENTIAL EXECUTIVE ORDER PROMOTING HEALTHCARE CHOICE AND COMPETITION ACROSS THE UNITED STATES, October 12

THE BRONX’S QUIET, BRUTAL WAR WITH OPIOIDS, Jose Del Real, New York Times, October 12