HHS Selects 8 States for § 223 Certified Community Behavioral Health Clinic Demo

The Secretary of Health and Human Services (HHS) announced December 21 the eight states selected for participation in the Protecting Access to Medicare Act § 223 demonstration.

The eight states HHS selected for the two-year Certified Community Behavioral Health Clinic (CCBHC) demonstration program (also known as the “Excellence in Mental Health Act Demonstration”) are Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. States have until July 1, 2017 to begin running their programs.

The demonstration is designed to integrate behavioral health with physical health care at community health clinics and, in the process, increase consistent use of evidence-based practices and improve access to high quality care for people with mental and substance use disorders.

In 2015, HHS awarded planning grants to 24 states to support certification of community behavioral health clinics, solicit input from stakeholders, establish prospective payment systems for demonstration reimbursable services, and prepare an application to participate in the demonstration program.

At the end of the planning grant year, 19 States submitted applications to participate in the demonstration program. The applications were reviewed by subject matter experts from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), and Office of the Assistant Secretary of Planning and Evaluation for strengths and weaknesses. A key consideration in their selection was that participating states should represent a diverse selection of geographic areas, including rural and underserved areas.

The eight participating states will be reimbursed through Medicaid using a prospective payment system for behavioral health treatment, services, and supports to Medicaid-eligible beneficiaries.

The states’ programs will be evaluated using data from 21 quality measures collected through sources such as program records, Medicaid claims, managed care encounter data, and clinic cost reports. Qualitative data also will be obtained from interviews with state officials and clinic staff. HHS will report on the access, quality and financial performance of the demonstration programs annually beginning December 2017, using data from the evaluation.

Proactive Marketplace Enrollment for January 1 Up 400K Over 2015

More Americans have signed up than in previous years to have their health plan coverage through Affordable Care Act (ACA) Marketplace plans begin on January 1, despite the promises by the Trump Administration and Congress to repeal the ACA in January.

Health and Human Services Secretary (HHS) Sylvia Mathews Burwell announced December 21 that 6.4 million people had chosen Marketplace health plans in the 39 states relying on Healthcare.gov by the December 19 extended deadline for coverage that starts New Year’s Day — an increase of 400,000 enrollees from 2015. The number does not include data from states like New York and California that use their own on-line Marketplaces.

The five states with the most people enrolling for coverage on Healthcare.gov through Monday were Florida, with 1.3 million plan selections, Texas (776,000), North Carolina (369,000), Georgia (352,000) and Pennsylvania (291,000).

Secretary Burwell said that, on the original December 15 deadline for enrollment for January 1 alone, 670,000 people signed up, setting a record.

The 6.4 million does not include those individuals whose enrollment will automatically renew on January 1, nor does it include late enrollees whose coverage will begin later in 2017. Enrollment is open for 2017 until January 31.

Secretary Burwell predicted that enrollment is on pace to reach the 13.8 million that the HHS Assistant Secretary for Planning and Evaluation projected in October for the ACA’s fourth year.

115th Congress Begins at Noon, January 3, 2017
Implicit Bias and Mental Health

There is often a contradiction between participants’ explicit vs. implicit beliefs regarding mental health. Project Implicit Mental Health explains that implicit bias is discriminating without awareness of discriminating and how it impacts the way we think of others and ourselves, and, consequently, how it impacts our behavior.

Whenever there is a mass shooting in the United States there is generally, soon after, a nationwide discussion on ‘fixing the mental health problem’. Predicting this level of violence is incredibly challenging, yet mental illness becomes a quick focal point of discussion on how to end mass shootings, even though data does not support this analysis. There are numerous reasons for this that involve both explicit (conscious) and implicit (unconscious) bias. Jonathan M. Metzl, MD, PhD and Kenneth T. MacLeish, PhD, wrote in the American Journal of Public Health that in the aftermath of mass shootings, the term mentally ill stops being a medical classification and, instead, becomes a sign of violence threat.

One organization trying to understand bias toward people with mental illness is Project Implicit Mental Health (PIMH), the mental health sister-site of Project Implicit, a non-profit organization that aims to educate the public about hidden biases and is a virtual laboratory that collects data from numerous online implicit bias tests hosted by Harvard University. Miranda Beltzer, University of Virginia and PIMH researcher, says studies have shown a great deal of variability regarding mental illness stigma among the general public. For instance, one study found slightly positive explicit and implicit views toward people with mental illness (Persis, Teachman, & Nosek, 2008). In another study (college sample), participants’ explicit beliefs were that people with mental illness are bad and helpless, but not blameworthy. Their implicit beliefs, on the other hand, were that people with mental illness are bad, helpless, and blameworthy as compared to people with physical illness (Teachman, Wilson, & Komarovskyka, 2006).

While there is certainly variance, what’s clear is that there is often a contradiction between participants’ explicit vs. implicit beliefs. To understand why, we need to dig deeper into what is implicit bias and how it interacts with explicit beliefs, behaviors, and actions. Alexandra Werntz, University of Virginia and PIMH researcher, says implicit biases are simply automatic connections stored in a person’s mind outside of his/her conscious awareness. Contrarily, explicit biases are more familiar to people and are biases that people are able to identify and report. “They are influenced by a lot of different factors, like willingness to disclose and social desirability,” says Werntz. When thinking about implicit and explicit biases about mental health, she says to imagine the following scenario:

Person A has been getting lunch with the same coworker (Person B) for the past year. However, yesterday, Person B discloses that he has been seeing a therapist for the last six months because he has been feeling really down. After learning this information, someone asks Person A, “Do you think your coworker is bad or dangerous?” Person A may be inclined to say no—she knows it’s not socially desirable to be biased against people with mental illness. However, Person A may find herself not really wanting to go to lunch with this friend any longer.

The reason Person A may no longer want to have lunch with Person B is because she may have more automatic, less consciously controlled, associations between mental illness and concepts like danger.

Anthony Greenwald, cofounder of Project Implicit, describes implicit bias as discriminating without awareness of discriminating. Meaning, implicit bias is when people discriminate without intent to do so and without awareness that they are doing so. This results in their discrimination not only against others but also themselves. Greenwald says people’s minds work on two levels—one functions rationally and deliberately (explicit) while the other operates intuitively and automatically (implicit). The two levels aren’t entirely independent—the conscious level, he says, works with what it receives from the unconscious level, the basis for deliberate judgment and action.

In a presentation at the University of Washington, Greenwald turned to the Edward H. Adelson’s Checkershadow Illusion to illustrate the relationship between implicit and explicit thinking. In the graphic it appears that square A and B are not the same shade of gray when they are, in fact, the very same hue. It’s simply the context that makes people think otherwise. The viewer of the illusion has no idea how it’s happening or even awareness that an illusion is happening.

To determine implicit bias, Project Implicit examines automatic preference through a timed photo and/or word association Implicit Association Test (IAT). Project Implicit IATs focus on biases in an array of areas ranging from gender-career associations to age discrimination, while its mental health sister-site, PIMH, focuses specifically on mental health IATs. Users on the PIMH portal can take individual 10-minute tests to determine his/her implicit bias toward anxiety, depression, alcohol, eating disorders, or persons with mental illness. The tests primarily examine the participant’s true perceptions of himself/herself. A self-esteem test determines whether the user implicitly associates himself/herself as good or bad, the alcohol test examines whether the user thinks alcohol is irresistible, and the treatment test gets at whether the user implicitly favors medication over talk therapy.

The PIMH portal also hosts a mental illness test that examines whether the participant implicitly thinks people with mental illness are dangerous. The test solely uses questions and word associations to determine explicit and implicit bias.
Implicit Bias and Mental Health (cont’d from page 2)

The first portion focuses on explicit beliefs by asking participants numerous questions on his/her felt safety around people with mental illness. Questions include whether the participant would allow his/her children to go to the movie theatre alone if a group of former mental patients lived nearby. Participants are also asked whether he/she would recommend a qualified person for a teaching position at a grade school if the person had been a former mental patient. Other questions include whether the participant would be less likely to trust a person that had been a mental patient and whether he/she believes mental health hospitals’ main purpose is to protect the public from mentally ill people.

The second portion of the test hone in on implicit bias through quick word associations, where the user presses ‘E’ (for left) or ‘I’ for (right) in order to match a word with a category. The left and right categories change. At some point the test puts mentally ill people + harmless on the left and physically ill + dangerous on the right. At another point the categories are listed opposite, where mentally ill people + dangerous are on the left and physically ill + harmless on the right. (See Figures 1 and 2.) It’s repetitive and easy, pulling out the user’s automatic associations. The more a participant associates certain words, the more rapidly he/she responds. The words the participant organizes under the changing categories include dangerous, unsafe, violent, aggressive, harmless, safe, peaceful, gentle, Schizophrenia, Bipolar Disorder, Depression, Obsessive-Compulsive Disorder, Diabetes, Appendicitis, Cerebral Palsy, and Multiple Sclerosis.

Figure 1. Physically Ill People + Dangerous (right) and Mentally Ill People + Harmless (left)

People who participated in PIMH mental health studies between 2011 and 2015 explicitly responded that people with mental illness are slightly to moderately harmless. However, participants had slightly stronger implicit beliefs that people with mental illness are dangerous as compared to physically ill people. The result highlights that bias toward those with mental illness persists even though mental illness is common. “More than a quarter of Americans have a diagnosed mental illness (26.2% of Americans over the course of a year will meet criteria for mental illness),” says Beltzer. “Nearly half of Americans at some point in their life will meet full criteria for mental illness.” Implicit bias may factor into why people say they see therapy as a more effective form of treatment than medicine but are more apt to use medication over therapy. “The most common number of times people go to a therapist is once,” says Beltzer. “They go to a single session and don’t return.” Certainly, there are numerous reasons for this contradiction—cost, time, and transportation—but stigma and bias are part of the calculus.

What is interesting, but not necessarily surprising, are the many contradictions there are in people’s implicit vs. explicit mental health associations regarding themselves. For example, Alcohol PIMH study participants explicitly reported that they more strongly thought of themselves as abstainers, as opposed to drinkers. Yet, participants did not have an implicit bias toward automatically thinking about themselves as being drinkers or abstainers. Older age correlated with stronger implicit self-concepts of being an abstainer but stronger explicit self-concepts of being a drinker. Werntz says this may be a result of people’s implicit and explicit drinking identities. “Kristen Lindgren, PhD, Associate Professor, University of Washington, has found that for explicit drinking associations, considering oneself as an abstainer may be protective for adults under 25, as compared to adults over 25,” says Werntz. “This suggests that what people say in terms of their drinking identity is

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**Implicit Bias and Mental Health** (cont’d from page 3)

especially important for younger adults." (See more on drinking identity at Lindgren et al., 2016.)

Participants in the Anxiety PIMH study were quicker to automatically (implicitly) associate themselves with being calm than anxious. However, they did explicitly report that they more strongly thought of themselves as anxious, rather than calm. This contradiction may, in part, says Werntz, be because participants chose to participate in this particular test and thereby may already think of themselves as anxious individuals. The same she suspects is true for the Depression PIMH study where participants implicitly associated themselves with being happy, rather than sad. Yet, participants explicitly reported that they more strongly thought of themselves as being sad than happy. "Individuals who participated in the depression study were already interested in depression, so may be more willing to report being sad," says Werntz. "And because they were reporting anonymously, stigma may not have been a factor when deciding how to respond."

Interestingly, Werntz says PIMH research has shown that people are, overall, more likely to implicitly associate themselves with positive attributes, which may play a role in large group averages and responses. Research also suggests that implicit associations and biases become particularly important in predicting behavior when people are low on cognitive resources. One study found, says Werntz, that implicit biases about alcohol were more predictive of drinking alcohol when participants’ self-control resources were depleted, as compared to participants who had more resources for self-control (Ostafin, Marlatt, & Greenwald, 2008). Meaning, people may default to their automatic associations (implicit associations) as opposed to their rational mind (explicit associations) when they are cognitively drained.

Sometimes people’s implicit and explicit biases are in line with each other, says Werntz, but sometimes they diverge. "When they diverge, it’s important to stop and think about why this might be the case," says Werntz. "We’re not saying that one is necessarily the truth—it’s just that implicit biases and explicit biases exist and interact in ways that we’re still figuring out." As PIMH researchers learn more about negative implicit biases they also begin to ponder how to positively alter them. Unfortunately, says Werntz, thus far, Project Implicit is not aware of any evidence-based interventions to shift implicit bias about mental illness. What researchers do know, says Beltzer, is that people with mental health training have more positive implicit and explicit views of people with mental illness than the general public (Peris, Teachman, & Nosek, 2008). This can be for a variety of reasons, says Beltzer, such as exposure, self-selecting into that career, and training-information.

People don’t need to become experts in mental illness to dispel their own biases. Research indicates that exposure to people with mental illness, says Beltzer, makes people think of those with mental illness in less negative ways (Phelan & Link, 2004). Simply learning that a best friend or a family member has panic attacks or is depressed may counter negative implicit bias. Werntz’s recommends encouraging people to learn about their own implicit bias. Just this knowledge alone, she says, can get people to think critically about whether these biases are in line with their principles. "The more people are aware of their own biases, the more they may be able to slow down and act in ways that are aligned with their values.” For instance, if we revisit the example where Person B shared with Person A that he was feeling down and was seeing a therapist, Person A may behave differently if she learns more about her implicit bias. Meaning, if she learns that she implicitly thinks of individuals with mental illness as dangerous but doesn’t want to act in a way to discriminate against people with mental illness, she could make the conscious effort to continue to go to lunch with her friend. Over time, says Werntz, Person A would hopefully become more and more comfortable.

Stephanie Hepburn is a journalist, author of Human Trafficking Around the World: Hidden in Plain Sight + founder of Good Cloth. This blog has also been published on the Huffington Post website and on the NASMHPD website.

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**Trump Team, Advocates, and Congress Preparing for Health Program Changes in 2017**

The Trump transition health care policy team has begun meeting with stakeholder advocates in order to hit the ground running on January 20. At the same time, Republicans in Congress are planning how to repeal the Affordable Care Act and block-grant Medicaid while ensuring uninterrupted access to health care services, and advocates are gearing up to preserve crucial elements of the ACA and prevent funding reductions for a significantly changed Medicaid program.

The Trump transition team held its final pre-Christmas one-hour Listening Session at the American Enterprise Institute in Washington, D.C. on December 20, during which it heard from around 100 representatives of hospitals, insurers, physicians, and mental health providers—including NASMHPD, the Bazelon Center for Mental Health Law, Mental Health America, and the American Psychiatric Association—outline their concerns for the upcoming year.

In its own much abbreviated remarks, NASMHPD stressed the need to maintain the parity provisions of a repealed ACA, increase inpatient and outpatient crisis stabilization services, and align the statutory restrictions on substance use disorder treatment provider disclosures to other providers with Health Insurance Portability and Accountability Act (HIPAA) disclosure restrictions. NASMHPD also forwarded short issue briefs for later consideration on the need to preserve the Suicide Prevention Lifeline, increase the behavioral health workforce, authorize peer support coverage under Medicare, maintain block grant funding for early intervention, increase services for prodromal interventions, and enhance funding for supportive housing and supported employment.

Meanwhile, beneficiary advocates such as the Center for Budget Priorities were warning states that—judging from the 2015 Congressional Budget Reconciliation Act and Speaker Paul Ryan’s “A Better Way” policies platform—a reconfiguration of the Medicaid program would likely be accompanied by a multi-billion dollar reduction in program funding. Advocates warned that promises of increased state flexibility should be considered in the context of reduced Federal funding when Governors respond to the December 13 inquiry from the Senate Finance Committee. Democrats warned that changes made to the Medicaid program would likely be made quickly, with little public notice.
ENGAGE YOUR FAMILY IN AN IMPORTANT BEHAVIORAL HEALTH CONVERSATION

With the holiday season in full swing, SAMHSA’s Voice Awards program is partnering with Text, Talk, Act to encourage families (those we are born with and those we choose) to engage in conversations about mental health and substance use issues.

**HOW TO PARTICIPATE** - Between now and December 31, 2016, families can gather and text FAMILY to 89800 to receive a series of text messages that will guide them through a conversation on how they can support each other and strengthen each other’s emotional well-being.

**HELP SPREAD THE WORD** - Share this exciting opportunity with your family members, friends, peers, those in recovery, and networks that may be interested. Download the Text, Talk, Act infographic and share the social media messages below.

**Facebook and LinkedIn**
- SAMHSA’s Voice Awards program is partnering with Text, Talk, Act. Want to talk about behavioral health with your family, but don’t know how? Text FAMILY to 89800 to get started. [http://creatingcommunitysolutions.org/texttalkact](http://creatingcommunitysolutions.org/texttalkact)
- SAMHSA’s Voice Awards program is bringing families together for an important conversation about behavioral health through Text, Talk, Act. Learn how: [http://creatingcommunitysolutions.org/texttalkact](http://creatingcommunitysolutions.org/texttalkact)
- Gather your family members--both those you are born with and those you choose--and text FAMILY to 89800 to start an important behavioral health conversation. This Text, Talk, Act opportunity is available until December 31.[http://creatingcommunitysolutions.org/texttalkact](http://creatingcommunitysolutions.org/texttalkact)

**Twitter**
- SAMHSA’s #VoiceAwards is bringing families together for an important conversation via #TextTalkAct. Learn how: [http://creatingcommunitysolutions.org/texttalkact](http://creatingcommunitysolutions.org/texttalkact)
- Text FAMILY to 89800 to start a behavioral health conversation via #TextTalkAct. [http://creatingcommunitysolutions.org/texttalkact #VoiceAwards](http://creatingcommunitysolutions.org/texttalkact #VoiceAwards)
- From now until 12/31, text FAMILY to 89800 to talk about behavioral health.[http://creatingcommunitysolutions.org/texttalkact #VoiceAwards](http://creatingcommunitysolutions.org/texttalkact #VoiceAwards)

Follow Text, Talk, Act on [Facebook](http://creatingcommunitysolutions.org/texttalkact) and [Twitter](http://creatingcommunitysolutions.org/texttalkact) and be part of a nationwide conversation.
NASMHPD Early Intervention in Psychosis (EIP) Virtual Resource Center

In the spring of 2015, NASMHPD launched an Early Intervention in Psychosis (EIP) virtual resource center, which was made possible through the generous support of the Robert Wood Johnson Foundation (RWJF).

The intent of the EIP site is to provide reliable information for practitioners, policymakers, individuals, families, and communities in order to foster more widespread understanding, adoption and utilization of early intervention programming for persons at risk for (or experiencing a first episode of) psychosis. The site includes information from the national RWJF-funded demonstration to identify and prevent the onset of psychotic illness – the Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) – as well as a variety of other early intervention initiatives.

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

SAMHSA Fiscal Year 2017 Grant Opportunity

**Addiction Technology Transfer Centers (ATTC) Cooperative Agreements**

**Application Due Date:** Tuesday, February 9, 2017

**FOA:** TI-17-005

**Project Length:** Up to 5 Years

**Anticipated Award Amount:** ATTC National Coordinating Office: up to $1,175,294 (With $400,000 specific for OTPs); ATTC Regional Centers: up to $775,294

**Number of Anticipated Awards:** 11

**Total Amount Available:** $8.92 million

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) is accepting applications for FY 2017 Addiction Technology Transfer Centers (ATTC) Cooperative Agreements. The purpose of this program is to develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides substance use disorder (SUD) treatment and recovery support services. This is done by: accelerating the adoption and implementation of evidence-based and promising SUD treatment and recovery-oriented practices and services; heightening the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other co-occurring health disorders; and fostering regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community.

ATTC Network grantees will work directly with SAMHSA and amongst themselves on activities aimed at improving the quality and effectiveness of treatment and recovery, as well as work directly with providers of clinical and recovery services and others that influence the delivery of services to improve the quality of workforce training and service delivery. The program will also support Opioid Treatment Programs (OTPs) to develop workforce capacity.

**Eligibility:** Eligible applicants are domestic public and private nonprofit entities. For example:

- State and local governments;
- Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, Urban Indian Organizations (UIOs), and consortia of tribes or tribal organizations;
- Public or private universities and colleges; and
- Community- and faith-based organizations.

While any eligible organization may apply for any of the 11 ATTC Centers, a separate application must be submitted for each type of ATTC (ATTC National Coordinating Office and ATTC Regional Center). Each organization may submit only one application per type of ATTC. The maximum number of applications SAMHSA will review for any organization is two (2). Each applicant organization may receive only one (1) award. If an applicant submits two high scoring applications, award decisions will be made in the following priority order: 1) ATTC National Coordinating Office; and 2) ATTC Regional Centers. Only one ATTC Regional Center award will be made per region.
**Additional SAMHSA Fiscal Year 2017 Grant Opportunity**

**Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances**

**Application Due Date:** Tuesday, January 3, 2017  
**FOA:** SM-17-001

**Project Length:** 4 Years

**Anticipated Award Amount:** Up to $3 million per year for state applicants; up to $1 million for political subdivisions of states, territories, or Indian or tribal organizations.

**Number of Anticipated Awards:** 5 to 15  
**Total Amount Available:** $15,045,000

CMHS is also accepting applications for fiscal year (FY) 2017 Cooperative Agreements for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances *(Short title: System of Care (SOC) Expansion and Sustainability Cooperative Agreements)*. The purpose of this program is to improve behavioral health outcomes for children and youth (birth-21) with serious emotional disturbances (SED) and their families. This program will support the wide-scale operation, expansion, and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children’s Mental Health Initiative or CMHI).

This cooperative agreement will support the provision of mental health and related recovery support services to children and youth with SED and those with early signs and symptoms of serious mental illness (SMI), including first episode psychosis (FEP), and their families.

The SOC Expansion and Sustainability Cooperative Agreements will build upon progress made in developing comprehensive SOC across the country by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of evidence-based and evidence-informed services and supports. Other activities supported will include the implementation of systemic changes, training, and workforce development.

**Eligible Applicants:** State and territorial governments, governmental units within political subdivisions of a state, such as a county, city or town; Federally recognized American Indian/Alaska Native (AI/AN) tribes, tribal organizations, Urban Indian Organizations, and consortia of tribes or tribal organizations; and Indian or tribal organizations (as defined in Section 4[b] and Section 4[c] of the Indian Self-Determination and Education Assistance Act).

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**Minority Fellowship Program Grantees Accepting Fellowship Applications for 2017-18**

SAMHSA’s Minority Fellowship Program (MFP) grantees have started to accept fellowship applications for the 2017-18 academic cycle. The MFP seeks to improve behavioral health outcomes of racially and ethnically diverse populations by increasing the number of well-trained, culturally-competent, behavioral health professionals available to work in underserved, minority communities. The program offers scholarship assistance, training, and mentoring for individuals seeking degrees in behavioral health who meet program eligibility requirements. The following table outlines fellowship application periods for each of the grantees awarded funds to implement the MFP.

<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>
</tr>
</thead>
<tbody>
<tr>
<td>American Association for Marriage and Family Therapy</td>
<td>11/7/2016 – 1/17/2017</td>
<td>11/7/2016 – 1/17/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>American Nurses Association</td>
<td>4/30/16 - 4/30/17</td>
<td>Applications Open Until all vacancies filled</td>
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<td>American Psychiatric Association</td>
<td>10/31/2016- 1/30/2017</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>American Psychological Association</td>
<td>10/3/2016 – 1/15/2017</td>
<td>10/3/2016-1/15/2017</td>
<td>N/A</td>
</tr>
<tr>
<td>Council on Social Work Education</td>
<td>12/2016 – 2/28/17</td>
<td>Spring 2017</td>
<td>N/A</td>
</tr>
<tr>
<td>NAADAC: the Association for Addiction Professionals</td>
<td>N/A</td>
<td>N/A</td>
<td>9/30/2016 – 8/1/2017 Note: This application cycle will be an open “rolling application” period.</td>
</tr>
</tbody>
</table>
Studies Find Depression, Suicidal Thoughts Common among Medical Students, Airline Pilots

Two studies published in the last two weeks have found depression and thoughts of suicide common among medical students and airline pilots.

A literature review published December 6 in the Journal of the American Medical Association (JAMA) found 27.2 percent of medical students have depression symptoms and an overall prevalence of suicidal ideation among those students of 11.1 percent. Of those who screened positive for depression, only 15.7 percent sought psychiatric treatment.

The 27.2 percent is significantly higher than in the general population; the 2015 National Survey on Drug Use and Health reported that only 6.7 percent of adults in the general population experienced depression.

The authors extracted the medical data on depression from 167 cross-sectional studies and 16 longitudinal studies of a total of 116,628 medical students in 43 countries. All but one of the studies utilized self-reported assessments. The numbers on suicidal ideation were derived from 24 studies in 15 countries of a total of 21,002 medical students.

The study did not find significant differences between study participants from different countries.

Previous research had found similarly high depression rates among new doctors. In December 2015, a review in JAMA of 54 studies involving 17,500 medical residents over 50 years found a depression rate of 29 percent among medical residents. The authors of the more recent study say the similarity of depression rates among medical students and residents suggests depression might be common at all stages of physician training and practice. They suggest future research should explore whether depression in medical school predicts later depression as a physician.

Research published in the journal Environmental Health on December 14 by researcher Joseph Allen, an assistant professor of exposure assessment science at Harvard T. H. Chan School of Public Health, revealed that hundreds among a sample of 1,850 pilots currently flying commercial airlines were found to be clinically depressed. And many of those pilots with symptoms of depression did not seek treatment due to fears of negative career consequences.

The study of depression among airline pilots arose after a depressed Germanwings co-pilot deliberately crashed his plane into the French Alps with 150 passengers aboard in March of 2015.

The pilot data was drawn from responses to an anonymous web-based survey conducted between April and December 2015. Allen and his colleagues designed the survey with a mix of topics so as not to reveal the study’s focus on mental health.

Out of nearly 3,500 participants, 1,848 completed the questions about mental health. Within this group, 233 pilots--or 12.6 percent--met the criteria for likely depression. Of 1,430 pilots who said they’d worked within the past seven days, 193--or 13.5 percent--met the criteria for depression. Seventy-five pilots (4.1 percent) reported having suicidal thoughts in the previous two weeks.

Pilots who used higher amounts of sleep aid medication were more likely to be depressed, as were pilots who were victims of sexual harassment (36.4 percent) or verbal harassment (42.9 percent).

The Federal Aviation Administration requires aeromedical examiners to evaluate the fitness of pilots, but the examiners do not diagnose mental health conditions. The only way a mental disorder is even noted in a pilot’s health records is if he or she mentions it.

The authors of the study believe that public stigma and the fear of being grounded leads pilots to under-report mental health symptoms and diagnoses.
State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

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

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

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

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

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

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

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

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

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

These products are in addition to those that were developed last year as well as other materials on first episode programming. They can be obtained at [http://www.nasmhpd.org/content/information-providers](http://www.nasmhpd.org/content/information-providers). Any questions or suggestions can be forwarded to either Pat Shea (Pat.shea@nasmhpd.org) or David Shern (David.shern@nasmhpd.org).

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.

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.
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NASMHPD Links of Interest
(Inclusion on this list should not be read to imply NASMHPD support for the views expressed in the linked items.)

CONSIDERATIONS IN AFFORDABLE CARE ACT REPEAL AND REPLACE INITIATIVES, National Association of Medicaid Directors (NAMD)

CONSIDERATIONS IN MEDICAID STRUCTURAL REFORM PROPOSALS, NAMD

REGULATORY TRANSITION ISSUES FOR 2017: THE FIRST 100 DAYS: LAYING THE GROUNDWORK FOR A SUCCESSFUL FEDERAL–STATE MEDICAID PARTNERSHIP, NAMD

LEGISLATIVE TOP ISSUES FOR 2017, NAMD

THEY’RE ALL GOOD KIDS, Addiction Policy Forum Public Service Announcement on the Impact of Addiction on Families

WORK MATTERS: A FRAMEWORK FOR STATES ON WORKFORCE DEVELOPMENT FOR PEOPLE WITH DISABILITIES, Council of State Governments and National Conference of State Legislatures (NCSL), December 2016

TRACKING STATE INNOVATIONS IN MEDICAID: ENACTED LEGISLATION IN 2016, NCSL, December 2016

INSURANCE EXPANSION AND HOSPITAL EMERGENCY DEPARTMENT ACCESS: EVIDENCE FROM THE AFFORDABLE CARE ACT, Annals of Internal Medicine, December 20

WHAT’S CONFUSING US ABOUT MENTAL HEALTH PARITY, Health Affairs, Nathaniel Counts, Timothy Clement, Amanda Mauri, Paul Gionfriddo, & Garry Carneal (MHA & ParityTrak), December 22