



# National Association of State Mental Health Program Directors

## Weekly Update

### Congressional Committees Grill HHS Secretary Burwell on FY 2017 Budget

Health and Human Services (HHS) Secretary Sylvia Burwell spent two mornings this week in House of Representatives Congressional committees providing details about the President's FY 2017 Budget and responding to charges the Obama Administration had ignored the normal budget process in funding HHS programs.

On February 24, in [House Energy and Commerce \(E&C\)](#), and on February 25, in the [House Appropriations Labor-HHS Subcommittee](#), questions were raised about the levels of expenditures in the HHS FY 2017 budget. Appropriations Subcommittee members, in particular, were concerned that \$3.8 billion in new expenditures—including the \$1.1 billion earmarked for programs designed to address prescription opioid abuse—had been labelled in the budget as “mandatory”, a label traditionally reserved for permanently authorized entitlement programs, rather than “discretionary,” the label normally given expenditures authorized periodically by Congress. While full Appropriations Committee Chair Hal Rogers (R-KY) lamented the lack of flexibility afforded by mandatory expenditures to respond to changing circumstances, it was also clear committee members were unhappy over their loss of authority over the discretionary expenditures they typically manage.

Rep. Rogers particularly singled out two new programs the Obama Administration had labelled “mandatory”—the \$1.1 billion initiative dedicated to addressing the national epidemic of prescription opioid abuse, and the \$750 million earmarked for the National Institute of Health and the Food and Drug Administration to spend on Vice President Biden's “cancer moonshot”. The latter initiative particularly irked members such as Rep. Charles W. Dent (R-PA) and Rep. Rogers because its costs are offset in the President's budget by a \$2 billion reduction in the new discretionary spending authorized by Congress for NIH in the FY 2016 Budget, and because the cancer initiative was seen as potentially in conflict with the 21<sup>st</sup> Century Cures legislation already passed in the House. Secretary Burwell attempted to allay the members' concerns about the cancer initiative undermining the Cures measure by promising to work with Congress in incorporating any necessary statutory authority

for the Biden cancer initiative in the final version of the Cures bill, which is still awaiting Senate action.

An additional area for criticism was the \$1.9 billion in emergency funding sought for combatting the Zika virus domestically and internationally. Members such as Reps. Andy Harris (R-MD) and Nita Lowey (D-NY) suggested the Administration should instead be using unspent emergency funding appropriated in FY 2015 to combat the Ebola epidemic to address the newest pandemic.

Secretary Burwell received no criticism in either committee for the two-year, \$500 million in new mandatory funding for mental health and the \$1.1 billion in new mandatory funding for substance abuse programs. She said those new Federal mandatory expenditures were appropriate because mental health and substance abuse treatment programs are traditionally funded primarily at the state and local levels, but the limited levels of funding for those programs had raised questions about who should truly be responsible for those issues.

The issue of mental illness came up frequently in Democratic members' comments regarding how the Affordable Care Act has afforded additional coverage for mental health. In both committees, Secretary Burwell was complemented by Democrats on the Administration's budget proposal to restart the full 100 percent Federal match for states expanding Medicaid in the future.

One area of particular interest for which Secretary Burwell received praise, not criticism, was her pending approval of a Medicaid waiver to cover pregnant women and children affected by the lead-tainted water crisis in Flint, Michigan. The Secretary was complimented by E&C Chair Fred Upton (R-MI) in for her timely response to Michigan Governor Rick Snyder's request for assistance and her communications with Rep. Upton. She told Rep. Upton the waiver will include coverage for targeted case management and comprehensive services for children who show a specified level of lead exposure.

The SAMHSA budget will be [heard](#) in the House Appropriations Labor-HHS Subcommittee on March 2.

## Flint, Michigan, and the Failure of Public Agencies (Opinion Reprinted from the *JAMA Forum*)

By [JOSHUA M. SHARFSTEIN, MD](#)

On my first day as health commissioner in Baltimore in December 2005, the chief counsel to the city gave me some advice: When you see a problem, fix it. Don't let your first instinct be to wonder who caused the problem, or to wait for every possible detail, or to defer to others. He said that the most important question the public will ever have about any problem is whether it has been fixed. And then he added, in an unwavering, deep voice, that fixing the problem is the right thing to do.

After the disastrous decisions that led to contamination of the water supply in Flint, Michigan, public agencies stumbled again by failing to identify the problem and respond quickly. Delays led to [brutal](#) assessments of governmental inaction and likely played a role in the resignation of senior state and federal officials. It took the courageous work of a [professor](#) and a [pediatrician](#) to force public leaders to pay attention to a health crisis.

Whenever government agencies founder, some find fault in their leaders for heartlessness, ignorance, or incompetence (or a combination of all three). Yet there are also reasons why even well-intentioned and otherwise effective government officials may fail to recognize and fix problems. Without excusing any of the failures in Flint, it is worth considering whether these factors may have played a role there.

**The blind spot for crisis.** It is no secret that public officials, just like everyone else, prefer good news to bad news. A tap of the keyboard sends happy news releases and upbeat emails to the public, the media, and elected representatives. Agencies use positive news to generate internal pride and external momentum.

The emphasis on good news makes it more difficult to acknowledge bad news. Problems require more than words; they require attention, and many underfunded offices are stretched thin just meeting their daily obligations. Responding to a health or environmental challenge means intense focus, rapid decision-making, and robust engagement with communities; practically speaking, releasing bad news can require pulling staff from other important activities for days if not weeks or months. As a result, officials are susceptible to wishful thinking that concerns will resolve by themselves. In the case of Flint, some [public officials](#) apparently spent time developing reassuring press statements rather than planning a comprehensive response.

**The organizational chart trap.** Although public agencies can be quite large, any given technical topic is likely to be understood by only a few staff members located in a corner of the organizational chart. This is the group responsible for setting policy on the topic; it is also the group most likely to field questions about concerns that may arise.

If a crisis is brewing in an area of specialized knowledge, such as whether water from a new supply source has received adequate treatment, agency leaders need to assess the facts quickly and effectively. Relying on the same people responsible for having made key decisions in the first place risks falling into a trap of false reassurance. A better approach is to seek outside expert input. This apparently did not [happen](#) in Flint until it was too late.

**Legal quicksand.** When an agency leader is considering a bold course of action to address an unexpected problem, at least one person inside an agency is likely to ask, "Are we allowed to do that?" Legal concerns may be entirely appropriate. What often happens, however, is that leaders hold off on all action, including permissible steps, until the questions are resolved. As some involved in the Flint crisis have now discovered, an extended delay for legal review is [impossible to justify](#) after the crisis becomes widely known.

A better approach is for public officials to talk promptly and candidly about the crisis, explaining what options are under consideration. A clear statement setting out the facts about a public health hazard may even lead to voluntary action without the need for the agency to exercise legal authority.

**Missing warning signs.** Many problems come to light as a result of external investigations—from journalists, auditors, inspectors general, and others. Nearly always, the agency has a chance to spot clues about what is happening during the investigation and move fast to limit the damage. For example, a reporter may confront a health agency with uncomfortable facts or an auditor may ask for an unusual set of records. These are precious opportunities for public officials to recognize whether there is, in fact, a major crisis brewing and respond. Yet few agencies are set up to review these warning signs fairly and systematically and figure out if something is truly awry.

Failing to take advantage of early signals of trouble should be called "GSA moments," after the epic failure five years ago of the General Services Administration (GSA) to promptly recognize and address management failures that led to lavish parties held at the public's expense. By the time the Office of the Inspector General released its [report](#), it was [too late](#) for the agency. In the case of Flint, concerns expressed by citizens, journalists, and outside scientists provided multiple opportunities for public officials to dig further into the problem, but they led to GSA moments instead.

**The responsibility conundrum.** An agency taking responsibility for fixing a problem can find itself blamed for having caused it in the first place. Why? The public will assume that the agency is acting to address the consequences of its own making. Countering this assumption can be difficult — and counterproductive. Moving forward to get a job done is often incompatible with casting blame on others, especially those whose assistance is needed in a collaborative effort. Success may require giving others a pass (as well as, perhaps, an opportunity at redemption).

Yet a common phobia among public officials is the fear of being held accountable for a problem for which others share responsibility. This is not difficult to understand in a world of judgmental journalists, partisan political conflict, and social media. However, when multiple agencies are circling around the same crisis, as in Flint, this phobia can lead to paralysis, without any agency stepping forward and embracing the challenge. (Cont'd on page 6)

# Grants Available to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts

Short Title: SAMHSA Treatment Drug Courts”

Funding Opportunity Announcement (FOA) Information (FOA)  
Number: TI-16-009

Posted on Grants.gov: Monday, February 1, 2016

Application Due Date: Monday, April 4, 2016

SAMHSA is accepting applications for as many as 50 Fiscal Year 2016 [Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts](#). Grants will be for as much as \$325,000 annually for up to 3 years.

The purpose of the program is to expand and/or enhance substance use disorder treatment services in existing adult problem solving courts, and adult Tribal Healing to Wellness courts, which use the treatment drug court model in order to provide alcohol and drug treatment (including recovery support services, screening, assessment, case management, and program coordination) to defendants/offenders.

Grantees are expected to provide a coordinated, multi-system approach that combines the sanctioning power of treatment drug courts with effective substance use disorder treatment services. Grant funds must be used to serve people diagnosed with a substance use disorder as their primary condition

Eligible applicants are tribal, state and local governments with direct involvement with the drug court/tribal healing to wellness court, such as the Tribal Court Administrator, the Administrative Office of the U.S. Courts, the Single State Agency for Alcohol and Drug Abuse, the designated State Drug Court Coordinator, or local governmental unit such as county or city agency, federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations, and individual adult treatment drug courts.

## 2016 Center for Justice Reform Youth in Custody Certificate Program

The Center for Juvenile Justice Reform (CJJR) at Georgetown University’s McCourt School of Public Policy is accepting applications now through March 18 for its 2016 Youth in Custody Certificate Program. The program invites leaders and participant teams from around the country to the Georgetown campus for a week of intensive study from May 9 through May 13.

The 2016 Youth in Custody Certificate Program involves comprehensive scholarship and exploration of current research and best practices to support youth in post-adjudication custody, and is conducted in part with support from the Office of Juvenile Justice and Delinquency Prevention’s Center for Coordinated Assistance to States. The program focuses on youth in post-adjudication custody and provides detailed instruction and discussion on “what works.” Program modules review and integrate best practices such as: family engagement, trauma informed treatment, and strengths-based approaches. The program, however, does not stop at the onsite instruction. Participants continue their commitment to reform through the development and implementation of a grassroots Capstone Project, and induction into the CJJR Fellows Network.

Visit the CJJR Youth in Custody Certificate Program [website](#) for the application and guidelines, curriculum and instructors, tuition and available subsidies, and selection criteria. Questions should be directed to [jireform@georgetown.edu](mailto:jireform@georgetown.edu) or [jill.adams@georgetown.edu](mailto:jill.adams@georgetown.edu).

### Recent Training Activity under the State Mental Health Technical Assistance (TA) Project

NASMHPD coordinates a wide variety of SAMHSA-sponsored technical assistance and training activities under the *State Mental Health TA Project*. Recent examples include:

- **Arkansas:** Susan Gingerich, MSW, a Family Education trainer for the NAVIGATE First Episode of Psychosis Program, provided on-site training in Little Rock, Arkansas, for representatives from community mental health centers across the state. The two days of in-person training focused on the principles and techniques of working with families of individuals with first episode psychosis and helping them to be part of the recovery process. The interactive training included videos and hands-on activities such as modeling and role playing. Participants received a copy of the *NAVIGATE Family Education Manual* to use during and after the training.
- **Connecticut:** Consultants Lorna Moser, PhD and Stacy Smith, MEd, LPC, of the UNC Assertive Community Treatment (ACT) Technical Assistance Center, provided virtual and on-site training on monitoring adherence to fidelity standards for ACT, using the TMACT (*Tool for Measurement of ACT*). Webinars were conducted to orient staff to the fidelity tools. Subsequently, an on-site kick-off event was held for stakeholders, followed by a 2-day on-site review of a local ACT team.
- **National Webinar:** Wendy White Tiegreen, MSW, Director of Medicaid Coordination in the Georgia Department of Health and Developmental Disabilities, conducted a webinar on accessing Medicaid support for peer specialist services in diverse settings. Ms. Tiegreen shared lessons learned from Georgia, a state with a robust peer services workforce. Individuals interested in this topic who were unable to participate in the webinar can view an archived recording at: <http://www.nasmhpd.org/content/maximizing-medicaid-coverage-peer-support-services-lessons-learned-state-georgia>.

**To Request TA:** Submit your request into the on-line *SAMHSA TA Tracker*, a password-protected system. All of the State Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can grant authorization to other SMHA staff. Once on this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals that the state is seeking to address via this support. Users can also identify a specific consultant/expert with whom they would like to work. The log-in for the Tracker is: <http://tatracker.treatment.org/login.aspx>. If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: [tatracker@treatment.org](mailto:tatracker@treatment.org). For answers to other questions about making a TA request, please contact Pat Shea at [703-682-5191](tel:703-682-5191) or [pat.shea@nasmhpd.org](mailto:pat.shea@nasmhpd.org).

## Cooperative Agreements to Benefit Homeless Individuals (CABHI)

*Application Due Date: Tuesday, March 15, 2016 -- Anticipated Award Amount: Up to \$1,500,000*

*FOA Number: SM-16-007 -- Posted on Grants.gov: Wednesday, January 13, 2016*

*Funding Mechanism: Cooperative Agreement -- Anticipated Total Available Funding: \$19,576,000*

*Anticipated Number of Awards: Up to 30 awards -- Anticipated Award Amount: Up to \$1,500,000*

*Length of Project: Up to 3 years – No Cost Sharing/Match Required*

SAMHSA is accepting applications for FY 2016 [Cooperative Agreements to Benefit Homeless Individuals \(CABHI\)](#) grants. The purpose of this jointly funded program is to enhance and/or expand the infrastructure and mental health and substance use treatment services of states and territories (hereafter referred to as “states”), local governments, and other domestic public and private nonprofit entities, federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations, Urban Indian organizations, public or private universities and colleges, and community- and faith-based organizations (hereafter referred to as “communities”). CABHI grants will increase capacity to provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services; permanent supportive housing; peer supports; and other critical services for:

- Individuals who experience chronic homelessness and have substance use disorders (SUDs), serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring mental and substance use disorders (CODs); and/or
- Veterans who experience homelessness or chronic homelessness and have SUD, SMI, or COD; and/or
- Families who experience homelessness with one or more family members that have SUD, SMI, or COD; and/or
- Youth who experience homelessness and have SUD, SMI, SED, or COD.

Grantees are required to locate permanent housing for all individuals or families who experience chronic homelessness and veterans who experience homelessness or chronic homelessness served by the grant project. For families or youth experiencing homelessness, grantees are, at a minimum, required to link these populations to the U.S. Department of Housing and Urban Development (HUD) Coordinated Entry system, but are encouraged to permanently house these populations. Transitional housing is not permanent housing.

### ELIGIBILITY

Eligible applicants are:

- States and territories; Eligible state applicants are either the State Mental Health Authority (SMHA) or the Single State Agency (SSA). However, SAMHSA's expectation is that both the SSA and the SMHA will work in partnership to fulfill the requirements of the grant. To demonstrate this collaboration, applicants must provide a letter of commitment from the partnering entity in Attachment 5 of the application. If the SMHA and the SSA are one entity, applicants must include a statement to that effect in Attachment 5.
- Local governments; and
- Communities, which includes other domestic public and private nonprofit entities (e.g. federally recognized AI/AN tribes and tribal organizations, Urban Indian organizations, public or private universities and colleges, and community- and faith-based organizations).

Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

SAMHSA seeks to further expand the impact and geographical distribution of the CABHI-States program and the Grants to Benefit Homeless Individuals-Services in Supportive Housing (GBHI-SSH) program across the nation. **Therefore, grantees that received an FY 2014 (SM-14-010) or FY 2015 (TI-15-003) CABHI-States award or a GBHI-SSH award in FY 2014 or FY 2015 (TI-14-007) are not eligible to apply.**

**Proposed budgets cannot exceed \$1.5 million for states, \$800,000 for local governments, and \$400,000 for communities in total costs (direct and indirect) in any year of the proposed project.** Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

For contact information and application materials, go to <http://www.samhsa.gov/grants/grant-announcements/sm-16-007>.

# Applications Being Accepted for the FY 2016 Cooperative Agreements for System of Care Expansion and Sustainability

*Short Title: System of Care (SOC) Expansion and Sustainability Cooperative Agreements*

*FOA Number: SM-16-009*

*Posted on Grants.gov: Friday, February 12, 2016*

*Anticipated Total Available Funding: \$52,905,470*

*Anticipated Award Amount: Up to \$3,000,000 per year*

*Anticipated Number of Awards: Up to 53*

*Application Due Date: Monday, April 25, 2016*

*Length of Project: Up to 4 years*

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS), is accepting applications for [Fiscal Year 2016 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 to 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.

The goal is to continue CMHI efforts to ensure that its approach becomes the primary way in which mental health services for children and youth with SED are delivered throughout the nation.

## Eligibility

Eligibility for this program is statutorily limited to public entities, such as: state governments; Indian or tribal organizations; governmental units within political subdivisions of a state, such as a county, city or town; the District of Columbia government; and the U.S. territories).

Proposed budgets cannot exceed \$3 million for state applicants and \$1 million for political subdivisions of states, tribes, tribal organizations, and territories in any year of the proposed project.

## Cost-Sharing and Match Requirements

For the first, second, and third fiscal years of the cooperative agreement, participants must provide at least \$1 for each \$3 of Federal funds. For the fourth fiscal year of the cooperative agreement, participants must provide at least \$1 for each \$1 of Federal funds. Matching resources may be in cash or in-kind, including facilities, equipment, or services and must be derived from non-federal sources.

## Application Materials

You must respond to the requirements in both the FOA PART I and PART II when preparing your application.

- [FOA document Part I \(PDF | 711.49 KB\)](#)
- [FOA document Part I \(DOC | 421 KB\)](#)
- [FOA document Part II \(PDF | 446.67 KB\)](#)
- [FOA document Part II \(DOC | 160.5 KB\)](#)

**Note:** Grantees that received funding under the Cooperative Agreements for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances in FY 2013, FY 2014, and FY 2015, are NOT eligible to apply for this announcement. A list of current grantees ineligible to apply can be found in Appendix III of the FOA.

Nor may eligible state applicants for this grant choose local jurisdictions that have received a Cooperative Agreement for the Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances in FY 2013, FY 2014, or FY 2015. If a state applicant submits an application with a local jurisdiction that is a current grantee, the application will be screened out and will not be reviewed.

If a state applicant identifies a local jurisdiction that has submitted a separate application, SAMHSA will review and score both applications. If both applications are in the fundable range, the application with the highest priority score will be funded.

## [Capacity Building Initiative for Substance Abuse \(SA\) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults](#)

*FOA Number: SP-16-004*

*Posted on Grants.gov: Thursday, February 11*

*Application Due Date: Tuesday, April 19, 2016*

## Webinar Opportunity: Suicide Prevention Legislation and Schools

K-12 Session: Tuesday, March 1, from 1 p.m. to 1:45 p.m. EST.

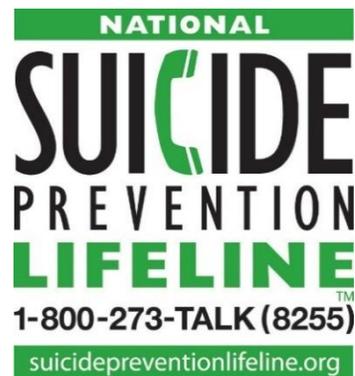
Higher Education Session: Thursday, March 24, from 1 p.m. to 1:45 p.m. EST.

Registration: <http://go.kognito.com/scottpoland>

Recent CDC data shows that youth suicide continues to be one of the top three leading causes of death in the 10 to 24 age group. Several states have passed legislation governing the role of school systems in addressing suicide prevention, but the legislation often does not incorporate best practices for suicide prevention programs.

This webinar series by [Kognito](#) will:

- address the current status and variability of school suicide prevention legislation in the United States;
- outline comprehensive best practice recommendations for state legislation; and
- provide a brief overview of litigation against schools resulting from student suicides, with a summary of lessons learned.



The presenter for the webinar, Scott Poland, Ed.D., Professor at the College of Psychology and Co-Director of the Suicide and Violent Prevention Office at Nova Southeastern University, is a world-renowned expert on school crisis and youth suicide. He has authored several books, including *Suicide in the Schools* (1<sup>st</sup> and 2<sup>d</sup> Eds.), as well as several articles on the subject. He is also past President of the National Association of School Psychologists and a Past Prevention Director for the American Association of Suicidology.

Prior to joining Nova Southeastern University, he directed psychological services for a large Texas school system for 24 years. He has appeared as an expert witness in several legal cases where school systems were being sued following a suicide. He has also testified before the U.S. Congress about the emotional and mental health needs of children.

The sponsoring organization, [Kognito](#), develops immersive learning web-based platforms. Attendees go through realistic scenarios at an individual pace and role-play real life situations by talking with virtual humans, building their skills in motivational interviewing and other evidence-based communication techniques.

## Flint, Michigan, and the Failure of Public Agencies (Opinion)

(Cont'd from page 2)

Effective public agencies are able to surmount all of these obstacles. Their leaders keep an eye out for the lurking crisis; they look outside for expert assistance when appropriate; they do not permit legal considerations to sap urgency; they react quickly to warning signs; and they embrace responsibility.

They do so not because they are sure to be rewarded for their actions at the end of the day, because there is no such assurance in public service. They do so because it's the right thing to do.

**About the author:** Joshua M. Sharfstein, MD, is Associate Dean for Public Health Practice and Training at the Johns Hopkins Bloomberg School of Public Health. He previously served as Secretary of the Maryland Department of Health and Mental Hygiene, as the Principal Deputy Commissioner of the US Food and Drug Administration, and as Commissioner of Health for Baltimore. He is a consultant for Audacious Inquiry, a company that has provided technology services and other support to Maryland's Health Information Exchange. A pediatrician, he lives with his family in Baltimore.

## NASMHPD LINKS OF NOTE

### [PREVENTION COLLABORATION IN ACTION \(SAMHSA\)](#)

SAMHSA's Center for the Application of Prevention Technologies has launched a new digital toolkit featuring collaboration success stories from SAMHSA grantees, resources and worksheets, and a search engine.

### [DEVELOPMENT OF THE COMMUNITY HEALTH IMPROVEMENT NAVIGATOR DATABASE OF INTERVENTIONS \(CDC\)](#)

In 2015, the Center for Disease Control and Prevention (CDC) released the Community Health Improvement Navigator to facilitate the development of a database of hospital community health needs assessments. This report describes the development of the database of interventions included in the Navigator, which allows the user to easily search for multisector, collaborative, evidence-based interventions to address the underlying causes of the greatest morbidity and mortality in the U.S.—tobacco use and exposure, physical inactivity, unhealthy diet, high cholesterol, high blood pressure, diabetes, and obesity.

### [PAYING FOR BEHAVIORAL HEALTH: THE ROLE OF THE AFFORDABLE CARE ACT \(CBHSQ REPORT\)](#)

ACA coverage expansion increased private insurance coverage of mental health treatment for young adults.

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## MEDICAL DIRECTORS LINK OF NOTE: "SOBER GRID" SMARTPHONE PEER-LOCATING APPLICATION

Sober Grid is a free smartphone app that enables people in recovery from alcohol and drug addiction to connect for 24/7, "on demand" peer support. The app has a large and growing community of 37,000 registered users across the country seeking to support one another in their management of the chronic disease of addiction. Sober Grid enables members to preserve their anonymity while finding others in their community and demographic to connect to in person or digitally. More information can be found at [Sobergridapp.com](http://Sobergridapp.com), and the app can be downloaded to mobile devices by following this link: [goo.gl/NglQWa](http://goo.gl/NglQWa)