CBO Estimates Implementing Alexander-Murray Would Reduce Federal Deficit $3.8 Billion

The Congressional Budget Office (CBO) has released a “score” of the Bipartisan Health Care Stabilization Act of 2017, the legislation drafted by Senate Health Education, Labor and Pensions Committee Chair Lamar Alexander (R-TN) and HELP Ranking Member Patti Murray (D-WA) to stabilize the individual insurance marketplace, would reduce the Federal deficit by $3.8 billion over 10 years.

The savings would result largely from rebates paid by insurers to individuals and the Federal government for too-high premiums approved by states and charged in 2018. Absent the CSR payments, Avalere Health estimates premiums for "benchmark" plans will be 34 percent higher than in 2017, in the 34 states using the Healthcare.gov exchange.

CBO also estimates that making catastrophic plans part of the single risk pool under the legislation would slightly lower premiums for other non-group plans, because the people who enroll in catastrophic plans tend to be healthier, on average, than other individual market enrollees. As a result of the slightly lower estimated premiums, CBO expects that federal costs for subsidies for insurance purchased through a marketplace established under the ACA would decline by about $1.1 billion over the 2019-2027 period.

However, the estimate released by the CBO October 25 suggests the legislation would not substantially change the number of people with health insurance coverage. And while the legislation would provide additional flexibility for states in applying for § 1332 Affordable Care Act waivers and speed the waiver approval process, the CBO states that the requirement that the cost of those waivers equal Federal subsidies that otherwise would be provided means no additional costs would result from additional waivers granted.

While the legislation would appropriate such sums as may be necessary to make payments for cost-sharing reduction payments (CSRs) to insurers through 2019, those payments are already in CBO’s baseline projections (totaling $18 billion for 2018 and 2019 and $99 billion over the 2018-2027 period), and would not affect direct spending or revenues relative to that baseline.

CBO acknowledges that the legislation would impose an intergovernmental and private-sector mandate limited under the Unfunded Mandates Reform Act (UMRA), but the cost of the mandates would fall below the annual thresholds established in UMRA ($78 million for intergovernmental mandates and $156 million for private-sector mandates) for 2017.

The cost estimate was released just as a Federal judge in San Francisco rejected a suit by 19 state attorneys general seeking to enjoin the President from ending the CSR payments. U.S. District Court Judge Vince Chhabria said the states had adequately prepared for the lost payments with various workarounds already in place.

Table of Contents
CBO Estimates Implementing Alexander-Murray Would Reduce Federal Deficit by $3.8 Billion

November 16 Webinar: The Ripple Effect of Opioids on Child Welfare
Joint NASMHPD-Treatment Advocacy Center Report Finds Adding Additional Psychiatric Beds Is Not Enough to Reduce Impacts of Serious Mental Illness
CMHS Funds FY 2018 Transformation Transfer Initiative (TTI) Grants; Applications Due TODAY, October 27
President Trump, Declaring Public Health Emergency to Address the Opioid Crisis, Promises Medicaid IMD Exclusion Waivers for Substance Use Disorder Treatment
November 15 Webinar Opportunity: First Episode Psychosis Resources: Focus on Effective Treatment Options
Technical Assistance Opportunities for State Mental Health Authorities
TA on Preventing the Use of Restraints and Seclusion
CDC Finds Rural Americans More Likely to Die by Suicide
October Children’s TA Network Upcoming Events
National Federation of Families for Children’s Mental Health Annual Conference, November 9 through 12
October Center for Trauma-Informed Care Trainings
SAMHSA Minority Fellowship Programs Application Dates
November 1 Webinar on Coping with Stress & Depression
November 9-12 Annual Conference on ADHD
November 1-3 NADD Annual Conference
75-House (10-Day) Certified Peer Specialist Training for Individuals Who are Deaf & American Sign Language Users
November 9 Centers for Medicare and Medicaid Services Special Open Door Forum - Medicare Card Project
Recovery to Practice CME Webinar Series: Clinical Decision Support for Prescribers Treating Individuals with Co-Occurring Disorders
May 2018 Annual Behavioral Health Informatics Conference
October 27 Older Adults Webinar Series: Collaborative Care Medicare Codes
New Resources Posted to the EIP Resource Center
NASMHPD Board & Staff NASMHPD Links of Interest

Congressional Work Days Left in 2017

House Work Days to Permanently Fund FY 2018 by December 8 – 20
Senate Work Days to Permanently Fund FY 2018 by December 8 - 24
The Ripple Effect of Opioids on Child Welfare

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

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

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

Register HERE

Jointly Released NASMHPD-Treatment Advocacy Center Report Finds Addition of Psychiatric Beds Is Not Enough to Reduce Impacts of Serious Mental Illness

An interconnected, evidence-based system of care is necessary to reduce the human and economic costs associated with severe mental illness. That is the central theme of Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care, a new report jointly issued by the National Association of State Mental Health Program Directors (NASMHPD) and the Treatment Advocacy Center.

The report makes 10 recommendations to policymakers for laying the foundation for improving the treatment system for individuals with severe mental illness. Among them are prioritizing development of a full continuum of psychiatric care, improving diversion of individuals with mental illness from the criminal justice system to the treatment system, penalizing hospitals whose emergency rooms treat psychiatric patients differently from other medical patients, and identifying public policies that act as disincentives for operating needed psychiatric beds.

“This report is a valuable contribution to our efforts to ensure sufficient treatment capacity to meet the acute, intermediate and long-term needs of individuals with mental illness,” said Elinore McCance-Katz, MD, Assistant Secretary for Mental Health and Substance Use at the Substance Abuse and Mental Health Services Administration, which provided funding for the project.

NASMHPD’s Executive Director Brian Hepburn says, “We are overdue to treat serious mental illness as we treat other medical conditions. Until we recognize and address these diseases with the same spectrum of outpatient and residential care that is routinely extended to other chronic and life-threatening medical conditions, individuals, families, and communities will suffer needlessly.”

Both NASMHPD and the Treatment Advocacy Center have consistently supported the vital role of psychiatric hospital beds for individuals with serious mental illness. In Beyond Beds, the organizations build on that important message to detail the different types of beds necessary to a functioning mental health system and describe how such beds fit into a comprehensive system of care that reduces negative consequences of untreated and undertreated serious mental illness.

Beyond Beds introduces nine other technical reports from NASMHPD on the aspects of a full continuum of psychiatric care. “Too often families confront overwhelming challenges when seeking psychiatric care for a loved one with a serious mental illness,” according to John Snook, Executive Director for the Treatment Advocacy Center. “This report and the ones that follow help to provide a roadmap for what a functioning system could look like, and details how providing a full continuum of services, including psychiatric hospital beds, could dramatically improve our current system of care.”

Nearly 10 million US adults are estimated to live with a diagnosable psychiatric condition sufficiently serious to impair their personal, social and economic functioning. Approximately half are untreated in any given year, according to the National Institute of Mental Health. Beyond Beds is grounded in the premise that people with serious mental illness deserve access to the same levels of care as individuals with other medical conditions.

Beyond Beds is co-authored by Debra A. Pinals, MD, Michigan’s medical director of Behavioral Health and Forensic Programs who contributes the perspective of an experienced mental health official, and Doris A. Fuller, who has been a professional mental illness treatment advocate as a Treatment Advocacy Center executive and a personal advocate as the mother of a young adult with serious mental illness.
CMHS Funds FY 2018 Transformation Transfer Initiative (TTI) Grants; Applications Are Due **TODAY**

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 today, October 27.

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

UPCOMING WEBINAR OPPORTUNITY

*First Episode Psychosis Resources: Focus on Effective Treatment Options*

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

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

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

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

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

**Register HERE**
President Trump, Declaring Public Health Emergency to Address the Opioid Crisis, Promises Medicaid IMD Exclusion Waivers for Substance Use Disorder Treatment

In invoking Federal statute 42 U.S.C § 247d to declare a public health emergency to address the nation’s opioid crisis, President Trump on October 26 promised rapid approvals of waivers of the Medicaid IMD exclusion sought by more than one-half dozen states.

In issuing his Presidential Memorandum, the President indicated in remarks that the actions to be taken would include “a new policy to overcome a restrictive 1970s-era rule [referencing the Medicaid IMD exclusion, as applied to substance use disorder treatment facilities] that prevents states from providing care at certain treatment facilities with more than 16 beds for those suffering from drug addiction.” The President said “A number of states have reached out to us asking for relief, and you should expect to see approvals that will unlock treatment for people in need. And those approvals will come very, very fast.”

States recently requesting at least partial waivers of the IMD exclusion include Arizona, Indiana, Illinois, Kentucky, Michigan, Utah, Virginia, and Wisconsin. Four states—California, Maryland, Massachusetts and New York—already have waivers of the IMD exclusion, according to Inside Health Policy.

The Centers for Medicare and Medicaid Services issued a State Medicaid Directors Letter in July 2015, entitled New Service Delivery Opportunities for Individuals with a Substance Use Disorder, which indicated such waivers could be made available as part of a continuum of care.

The emergency declaration was recommended by the President’s Commission on Combating Drug Addiction and the Opioid Crisis in an interim report issued on July 31. The Commission, chaired by New Jersey Governor Chris Christie, was created by the President March 29, by Executive Order. The Commission is due to issue a final report on November 1.

According to a White House Press Release, the Presidential Memorandum will authorize:

- expanded access to telemedicine services, including services involving remote prescribing of medicine commonly used for substance abuse or mental health treatment;
- the Department of Health and Human Services to more quickly make temporary appointments of specialists with the tools and talent needed to respond effectively to our Nation’s ongoing public health emergency;
- the Department of Labor to issue dislocated worker grants to help workers who have been displaced from the workforce because of the opioid crisis, subject to available funding; and
- the shifting of resources within HIV/AIDS programs to help people eligible for those programs receive treatment for substance use disorders, which the White House noted is “important given the connection between HIV transmission and substance abuse.”

President Trump’s public remarks and the written press release also noted related Trump Administration initiatives:

- The Centers for Disease Control and Prevention (CDC) has launched a multimedia Prescription Awareness Campaign featuring the real-life stories of people who have lost loved ones to prescription opioid overdose and people in recovery.
- The Food and Drug Administration (FDA) is imposing new requirements on the manufacturers of prescription opioids to help reverse the overprescribing that has fueled the crisis. Mr. Trump said the FDA is now requiring drug companies that manufacture prescription opioids to provide more training to prescribers to help prevent abuse and addiction, and has requested that one especially high-risk opioid be withdrawn from the market immediately.
- The Department of Justice (DOJ) Opioid Fraud and Abuse Detection Unit is targeting individuals that are contributing to the prescription opioid epidemic, and recently netted a significant opioid-related health care fraud takedown. DOJ also has secured the first-ever indictments against Chinese manufacturers of fentanyl, the synthetic opioid manufactured in China that is said to be 50 times stronger than heroin, and has seized Alpha Bay, a large Internet-based criminal marketplace for fentanyl and heroin.
- The State Department has secured a binding United Nations agreement making it harder for criminals to access fentanyl precursors.
- The National Institutes of Health has initiated discussions with the pharmaceutical industry to establish a partnership to investigate non-addictive pain relievers and new addiction and overdose treatments, as well as a potential vaccine for addiction.
- The Department of Defense, Department of Veterans Affairs, National Institutes of Health, and Department of Health and Human Services are collaborating on a six-year, $81 million joint research partnership focusing on non-drug approaches to managing the pain of service members and veterans.

Mr. Trump also announced that the U.S. Postal Service and the Department of Homeland Security are strengthening the inspection of packages coming into the U.S. to seize shipments of fentanyl. He said that, in two weeks, when he is in China with President Xi, he will mention staving the flood of fentanyl into the U.S. as a top priority.

He also complimented CVS Caremark for announcing last month it would limit first-time opioid prescriptions to seven-day supplies, and encouraged other companies to take similar actions to stop the epidemic.
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.

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.
Centers for Disease Control and Prevention: Rural Americans More Likely to Die by Suicide

According to study data published October 6 in the Centers for Disease Control and Prevention’s (CDC’s) Morbidity and Mortality Weekly Report, rural counties have significantly higher suicide rates than urban counties.

The study examined annual county-level mortality data from the National Vital Statistics System, including demographics, urbanization levels (rural, medium/small, or large metropolitan counties) and method of death from all death certificates filed in the U.S. during 2001 to 2015. The data showed that over one-half million suicides occurred during the study’s time period.

The researchers concluded that deaths by suicide in rural counties was 17.32 per 100,000 population in rural counties, 14.86 per 100,000 in medium/small metropolitan counties, and 11.92 per 100,000 in large metropolitan counties.

White non-Hispanics had the highest suicide rate in metropolitan counties, whereas American Indian/Alaskan Native non-Hispanics had the highest rate in rural counties. Suicide rates for non-Hispanic blacks were lowest in rural counties and highest in metropolitan areas.

Males were 4 to 5 times more likely to die by suicide than females across all three urbanization levels. Within age groups, suicide rates were highest among adults 35 to 64 years of age across metropolitan and rural counties. Rates of suicide by firearm were almost two times higher in rural counties than in large metropolitan counties.

Lead researcher, Dr. Asha Z. Ivey-Stephenson, from the Division of Violence Prevention, National Center for Injury Prevention and Control at CDC, and her associates suggest that the negative impacts (i.e., housing foreclosures, unemployment, and underemployment) of the Great Recession may have been more prevalent in rural counties, thereby negatively increasing a rural community’s suicide risk. James A. Mercy, Ph.D., Director of CDC’s Division of Violence Prevention, commented in the CDC press release, “The trends in suicide rates by sex, race, ethnicity, age, and mechanism that we see in the general population are magnified in rural areas. This report underscores the need for suicide prevention strategies that are tailored specifically for these communities.”

CDC released a technical package (policies, programs and strategies to prevent suicide) accompanying the study that includes programs tailored to meet the cultural needs of different racial and ethnic groups. For example, the package showcases a suicide prevention program, Sources of Strength, developed for rural and tribal communities in North Dakota to encourage community connectedness among youth and adults. In addition, the Health Resources and Services Administration (HRSA) has developed policies and resources for rural communities, including epidemiologic studies and telemedicine.

October TA Network Events

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 Delinquency Prevention’s (OJJDP) Juvenile Justice Model Data Project.

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

Call for proposals: The 31st Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health will be held March 4-7, 2018, at the Hilton Tampa (Fla.) Downtown Hotel. The call for proposals is now open! Proposals should focus on research benefiting children, youths, and their families. Submission deadline: Oct. 27.

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

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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<th>Application Period for the MFP- Masters Level Youth Focused Program</th>
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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
The entire ADHD community will convene in Atlanta at the 2017 Annual International Conference on ADHD. **CONNECT AND RECHARGE** is the theme of the first-ever joint CHADD and ADDA Conference, to be held November 9 through 12 at the Atlanta Hilton.

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

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

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

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**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.

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

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

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

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

For more information, visit the New Medicare Project website and Transcripts webpage.
Recovery to Practice Announces an On-Demand Continuing Medical Education (CME) Webinar Series

Clinical Decision Support for Prescribers Treating Individuals with Co-Occurring Disorders

This two-course series offers information and resources for physicians, clinicians, and other practitioners serving individuals with serious mental illness and co-occurring substance abuse disorder.

In this scenario-based series, participants meet "Nick," a young father with many strengths and who is challenged by both substance abuse and mental illness. The course explores the question: How do I approach Nick and help him meet his needs in ways that are both clinically sound and recovery-focused?

The faculty are national experts in recovery, including psychiatrists, a psychologist, a social worker, a nurse, and peers. They offer tools, tips, and strategies for addressing Nick’s needs, and those of other individuals facing similar challenges.

Course 1: Principles, Assessment, and Psychopharmacology in Recovery-Oriented Care

Course 2: Engagement, Staged Interventions, and Recovery Supports for Co-Occurring Disorders

Watch one or both courses at your convenience! Each course is approved for 1.5 AAFP (American Academy of Family Physicians) prescribed credits.

Course Objectives

After viewing, learners will be able to:

1. Summarize a recovery-oriented approach to the treatment of individuals with co-occurring mental and substance abuse disorders.

2. Describe the process of recovery-oriented, strength-based engagement, assessment, and intervention, including psychopharmacology treatment, for individuals with co-occurring mental and substance abuse disorders.

3. Describe non-medication recovery and support approaches for individuals with co-occurring mental health and substance abuse conditions.

Course Faculty

Curley Bonds, M.D.  Jackie Pettis, M.S.N, R.N.
Medical Director,  Advisor and Trainer for Psychiatry to Practice
Didi Hirsch Mental Health Services  Project

Wayne Centrone, N.M.D., M.P.H  Ken Minkoff, M.D.
Senior Health Advisor, Center for Social Innovation  Senior System Consultant, ZiaPartners, Inc.
Executive Director of Health Bridges International  Clinical Assistant Professor of Psychiatry,
Chris Gordon, M.D.  Harvard Medical School
Medical Director and Senior Vice President for  Executive Director, Center for Psychiatric
Clinical Services, Advocates, Inc.  Rehabilitation, Boston University
Associate Professor of Psychiatry, Harvard Medical
School

Melody Riefer, M.S.W., Senior Program Manager, Advocates for Human Potential
Older Adults Webinar Series: Collaborative Care Medicare Codes

Friday, October 27, 2 p.m. to 3:30 p.m. ET
With Support from the National Council on Behavioral Health

This webinar will focus on the recently introduced Medicare payment codes for collaborative care with a specific focus on the use within behavioral health contexts. The presenters will discuss the role of collaborative care in Medicare, identify and the application of new payment codes and behavioral health integration. There will also be time for questions.

Following the webinar, participants will:

- Understand the prevalence and impact of behavioral health conditions among patients in general medical settings;
- Understand the prevalence and impact of co-occurring behavioral health and physical health conditions;
- Recognize the elements of effective behavioral health integration, particularly the Collaborative Care model; and
- Recognize and understand the application of new Medicare codes for behavioral health integration including those that support Collaborative Care.

Presenters:

- **Moderators:** Christopher D. Carroll, M.Sc., Director of Health Care Financing and Systems Integration and Mitchell Berger, MPH, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Michael Schoenbaum, PhD, Senior Advisor for Mental Health Services Epidemiology & Economics, National Institute of Mental Health (NIMH), National Institutes of Health
- Lori Raney, MD, Principal, Health Management Associates

Questions? Contact: communications@thenationalcouncil.org

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

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

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

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

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

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

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

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

**Issue Brief: Substance-Induced Psychosis in First Episode Programming** by Delia 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.

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

To view the EIP virtual resource center, visit NASHPD’s EIP website.
The CDC reports that every day in the United States, one person dies every 16 minutes from an opioid overdose. State and local governments seek solutions to fight this epidemic that impacts citizens in every state, at all socioeconomic levels, and at every age.

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

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

Host: Bob Nevins, Director of Health and Human Services Strategy, Oracle. Moderator: Ann Flagg, Director, APHSA’s Center for Child and Family Well-Being.

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