The Department of Health and Human Services on September 28 posted the final version of revised regulations governing Medicaid and Medicare long-term care facilities. The regulations had not previously been revised in a comprehensive manner since September 1991, despite significant changes in the industry since that time. Since proposing to update the rules in July 2015, CMS says it received and reviewed nearly 10,000 public comments.

The final regulations take effect, in part, on November 28, 2016, in a phased-in implementation over three years. The regulations prohibit long-term care facilities from requiring residents to sign pre-dispute arbitration agreements as a condition of admission. Facilities and residents will still be able to use arbitration on a voluntary basis at the time a dispute arises, but the agreements will need to be clearly explained to residents, including that the agreement is voluntary and that the agreement may not be used to prevent or discourage residents and families from talking to authorities about quality of care concerns.

Other changes in the regulations are designed to help ensure that:

- long-term care facility staff members are properly trained on caring for residents with dementia and in preventing elder abuse;
- long-term care facilities take into consideration the health of residents when making decisions on the kinds and levels of staffing a facility needs to properly take care of its residents;
- facility staff have the right skill sets and competencies to provide person-centered care to residents;
- care plans developed for residents take into consideration their goals of care and preferences; and
- patient care planning includes discharge planning for all residents involving the facility’s interdisciplinary team and consideration of the caregiver’s capacity, giving residents the information they need for follow-up after discharge, and ensuring that instructions are transmitted to any receiving facilities or services.

D.C. Work Days Left in the 114th Session of Congress (2015-2016)

- 0 – House Work Days before Election Day
- 16 – House Work Days after Election Day
- 0 – Senate Work Days before Election Day
  (Senate Adjourned Earlier than the Originally Scheduled First Week of October)
- 20 – Senate Work Days after Election Day

Both Chambers Return November 14

Congress Approves Fiscal Year 2017 Continuing Resolution

President Obama on September 29 signed a Fiscal Year 2017 (FY 2017) Continuing Resolution (CR), passed by the House by a vote of 342-85 the previous evening.

The CR will fund the Federal government past September 30 at FY 2016 levels, minus one-half percent. The measure expires December 9. A full omnibus FY 2017 funding bill must be approved during the Lame Duck session of Congress, following the 2016 election.

The House vote followed Senate approval by 72-26 earlier on September 28. A Senate vote had been delayed several days by Democrats’ insistence that the bill include funding to address the Flint, Michigan, water crisis. The House voted 399-25, also on September 28, to include dollars for Flint in a separate water resources funding measure, H.R. 5303.

The C.R., which was amended into the Congressional legislative funding bill, H.R. 5325, includes $17 million for the Department of Health and Human Services (HHS) and $20 million for the Justice Department to start their programs under the Comprehensive Addiction and Recovery Act (CARA) of 2016, signed into law July 22. The funding level is well below the $1.1 billion sought by President Obama over two years.
Mental Health Advocacy Organizations Ask October 9 Presidential Debate Moderators to Seek Responses from Candidates on Mental Health and Mental Illness

A group of mental health advocacy organizations, led by the National Alliance on Mental Illness (NAMI), have sent an open letter to the moderators of the October 9 Presidential Debate, Anderson Cooper and Martha Raddatz, asking that they ask the candidates during the debate about their plans for addressing mental health and mental illness.

In addition to NAMI, the letter is signed by NASMHPD, the American Psychiatric Association, the American Psychological Association, the Eating Disorders Coalition, Mental Health America, , and Sandy Hook Promise. A social media campaign has been launched supporting the request with the hashtag #debates.

Six TTI Grants of $220,000 to be Awarded for FY 2017; Applications Due End of October

NASMHPD has received the good news that SAMHSA’s Center for Mental Health Services will fund another year of the Transformation Transfer Initiative (TTI). Administered by NASMHPD, the TTI provides, on a competitive basis, flexible funding awards to states, D.C., and the U.S. territories to strengthen cutting-edge programs.

For FY 2017, CMHS will award TTI grants of $220,000 to six (6) states or territories for projects related to developing, strengthening, or sustaining innovative projects or programs focusing on co-occurring intellectual/developmental disabilities (IDD) and mental health.

Application proposals must be submitted by October 31. If you have questions, please contact NASMHPD Project Director David Miller at david.miller@nasmhpd.org or 703-682-5194,

SAMHSA to Hold October 1 Public Meeting on CARA’s PA and NP Rx Training Requirements

On July 22, the Comprehensive Addiction and Recovery Act (CARA) was signed into law by President Obama. The new law authorizes prescribing privileges of covered medications in office-based settings by nurse practitioners (NPs) and physician assistants (PAs) for five years (until October 1, 2021).

The Substance Abuse and Mental Health Services Administration (SAMHSA) will hold a public meeting on October 1 from 9 to 11 a.m. to review and then discuss the training requirements for NPs and PAs that have been stipulated in CARA. At this meeting, SAMHSA will be seeking input on how to best implement the requirements that all NPs and PAs must have 24 hours of training before obtaining a waiver to prescribe covered medications. Organizations listed in statute and the general public may attend. SAMHSA is seeking input on existing training programs that may meet the statutory requirements for training and, within the 24 hours of training, the number of hours that NPs and PAs should have to complete on each topic listed in the CARA Act.

The session will be held in Newark, NJ. at the Newark Liberty International Airport Marriott, 1 Hotel Rd. Newark, NJ 07114.

Participation by Phone: Phone Number: 888-942-9687; Passcode: 5093420.


SAMHSA will post additional logistical information on how to participate in person, by phone, or on the web at: http://caralisteningsession.eventbrite.com in advance of the listening session.

For further information concerning the meeting, please contact: Dr. Mitra Ahadpour, Director, Division of Pharmacological Therapies, Center for Substance Abuse Treatment, SAMHSA, (240) 276-2134 or mitra.ahadpour@samhsa.hhs.gov.
NIMH Research Funding Opportunities

Research on Autism Spectrum Disorders (R21) (PA-16-386)

The purpose of this Funding Opportunity Announcement (FOA) is to encourage research grant applications to support research designed to elucidate the etiology, epidemiology, diagnosis, treatment, and optimal means of service delivery in relation to Autism Spectrum Disorders (ASD). An R21 grant supports early-stage exploratory studies of novel scientific ideas or new model systems, tools, or technologies that have the potential for significant scientific impact. Applications for R21 awards should describe projects distinct from those supported through the traditional R01 activity code. For example, long-term projects, or projects designed to increase knowledge in a well-established area, are not appropriate for R21 awards. Preliminary data are not required for R21 applications; however, they may be included if available.

Eligible Applicants: Public/State-Controlled Institutions of Higher Education and Private Institutions of Higher Education, nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education), nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education), small businesses, for-profit organizations, state governments, county governments, local governments, Indian/Native American tribal governments recognized and unrecognized, U.S. Territories, independent school districts, tribal organizations, public housing authorities, faith-based and community-based organizations, and Federal Agencies.

First Standard Application Receipt/Submission Date(s): October 16, 2016, by 5:00 PM local time of applicant organization.

Open Date (Earliest Submission Date): September 16, 2016

Expiration Date: September 8, 2019

The combined budget for direct costs for the two year project period may not exceed $275,000. No more than $200,000 may be requested in any single year. The total project period may not exceed two years.

Research on Autism Spectrum Disorders (R03) (PA-16-387)

The purpose of this Funding Opportunity Announcement (FOA) is to encourage research grant applications to support research designed to elucidate the etiology, epidemiology, diagnosis, treatment, and optimal means of service delivery in relation to Autism Spectrum Disorders (ASD). An R03 grant application may not contain extensive detail or discussion. R03 applications may include development of new research methodologies or technology, secondary analysis of existing data, and pilot or feasibility studies. Preliminary data are not required, particularly in applications proposing pilot or feasibility studies.

Eligible Applicants: Public/State-Controlled Institutions of Higher Education and Private Institutions of Higher Education, nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education), nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education), small businesses, for-profit organizations, state governments, county governments, local governments, Indian/Native American tribal governments recognized and unrecognized, U.S. Territories, independent school districts, tribal organizations, public housing authorities, faith-based and community-based organizations, and Federal Agencies.

First Standard Application Receipt/Submission Date(s): October 16, 2016, by 5:00 PM local time of applicant organization.

Open Date (Earliest Submission Date): September 16, 2016

Expiration Date: September 8, 2019

The combined budget for direct costs for the two year project period may not exceed $100,000. No more than $50,000 in direct costs may be requested in any single year. The total project period may not exceed two years.

Research on Autism Spectrum Disorders (R01) (PA-16-388)

The purpose of this Funding Opportunity Announcement (FOA) is to encourage research grant applications to support research designed to elucidate the etiology, epidemiology, diagnosis, treatment, and optimal means of service delivery in relation to Autism Spectrum Disorders (ASD).

Eligible Applicants: Public/State-Controlled Institutions of Higher Education and Private Institutions of Higher Education, nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education), nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education), small businesses, for-profit organizations, state governments, county governments, local governments, Indian/Native American tribal governments recognized and unrecognized, U.S. Territories, independent school districts, tribal organizations, public housing authorities, faith-based and community-based organizations, and Federal Agencies.

First Standard Application Receipt/Submission Date(s): October 5, 2016, by 5:00 PM local time of applicant organization.

Open Date (Earliest Submission Date): September 5, 2016

Expiration Date: September 8, 2019

The number of awards is contingent upon NIH appropriations and the submission of a sufficient number of meritorious applications. Application budgets are not limited but must reflect the actual needs of the proposed project. The total project period may not exceed 5 years.
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.
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](mailto:Pat.Shea@samhsa.gov) by email or at 703-682-5191.

**Destination Dignity Rally & March | October 10, 2016 | Washington, DC**

Join the March for Dignity and Change for Mental Health!

**TIME OF MARCH: 11 A.M. to 3 P.M.**

**STARTING POINT: Capitol Reflecting Pool / END POINT: Washington Monument**

The march will begin at the corner of 3rd St NW & Pennsylvania Ave NW. It will then head NW on Pennsylvania Ave for approx. 6 blocks (Pennsylvania Ave briefly merges w/ Constitution Ave NW, then resumes as Pennsylvania). At the end of the six blocks, it will head south on 15th St NW for approx. 2.5 blocks (until just past Madison Drive NW).
On September 29, the White House convened an event entitled “Making Health Care Better on Suicide Prevention.” The event was the fourth in a series of events held this year on “Making Health Care Better,” which have focused on advances in health care prevention, research, quality of care, and coverage during the Obama Administration, as well as the challenges still remaining. A June event focused on improving mental health care.

To kick-off this week’s event, the White House Domestic Policy Council (DPC) released a progress report, Making Health Care Better—Addressing Mental Health: Progress in Research, Prevention, Coverage, Recovery and Quality, that addresses how the Affordable Care Act and parity regulations have expanded resources and rights for people with mental health conditions.

The event itself featured presentations and two panel discussions on advancements in suicide research and prevention, access to care, and policy challenges impacting suicide prevention, as a means of updating stakeholders on the progress in implementing the 2012 National Strategy for Suicide Prevention.

The first panel presentation included the Veterans Health Administration (VHA), Indian Health Services (IHS), Substance Abuse Mental Health Service Administration (SAMHSA), and National Institute of Mental Health (NIMH) as well as representation from the private sector and nonprofits. Panel members highlighted how they are implementing goals 8 and 9 of the National Strategy for Suicide Prevention—promoting suicide prevention as a core component of health care services, and promoting and implementing effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors. The private-sector panelists reported on their efforts in embedding the Zero Suicide movement in their health care settings. A representative from the Trevor Project noted how they are reaching out to LGBTQ youth by utilizing youth-friendly digital platforms and promoting peer support.

The VHA representative reported the VA has embedded over 300 suicide prevention coordinators across the VA’s health care system, the largest health care system in the country. The VA is hoping to expand by the end of 2016 a policy of guaranteeing same-day mental health services that it is currently piloting in 90 VA health centers. The IHS representative focused on the importance of a community-based approach in the American Indian and Alaska native communities, focused on addressing historical trauma by promoting community resiliency. All panelists emphasized the importance of partnerships, data surveillance, and technology in moving the needle in reducing America’s suicide rate.

The second panel, which included NASMHPD staffer Leah Harris, focused on incorporating the voices of individuals with lived experiences into national suicide prevention efforts. Panelists, with National Suicide Prevention Lifeline Director John Draper moderating, shared personal stories of their suicide experiences and how those experiences had shaped their professional and personal lives. The panel recommended engaging people with lived experiences in shaping community suicide prevention efforts and the health care settings.

Ms. Harris suggested the trauma-informed care approach slogan of “It’s not what’s wrong with you, but what’s happened to you” and a focus on early adverse childhood experiences are the missing pieces in suicide prevention. She noted that the Adverse Childhood Experiences (ACE) study found that two-thirds of adult suicide attempts and 80 percent of youth suicide attempts could be attributed to ACE. She recommended suicide prevention programs encourage the message of healing, hope, and recovery.

**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.
NASMHPD has posted the 2016 Technical Assistance Coalition Assessment Working Papers on-line. Below is a synopsis of each paper, with the first eight Assessment Working Papers addressing multiple issues related to the use of technology in behavioral health. Assessment #9 is not a part of the technology compendium.

Assessment #1 - Clozapine Underutilization: Addressing the Barriers
While clozapine has demonstrated unique efficacy for the treatment of serious mental illness, its real-world use presents challenges to clinicians in a variety of settings, leading to its under-utilization. These challenges can best be addressed by understanding the benefits and risks of clozapine, its place in treatment, and the barriers that impact clozapine treatment. In addition to identifying specific barriers, this paper offers a series of recommendations for a variety of stakeholders that, if implemented, would promote access to clozapine, address barriers to its use, and improve the management of patients receiving clozapine.

Assessment #2 - Technology to Address the Needs of Justice-Involved Persons with Behavioral Health Issues
As states and counties struggle with workforce shortages and tight budgets for behavioral health services, the use of technology offers new opportunities for effective service interventions for justice-involved persons with a mental illness. This report highlights exemplary programs at the state and county level that are successfully leveraging the use of technology to expand service and program capabilities. The featured programs were chosen because they are using technology to maximize communication and data-sharing among stakeholders at various interception points along the Sequential Intercept Model.

Assessment #3 - Technology and Human Trafficking
Human traffickers worldwide use technology to recruit, exploit, and monitor their victims. They lure victims in Internet chats and forums, post online recruitment and classified advertisements, and use sophisticated anonymity software to cloak their identities. The victims are trafficked for sex and forced labor. As technology becomes more sophisticated so, too, do traffickers in using it to help them recruit victims, sell victims, and hide from authorities. However, that same technology is one of the best means for victims to reach out for help and receive help. This paper examines how the National Human Trafficking Resource Center is pioneering the use of technology to reach victims.

Assessment #4 - State Behavioral Health Authorities’ Use of Performance Measurement Systems
The evolution of technology has enhanced the abilities of state behavioral health authorities (SBHAs) to collect and analyze data for performance measurement. Improvements in technology have reduced the lag between the submission of data and the receipt of reports, allowing providers to more quickly address the needs of individual clients. While not there yet, the hope is that these performance measurement systems will evolve to ultimately allow for the implementation of performance medicine, which is “the tailoring of medical treatment to the individual characteristics of each patient.” This paper explains how SBHAs use performance measurement systems to inform policy and improve practice.

Assessment #5 - Promoting Young Adult Mental Health through Electronic and Mobile Technologies
Several technology-based mental health services and supports have been proven to be effective for young adults, but overall the field is in its early stages, with significant knowledge and practice gaps. In this paper, we explore the current role of technology in supporting the mental health of young adults, whether as a form of self-help, as a complement to formal treatment, or as a treatment itself. Also explored is the potential for technology to enhance young adult mental health through development and research.

Assessment #6 - Improving Community Options for Older Adults
With a rapidly growing older adult population, the need for long term services and supports (LTSS) and specialty mental health care will continue to increase. Dovetailing with the change in demographics is a national effort to improve and expand community based options for LTSS and reduce reliance on institutional long term care settings such as nursing facilities. With this national effort for states to rebalance their Medicaid LTSS systems, some states are making strides by improving the efficiency of their Preadmission Screening and Resident Review (PASRR) systems through the use of a secure web-based or electronic system and by developing a timely linkage between the PASRR and their broader access systems to LTSS.

Assessment #7 - Integrating Behavioral Health into Accountable Care Organizations: Challenges, Successes, and Failures at the Federal and State Levels
The concept of the Accountable Care Organization (ACO) as a public health program element was initially promoted as an option for the Medicare program and, as proposed, offered little room for participation by behavioral health providers, either as lead entities in forming ACOs or as participants in ACO networks. However, the incorporation and integration of behavioral health into the ACO model began to grow in design and popularity only after the Centers for Medicare and Medicaid Services (CMS) introduced the concept of the “Integrated Care Model” in a pair of 2012 State Medicaid... (continued on next page)
NASMHPD Posts 2016 Technical Assistance Coalition Assessment Working Papers

(continued from previous page) Director Letters. Although researchers have found significant interest in integrating behavioral health providers into the ACO model, challenges have been posed by behavioral health workforce shortages and the slow adoption of costly health information technology by behavioral health providers lacking access to the Medicaid and Medicare meaningful use provider incentives available to other types of providers. Even within ACOs striving toward achieving integration, levels of integration vary among sites.

Assessment #8 - Promising and Emerging Approaches and Innovations for Crisis Intervention for People Who Are Deaf, Hard Of Hearing, And Deafblind

This paper addresses the need for linguistically and culturally appropriate crisis interventions for people who are deaf, Deaf, late-deafened, deafblind, and, to some degree, hard of hearing. These interventions often include the use of technology. Research in suicide and suicide prevention in the Deaf Community is limited, so that it is generally not known that deaf people are at significant risk for depression and attempt or consider suicide at a significant rate. This paper provides background on the use of technology in communication for deaf people; highlights technological approaches that work and show promise; and provides recommendations for establishing linguistically and culturally appropriate crisis services for people who are deaf.

Assessment #9 - 2016 Compilation of State Behavioral Health Patient Treatment Privacy and Disclosure Laws and Regulations

As the Substance Abuse and Mental Health Services Administration (SAMHSA) prepared revised regulations updating the 42 Code of Federal Regulations Part 2 restrictions on the disclosure of confidential alcohol and substance use treatment patient records, the attorneys in the Legal Division of the National Association of State Mental Health Program Directors (NASMHPD) thought it might be helpful to compile, in one place, state laws and regulations impacting those same disclosures and Health Insurance Portability and Accountability Act (HIPAA)-related disclosures, in order to determine where state law might be more restrictive than the Federal law and rules.

VA Finalizes Regulations for New Loan Repayment Program for Psychiatrists Agreeing to VA Service

The Veterans Administration (VA) on September 29 published final regulations in the Federal Register governing an educational loan repayment program for psychiatrists that agree to two years of full-time, permanent employment with the VA. The regulations took effect on the date of publication.

The three-year pilot Program for the Repayment of Educational Loans (PREL) was authorized under § 4 of the Clay Hunt Suicide Prevention for American Veterans Act, Pub. L. 114-2, enacted February 12, 2015.

At the time of VA employment, applicants must be licensed or eligible for licensure to practice psychiatric medicine and in their final year of a post-graduate physician residency program.

A participant must agree to maintain an acceptable level of performance, as determined by supervisory review, in the position to which the VA appoints the participant, terms and amount of payment, and to relocate, at the participant’s expense, if required, to a location determined by the VA. The VA will provide a list of VA medical facilities available for assignment to an applicant at the time the acceptance of conditions is signed. The participant will then be allowed to choose and rank preferred locations, with the VA making the final assignment.

The VA will select at least 10 individuals to participate in the program each year, paying no more than $30,000, tax free, to a participant in any one year. Personal loans and home equity loans will not qualify for repayment.

Loans must pay for the actual costs of tuition and other reasonable educational expenses such as living expenses, fees, books, supplies, educational equipment and materials, and laboratory expenses.

Speaker Ryan Expects Lame Duck Session to Address Mental Health Reform

Speaker Paul Ryan (R-WI) told reporters on September 29 that the post-election Congressional agenda, which begins November 14, will include mental health reform legislation. His prediction was made after Senators signaled recently they've reached agreement on amendments to the Health Education, Labor and Pensions (HELP) Committee measure to improve the nation's mental health-care system, S. 2689, reported out of the HELP Committee at the end of April.

House lawmakers have been pressing the Senate to act on H.R. 2646, the House version of the HELP bill, sponsored by Rep. Timothy Murphy (PA-R), Rep. Murphy and Rep. Eddie Bernice Johnson (D-Texas) sent a September 22 letter, signed by 211 House members, to Senate Majority Leader Mitch McConnell (R-Ky.) and Minority Leader Harry Reid (D-Nev.) asking the leaders to “take up and pass” H.R. 2646.

Rep. Murphy told Bloomberg BNA on September 28 that he's hoping the Senate moves quickly in November to pass its bill so a conference committee can create a unified bill to send to the President. Alternatively, senators could simply amend the House-passed version and send it back to the House to concur. Democrats, led by Rep. Joe Kennedy (D-MA), want the bill amended to improve parity compliance through greater insurer transparency.
The Friend of the Field Award: Michael Botticelli, MEd, Director, White House Office of National Drug Control Policy (ONDCP)
This award was established by AATOD’s Board of Directors and recognizes extraordinary contributions to the field of opioid use disorder treatment by an individual whose work, although not always directly related to treatment of opioid use disorders, has had a significant impact on our field.

Nyswander/Dole "Marie" Award
AATOD will be honoring 10 individuals who have been nominated and selected by their peers for extraordinary service in the opioid treatment community. These successful award recipients have devoted themselves to improving the lives of patients in our treatment system. Dr. Vincent Dole and Dr. Marie Nyswander were the first recipients of this award in 1983.

- Ray Caesar, LPC, Oklahoma
- Spence Clark, MSW, North Carolina
- Alice Gleighorn, PhD, California
- Robert Kent Esq., New York
- Robert Lambert, MA, Connecticut
- Richard Moldenhauer, MS, Minnesota
- Kenneth Stoller, MD, Maryland
- Trusandra Taylor, MD, Pennsylvania
- Hoang Van Ke, MD, Vietnam
- Einat Peles, PhD, Israel

The Richard Lane/Robert Holden Patient Advocacy Award: Brenda Davis, MSW
This award honors the work of Richard Lane and Robert Holden. Both are recovering heroin-addicted individuals who changed their lives and the lives of many by establishing and managing Opioid Treatment Programs. Their work and commitment has shown that medication-assisted treatment does work. This award was established in 1995 and recognizes extraordinary achievements in patient advocacy.

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.
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NASMHPD Links of Interest

(Inclusion on this list should not be read to imply NASMHPD support for positions taken within the items linked.)

National Association of Medicaid Directors’ (NAMD) Memo to Congressional Staff on the Medicaid IMD Exclusion and the Center for Medicare and Medicaid Innovation’s (CMMI) Decision not to extend the Medicaid Emergency Psychiatric Demonstration (MEPD).

Estimates of the Top 15 Languages Spoken by Individuals with Limited English Proficiency for Each of the 50 States, D.C., and the U.S. Territories (for Purposes of Posting Notices of Nondiscrimination and Taglines Notifying Enrollees with Limited English Proficiency of the Availability of Language Assistance Services)


Electronic Tools for Use in the Continuum of Care for Patients with Addiction, Free Online Course, National Institute on Drug Abuse (NIDA) and Institute for Research, Education and Training in Addictions (IRETA)